He was seen again at 11.30 p.m. and at 9 the next morning, and on neither occasion was there any change.

Dr. Mackinlay saw him at 3 p.m., when he was sleeping. At 5 p.m. he got out of bed to try to get relief, and was again seized with intense pain, starting in the abdomen and shooting through to the back and up the right side. He was seen again about 6 p.m., when he was moaning a good deal; and turning him over in bed to examine him at once aggravated the pain, which was then mainly over the base of the right lung. At 7.30 he was seen by Dr. Weeks. There was then marked dullness at the base of the right lung, with absence of breath sounds. There was marked pulsation in the epigastrium, but no murmur. Up to this point we were in favour of ruptured duodenal ulcer into the lesser sac, but the evidence was not sufficient. Dr. Weeks did at one time think of aneurysm as a diagnosis, but as the patient's condition was not improved he was removed to the infirmary, Middlesbrough, where he was seen by Mr. Dickie at 9 p.m. After examining the patient Mr. Dickie was unable to arrive at a diagnosis, except that it might be some early chest condition, and advised no operation. The patient gradually became weaker, and died at 7 a.m. on November 4th.

A post-mortem examination was made the same afternoon. The right pleural cavity was full of blood, which was pushing the lung upwards. The left lung was normal; the heart was enlarged and fatty; the arch of the aorta was dilated and covered with calcareous patches. At the point where the aorta passes through the crura of the diaphragm there was an aneurysmal dilatation on the posterior side the size of an orange. It had eroded the eleventh dorsal vertebra to the depth of half an inch and the circumference of a two-shilling piece. The walls were firm, and looked like normal arterial walls. On the anterior wall and to the right there was a large perforation into the right pleural cavity. There was marked extravasation into the cellular tissues up the spine and into the abdominal cavity extraperitoneally. The liver was enlarged and fatty. The gall bladder contained a number of large stones. All the other organs were normal.

A CASE OF SPONTANEOUS HAEMO-PNEUMOTHORAX.

BY

THOMAS BUSHBY, M.B., M.R.C.P.,

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J. P., aged 17 years, a junior clerk in a commercial firm, was admitted to the Northern Hospital on July 21st, 1913.

Onset.

On the morning of July 21st, while running to catch a boat, he suddenly felt giddy, his legs gave way, and he fell over; being unable to rise, he was conveyed by ambulance to the hospital.

Condition on Admission.

He was in a state of profound collapse, with rapid shallow respirations, barely perceptible pulse, pinched features, and cold extremities. The percussion note over the whole of the left side of the chest was absolutely dull, with the exception of Traube's area, which was resonant; the heart was displaced to the right of the sternum nearly to the right nipple line; the breath sounds on the left side were inaudible. The condition of the patient precluded any very searching examination.

The patient was of poor physique, and his mother informed us that she had always considered him delicate, but that he had had no special illnesses, and had not been troubled by any cough.

Course.

On the following day the physical signs were much the same, except that resonance over Traube's area was now abolished. The collapse had in great measure passed off.

The left pleura was explored, and a syringeful of blood withdrawn.

In the course of a week or two, while the heart remained displaced well to the right of the sternum, the dull percussion note over the front of the left side of the chest became gradually replaced by a tympanitic note, extend-

ing to the level of the fifth space in the mid-axillary line, passing abruptly into absolute dullness; the level of dullness passed round to the back to the level of the eighth dorsal spine. There was free shifting of the level of dullness, the tympany in front being replaced by dullness on the patient being turned towards his face, and the basal dullness becoming changed to over-resonance. The breath sounds over the resonant area were greatly diminished; at places distant amphoric breath sounds were heard. The *bruit d'airain* was not obtained.

Subsequently the fluid reaccumulated till the left pleural cavity was once again filled to its full capacity; he was tapped, and a pint of deeply blood-stained fluid was removed. From this time he made steady improvement. After a period during which the physical signs of pneumothorax predominated, breath sounds returned and the heart resumed its normal position. He was discharged from the hospital on October 29th, at which time no morbid signs were observed, with the exception of impaired percussion and feeble breath sounds at the extreme base of the left lung.

REMARKS.

There was some suspicion of his being of the haemorrhagic diathesis. This was supported by the fact that troublesome bleeding had occurred on the occasion of teeth extraction, and by his statement that he bled freely from small wounds; there was, however, no record of any other case in the family history, and the bleeding from the extraction of teeth did not appear to have been of any great severity.

The case was regarded as one of rupture of the lung, probably due to a small superficial cavity, with simultaneous laceration of a small vessel.

LITHOPAEDION.

BY

JOHN B. FRASER, M.D., C.M.,

TORONTO.

EARLY in the year 1870 a small, active woman, then aged 25 years, who had had three children, became pregnant for the fourth time. Matters progressed as usual for six months, then seemed to stand still; later the milk left the breasts, fetal movements lessened, and finally ceased. Her girth decreased, and in a few months only a firm mass was felt at the brim of the pelvis.

Anxious and puzzled, she consulted a doctor, who doubted that she had been pregnant, and advised leaving the mass alone as long as no serious inconvenience was felt. She followed his advice, and as time passed she had four more children; at each pregnancy the mass rose with the growth of the fetus, and returned to its old position after the birth of the child.

In January, 1912, she consulted me for long-continued costiveness, which she said was increasing. She did not then tell me of the events of 1870. I tried cathartics with only temporary relief; then suspecting obstruction, an examination showed more than one mass in the pelvis. I advised an operation. She entered the Victoria Hospital, Toronto, and with Dr. C. H. Thomas an operation was performed in March, 1912. Dr. J. E. Forfar gave the anaesthetic, and we found a lithopaedion at the brim of the pelvis; the head was easily movable, but the lower part of the body was almost surrounded by firm cartilaginous bands attached to the uterus, omentum, and intestines. The calcified placenta was found opposite the third sacral vertebra, and so bound down by adhesions that it was difficult to remove it. To make matters worse, a fibromyoma had formed in a loop of intestine where it touched the placenta; thus we had to resect over 3 in. of the intestine; the adhesions made this much more difficult.

The head was covered by a thin membrane containing some blood vessels; the antero-posterior circumference was 8½ in. and the occipito-mentum circumference 9½ in.; the frontal, parietal, and occipital bones were well marked, and there was only a slight depression of the fontanelles; the eyes, nose, chin, and mouth were easily seen; the head was flexed and turned toward the left shoulder, and had a rough, stony feel. The legs and arms were flexed, with their outlines more visible on the right side;

the ribs on the right side were easily seen, but the spinal vertebrae were indistinct. The placenta, somewhat bi-convex, and with the centre more friable than the outer surface, measured $9\frac{1}{2}$ in. in circumference, and was $\frac{3}{4}$ in. thick in the centre.

At the time of the operation the patient was 67 years of age, and although the operation was unusually severe she made a splendid recovery, and inside three months was doing her own housework.

The case presented three interesting points: (1) The marked reduction in size and weight that took place during calcification. (2) The length of time it was carried by the mother, namely, forty-two years—possibly the world's record. (3) The comparatively slight disturbance it caused for almost forty years, and then only indirectly, as the costiveness was caused by the fibromyoma narrowing the lumen of the intestine to one-third of an inch.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

TREATMENT OF CHRONIC ULCERS OF THE LEG.

THE idea from which the treatment of chronic ulcer of the leg which I am about to describe was elaborated from an article which appeared many years ago in the *Midland Medical Miscellany*. It presents the following advantages: (1) The dressing is easily applied; (2) it is economical; (3) it can remain undisturbed (after the first two or three dressings) for a week, or even ten days; (4) the patient is not laid up, but can get about his ordinary avocations. The success of the plan is due entirely to its being founded on antiseptic principles, and, unlike the oxygen-immersion system demonstrated by Dr. Stoker at the annual meeting of the Association in 1895, it does not necessitate rest in bed.

When a patient comes for treatment I first of all see that the leg on which the ulcer or ulcers are situated is thoroughly well washed in warm water to which some carbolic acid has been added, using at the same time carbolic or other germicide soap; then, without drying the limb or handling the cutaneous surface in any way, the patient is told to place his heel on a low stool, and with an ordinary spray apparatus I thoroughly and effectually spray the whole surface, ulcers included, with pure sulphurous acid. Personally I have never varied the treatment in this respect, but I see no reason why solutions of carbolic acid or hydrarg. perchlor., or hydrogen peroxide, or picric acid, recommended in the *JOURNAL* (September, 1896) for burns and scalds, should not be used instead. I have not tried any of these alternatives, as the sulphurous acid has always succeeded so admirably. In this connexion it may be noted that Dr. Stoker, in a paper published in the *JOURNAL* for March 19th, 1898, stated that a healing condition in wounds did not set in so long as their reaction was highly alkaline. When the spraying is finished I usually fill up the ulcers, if they are deep, with boracic acid powder. The last stage of the dressing is now reached, and consists in applying strips of adhesive plaster from $1\frac{1}{2}$ in. to 2 in. broad and sufficiently long to equal a circumference and a half of the limb to which they are to be applied. This strapping begins from 2 to 3 in. below the lower border of the lowest ulcer, and is continued for the same distance above the upper border or edge of the highest ulcer if there be more than one. In order to make the strips adhere, and also to make them aseptic, they are, just before being applied, run through some hot water in a saucer to which carbolic acid, 1 in 20, has been added. A bandage is now applied from the toes to the knee, and the limb rested for a little time till the plaster dries.

The whole process does not occupy more than fifteen minutes, and the dressing need not be renewed for a week. Perhaps after the first and second dressings, and especially in the case of foul ulcers, it is well to ask the patient to return in a couple of days, when, if the dressing has become soaked with discharge or if the ulcer is painful, it would be well to remove the dressing and repeat the process as indicated. The removal of the

plaster is easily accomplished by seizing the lower border with a pair of dressing forceps and cutting it open with blunt-pointed scissors. When completely divided it readily peels off in one piece. I have generally found that the first dressing gives great and immediate relief in the case of those irritable ulcers where the pain is out of all proportion to its apparent cause, and where the patient may not have had a good night's rest for months. In most cases five or six dressings, extending over a period of one month, have usually been sufficient for the complete cure of a bad leg that has been a source of torment to its owner for years. I must admit failure in one case of a circular ulcer extending completely round the limb, and where, of course, there was loss of continuity of the skin.

Southport.

WM. ROBERT SPEIRS, M.B., C.M. Glasg.

ADDISON'S DISEASE TREATED WITH FRIEDMANN'S TUBERCULIN.

A TALL, spare woman, a shopkeeper, aged 59, of good family history, began to feel very languid and easily tired on exertion about two years before she came under my care. She got weaker and weaker, also lost flesh, and had a feeling of oppression in the chest and palpitation on the least exertion.

I was called to see her in the beginning of May, 1913. Her weight was then 9 st. 11 lb. She was very emaciated and anaemic, and complained of great weakness. There was a diffuse darkening of the skin, especially on the exposed parts, and around the nipples. The mucous membrane of the mouth was not pigmented. The heart's action was feeble, irregular, and quickened; there was no albumin or sugar in the urine; and the chest sounds were normal.

I ordered her complete rest, easily digested diet, and gave her injections of sodium cacodylate, but she steadily became weaker and the skin more pigmented—a diffuse darkening with dark patches throughout. Later, these dark patches became more marked on the extensor aspects of the legs. Iron tonics, cod-liver oil, and other measures were tried with no effect. For the heart I gave her Hoffman's digalen, as I believe it to have no haemolytic effect on the blood, and therefore considered it to be safer in the circumstances than digitalis. Her heart improved somewhat; as she showed a positive reaction with von Pirquet's test, I used Koch's T.O. and later T.E. in increasing doses, but with little or no benefit. Towards the end of May she had several attacks of diarrhoea, which left her still more prostrate.

As Koch's tuberculin had apparently failed, I gave my patient somewhat large doses of Friedmann's turtle tuberculin. This caused distinct focal and general reaction, and was followed by marked improvement in the general health. She began to put on flesh rapidly; the pigmentation quickly cleared up; the heart became stronger, and the temperature fell to normal within a short time. Her weight at the end of June increased to 9 st. 11 lb. The patient has continued to improve ever since, and, apart from slight cardiac weakness, she is in better health than she had been for years.

The case is interesting on account of the effect produced by Friedmann's tuberculin, after other forms of tuberculin had failed, and because for a considerable time the case looked quite hopeless.

Edinburgh.

A. COWAN GUTHRIE, M.B.

RAPID DELIVERY IN ECLAMPSIA.

I SHOULD like to draw attention to the advantages attending the use of dilators, such as Bozzi's or Mensinga's, for rapid delivery in eclampsia. I have treated several of these cases during upwards of twenty years' general practice, and have now discarded such temporizing measures as chloral and bromide, venesection, and transfusion, etc. (except as adjuncts), as I have had such good results from prompt emptying of the uterus.

If more than one fit occur, I prefer to give a full dose of morphine, and proceed to dilate under chloroform. Mensinga's instrument is equally good as the much more cumbersome and expensive one of Bozzi, and, though not provided with removable shoes, or shouldered ends, does not tend to slip out if properly introduced well within the internal os. If the external os will admit the tip of the finger, the instrument is introduced, and cautiously