

corresponding to the ilio-femoral band of the capsular ligament (which is most severely stretched when the thigh is over-extended, as when the trunk is flung violently backwards, the commonest cause of a sprained hip).

2. For the knee-joint, at the back of the lower edge of the internal condyle—in other words, at the posterior border of the internal lateral ligament, where it blends with Winslow's ligament, and where the semi-membranosus tendon is in intimate relation with it. These parts suffer most because, as Mr. Morris says, "During extension they resist rotation outwards of the tibia upon a vertical axis," and a sprained knee is almost always caused by a twist outwards of the foot.

3. For the shoulder at the point corresponding to the bicipital groove, because in nine cases out of ten a man sprains his shoulder to prevent himself from falling, his hand grasps the nearest support, the body is violently abducted from the arm, the long head of the biceps is called upon to exert its utmost restraining power, the bicipital fascia is overstretched, and the tendon very often displaced.

Again, for the elbow the painful place is at the front of the tip of the internal condyle; the fan-shaped internal lateral ligament has its apex at that point, and it is most stretched in over-supination, with extreme extension of the forearm. On the front of the external malleolus, at the apex of the plantar arch, the tip of the fifth metatarsal bone, the styloid process of the ulna, the inside of the thumb, and the annular ligament in the front of the wrist, are respectively the most painful spots when those joints are severally sprained.

The manipulative part of the treatment of joints stiff from being sprained may be briefly said to consist in pressure over the part most injured, and momentary extension of the limb, followed by sudden forcible flexion. The method of doing it varies with each joint, and I can with confidence refer you to the descriptions given by Dr. Wharton Hood, as being faithful word-pictures, supplemented, too, by very accurate drawings.

The following are some of the lesser injuries the non-recognition of which has frequently come under my notice at Whitworth. In the upper limb: Fracture of the tip of the acromion; partial luxation of the acromio-clavicular and sterno-clavicular joints (often happening to men who carry weights on their shoulders); partial dislocation of the long head of the biceps, with over-extension of the bicipital fascia (common in men who throw weights or use a shovel, as malsters or navvies). Dislocation of the head of the radius forward on the condyle, which is very common in children, and has a marked tendency to cause stiff elbows; fracture of the tip of the internal condyle; overlooked Colles' fracture; partial luxation of the head of the ulna (impeding supination of the hand, and having a tendency to gradually grow worse); severe sprain at the carpo-metacarpal joint of the thumb (very common in stonemasons, and caused by the "jar" of heavy chisels).

In the lower limb: Fracture of the fibula just above the malleolus and at its tip (these are fruitful sources of lameness, often overlooked, and, if of old standing, very troublesome to treat); partial rupture of the ligamentum patellæ at its insertion into the tubercle of the tibia, which is much more common than is ordinarily supposed;<sup>3</sup> neglected overstretching of the ligaments of the plantar arch, and tearing of the plantar ligament at its insertion into the os calcis; rupture of the penniform muscular attachments of the tendo Achillis, and muscular hernia in the calf.

I trust I shall be forgiven if I have dwelt too much on the *étourderie* of some of us, but I am sure so-called trifling injuries deserve more attention at our hands, since living at the high pre-sure men do nowadays, with every part of their bodies tested to its utmost capacity, the slightest impairment of the mechanism of a limb must be an incalculable source of personal annoyance, discomfort, or disability.

<sup>3</sup> I have seen almost complete rupture unrecognised; while tearing of the ligament from its extensive insertion into the surface of the tibia is very frequent.

## CONGENITAL CYSTIC HYGROMA.<sup>1</sup>

By EDMUND OWEN, F.R.C.S.,

SURGEON TO ST. MARY'S HOSPITAL.

IN the volume of the Transactions of the Medical and Chirurgical Society for the year 1839 is a paper by Mr. Cæsar Hawkins upon the subject of the present communication. It is, so far as I know, the first treatise that we have upon these cystic growths, and I very much doubt if any matter of importance, either as regards their pathology, diagnosis, or treatment, was left by Mr. Hawkins for future writers to fill in.

Congenital cystic hygroma is by no means of unfrequent occurrence, and it is strange that so little notice is taken of it in our works on general surgery.

The first case to which I will direct attention is that of the little girl that has just been examined by the meeting. She is now between three and four years old. A few days after birth her mother noticed a swelling under the right side of the tongue, which, on being shown to the doctor who attended her, was called a "ranula." He refused, however, to interfere with it. The supposed ranula grew, extending across the floor of the mouth and amongst the muscles behind the symphysis of the maxilla, until a definite tumour appeared against the angle of the jaw. The little patient was then brought to me, when I told the mother that nothing was to be done to the tumour, which, as it was growing rapidly, might entail serious consequences. My impression is that this enormous mass has now ceased to grow. It is certainly harder than it was, though its cystic nature is still quite evident. It is not tender, nor does it apparently interfere with the child's health or with the nutrition of the skin. I am still content to watch and wait.

The second case is that of a boy of five months who was under my care at the Children's Hospital. He had a cystic hygroma of the size of a walnut in each subclavian region and in each axilla; it was doubtful whether the upper and lower tumours were in communication. Mr. Thomas Smith saw the child with me, and we agreed that no active treatment should be undertaken. When I next saw the little patient, after an interval of three weeks (the mother lived at a distance, and was not led to expect much from treatment), the upper pairs of tumours had almost met across the episternal region; there was difficulty on swallowing, and commencing oedema of the eyelids and of each upper extremity. Translucency showed the cystic nature of the superficial part of the subclavian masses. A week afterwards the mother came to tell me that the child had died on the previous day, and that the tumours had gone on growing so that at last the child could hardly breathe. She said also that the oedema of the hands and arms had gone on increasing until the day before the death, and that the legs and thighs had towards the last days also begun to swell. Her opinion was that death was caused by suffocation. No post-mortem examination was made.

Here, then, are reports of two cases of, so far as one can tell, a similar pathological nature, in one of which fatal complications brought on a sudden termination, whilst in the other a quiescence which one hopes is genuine seems to point to the fact that activity of growth has given place to spontaneous degeneration or atrophy. It is impossible to say what course a cystic hygroma may take; whether it is about to undergo immediate or future growth, or whether it is about to undergo interstitial changes which shall reduce it to a "loose pendulous bag of fat." Inflammation of the tissues, either spontaneous or induced, will at times determine their atrophy, and from the increasing hardness in the case of the little girl, I suspect that such a change is at hand. As Mr. Hawkins remarked, some of these tumours look as if they could be easily dissected out, but to remove one from the neck the operator may have to work around the carotid vessels and possibly behind the pharynx. I once dissected such a tumour from the side of the chest, and even then I had to root it out from beneath the border of the latissimus dorsi. Mr. Hawkins suggested that their treatment should consist in puncture of the larger cysts, and in the application of pressure and counter-irritants. To which

THE MUSICAL SOCIETY OF UNIVERSITY COLLEGE, LONDON.—This Society, having secured the co-operation of Mr. Alberto Randegger, will hold its first practice meeting in the Mathematical Theatre on Friday, November 24th, at 4.30 P.M.

<sup>1</sup> Read before the Medical Society of London, Nov. 6th, 1882.

one might perhaps add that in certain cases atrophy may follow the inflammation caused by the presence of one or more setons through the mass. Probably spontaneous inflammation is their most desirable complication.

In conclusion, I would remark that, as in the first case, a congenital cystic hygroma in the sublingual region may be mistaken for a ranula, an error in diagnosis which is more likely to lead to disappointment than to damage. That in whatever situation it may occur it is apt to be mistaken for a subcutaneous nævus, or for one beneath the mucous membrane; and, lastly, that at times the resemblance to a fatty tumour is extremely close.

A second child exhibited possesses the remains of a hygroma on the arm. The patient has been three years under observation, but the mass, which now resembles a diffuse fatty tumour, was, when first under observation, of evident cystic formation. This is the only instance which I have seen of a congenital cystic hygroma situated upon an extremity; their favourite seat is the armpit and the floor of the mouth.

Seymour-street, W.

## PENETRATING WOUND OF THE ORBIT, INVOLVING THE BRAIN;

NO MARKED SYMPTOMS UNTIL THE THIRD DAY.

By ENGLEDEU PRIDEAUX, L.R.C.P., M.R.C.S., &c.

W. T—, aged twelve, was playing with two other boys on the morning of Feb. 24th. The boys had hazel sticks about two feet long and half an inch in diameter, pointed at one end and cleft at the other, and in the cleft they fixed stones. One boy in slinging his stone let the stick slip, which went off with the stone and struck the patient in the right eye, entering by the pointed end. The boy pulled the stick out and walked home, about a mile, and told his father he had been struck in the eye. His mother bathed the eye, which appeared uninjured, and thought no more about it. They remarked that blood came from his nose and mouth. However, the boy remained well until the following Saturday. When he got up that morning his eyelids were so swollen he could not open them; he complained a good deal of pain. His eye was poulticed, but he was not kept in bed. He took his meals; and beyond complaining of the pain was not otherwise affected. In the evening, after he had taken his tea and gone to bed, he was found insensible, and I was sent for. When I arrived the boy was quite unconscious and very restless, turning over and over. Pulse 120, regular; temperature 101°. The eyelids were so much swollen I could not open them. A little pus was oozing out at the inner angle of the eye and some coming down the nostrils. He was quite unable to swallow. I placed a little calomel upon his tongue. The next morning he was quieter, his attention could be arrested by shouting to him. I got him to swallow a few spoonfuls of milk. Pulse and temperature the same. He died the same night, becoming more and more comatose during the day.

I made a post-mortem examination, and found a small external penetrating wound at the inner angle of the eye, but all the structures of the eyeball were quite uninjured. Internally I found a small ragged hole, large enough to admit the little finger, at the junction of the sphenoid and ethmoid bones. The under surface of the anterior lobe of the right cerebrum was completely destroyed. On placing the brain in water it all washed away, leaving a large ragged cavity the size of a duck's egg, and in which were two pieces of bone each as large as a threepenny piece. The whole brain was highly congested, with a patch of fresh lymph as large as a shilling under the dura mater at the vertex.

Wellington, Somerset.

**PRESENTATION.**—On the 9th inst. Dr. Scott Orr, on behalf of the nurses of the Glasgow Royal Infirmary, presented Dr. Thomas, for fifteen years superintendent of the infirmary with a large and handsome silver tray, bearing a suitable inscription. The testimonial was given as a token of the regard of the donors for Dr. Thomas, and as an evidence of their high sense of the efficient manner in which his various duties had been performed, and of the kindness which he had invariably shown to them.

## A Mirror

OF

## HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

### MIDDLESEX HOSPITAL.

#### TWO CASES OF FRACTURE OF THE SKULL IN YOUNG PATIENTS.

(Under the care of Mr. GEO. LAWSON.)

THE two following cases show from what severe injuries of the head young patients may recover. In the first case there was an indented fracture of the skull; and although there was a considerable depression of bone, yet, with the exception of a slight drowsiness for a few hours after the accident, the child had no cerebral symptoms, and left the hospital after three weeks quite well; indeed, he was only detained in the hospital because it was probable that some head symptoms might arise. The second case is very remarkable. The child fell the height of seventeen feet from a loft on to the stones below. There was without doubt a fracture of the vertex extending into the base of the skull, as was evidenced by the repeated vomiting of blood, the altered shape of the skull, and the intense and prolonged coma. The child was admitted on September 30th in a state of deep coma, and she remained in a state of unconsciousness five days, until October 5th, and unable to swallow any food except three teaspoonfuls of milk on the afternoon of the 4th. During this period she was fed with nutrient enemata. To account for this prolonged insensibility there must have been severe brain lesion, and yet the child has recovered, and now, without any apparent discomfort, is able to play with her toys, and behave as if she suffered no inconvenience from the injury. Another interesting point in the case is the time which elapsed before she was able to speak. It was not until the sixteenth day after the accident that she could be induced to answer any question, although, apparently, she often tried to say something.

**CASE 1.** *An Indented Fracture of Skull; very Slight Head Symptoms; Recovery.*—John G—, aged sixteen months, was admitted into Bird ward on July 8th, 1882, with an indented fracture of the skull. Shortly before being brought to the hospital the child fell off a high stool, and in his fall his head came into direct contact with the abrupt end of the leg of another stool which had been overturned.

*State on admission.*—There was a depression in the skull just above and to the left of the occipital protuberance, which corresponded exactly to the end of the stool. The depression was about one-tenth of an inch deep, visible to the eye, and the sharp edge of the surrounding bone could be easily felt with the finger through the integument. The child seemed drowsy, but, with this exception, there were no cerebral symptoms. The anterior fontanelle was not completely closed, but the posterior fontanelle was quite filled in with bone. An ice-bag was applied to the head, and the child kept quiet in bed.—9th: The child seems very well, and in no way affected by the accident. He soon recovered from the drowsiness, and eats and sleeps well, and plays well.—20th: The child has been kept in the hospital lest head symptoms might arise. He is very well and cheerful. The indentation, so marked on admission, is much less, the depressed bone having been partially raised towards the surface.—31st: As the child seems quite well he was discharged from the hospital. There was still a slight depression of the bone.

**CASE 2.** *Ethel D—*, aged six, was admitted into Bird ward on Saturday afternoon, September 30th, 1882, having just fallen from a stable loft on to the stone paving below, a height of seventeen feet. She was standing on a chair playing, when she tipped forwards and fell head foremost on to the paving, her head first striking the ground.

*State on admission.*—The child was in a state of profound coma. The left side of the head was very large from an extensive hæmorrhage beneath the scalp. Soon after her admission she vomited a quantity of blood, and twice the next day threw