hearing involvement. On opening the orbits from above the orbital tissues were found to be very cedematous, but with the exception of an increase in the orbital fat otherwise normal. The lateral ventricles and choroid plexuses were normal. There were nowhere signs of meningeal tubercle.

The conclusion arrived at as a result of the operation and autopsy was, that this condition originated probably in an attack of cerebro-spinal fever some years previously which had cleared up and left a thickened pia-arachnoid which interfered with the return flow of lymph from the orbit. The condition, in fact, seemed to be one of lymphatic oedema of the orbital tissues with most pronounced bilateral exophthalmos.

A CASE OF SARCOMA OF THE KIDNEY IN A YOUNG BOY.

BY FRANK M. HUGHES, M.D. BRUX., M.R.C.S. ENG.

SARCOMA of the kidney being unusual at an early age makes the following case worth recording.

A boy, aged 4 years, was brought to see me recently, with the following history: Six weeks previously he had fallen over a brick on to his abdomen. He was carried home and was unable to sit up for a week. There were no signs or symptoms of injury and no vomiting. A week after the injury he was able to walk, and shortly afterwards appeared quite to have recovered. The child was brought to see me because his mother had noticed a large swelling on the left side of his abdomen displacing the lower ribs and extending downwards on the left side. She had observed this when bathing him a week before.

On examination I found a large hard swelling extending from the left loin down to the anterior superior spine. It was quite painless on palpation and dull on percussion. The child had obviously recently lost much weight. X ray examination showed a mass extending from the left loin down to the anterior superior spine and across the abdomen and up towards the right renal region. The diagnosis of sarcoma of the kidney was confirmed by Sir Hugh Rigby and Dr. Cecil Wall. Laparotomy was considered inadvisable. Autopsy was refused.

The case is of interest in comparing the diagnosis with that of a diagnosis of congenital cystic kidney.

A CASE OF STRANGULATED INGUINAL HERNIA COMPLICATED WITH TORSION OF AN UNDESCENDED TESTICLE.

BY C. P. G. WAKELEY, F.R.C.S. ENG.,
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THE following case is sufficiently rare to merit record:—

A youth, aged 19, was admitted to King's College Hospital in April, 1922, complaining of a swelling and pain in the right groin. On the day previous to admission, while the patient was lifting some heavy boxes, he experienced an acute pain in the right inguinal region and fainted. He was taken home to bed; he vomited most of the night and was sent up to hospital next day. On admission there was a swelling the size of a hen's egg in the right inguinal canal; it was very tender and the skin over it was cedematous. It was seen that there was only one testicle in the scrotum and the patient stated that he had never noticed more than one testicle. There was a purulent urethral discharge. At first it appeared that the case might be due to a gonococcal epididymitis in an undescended testicle; but the vomiting and fainting attack on the previous day suggested a bowel condition. An incision was made over the swelling in the direction of the inguinal canal, the right testicle was exposed, and behind it was a knuckle of acutely inflamed small intestine. The right testicle was of an almost black colour and was twisted on its cord. It was not thought justifiable to try and perform an orchidopexy, owing to the very inflamed condition of the testicle; also the vessels in the cord appeared to be thrombosed. Consequently, an orchidectomy was performed, and the loop of gut, after enlargement of the opening into the abdomen, was found to assume a more normal colour, so it was returned to the abdomen. The inguinal canal was completely repaired.

Recovery was uneventful. A microscopic section of the testicle showed hæmorrhages throughout the organ.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

SECTION OF ORTHOPÆDICS.

EXHIBITION OF CASES.

A MEETING of this section of the Royal Society of Medicine was held on Nov. 7th. In the absence of the President (Mr. T. H. OPENSHAW), Mr. E. LAMING EVANS was in the chair.

Mr. H. A. T. FAIRBANK showed two cases of

Ischæmic Paralysis.

The first was a boy, aged 11, who had sustained a supracondylar fracture of the right humerus in May, 1918, which was treated "for a few weeks" by splints; on the removal of the splints contraction of the fingers and thumb was noticed. Massage was given without benefit. In August, 1918, operation was performed at a provincial hospital and some bone removed, and this was followed by prolonged massage and electrical treatment. On admission to the Hospital for Sick Children in April, 1922, there was marked flexion of the fingers and thumb; extension could not be performed voluntarily and passive extension was only possible when the wrist was flexed. There were no sensory changes and no wasting of the intrinsic muscles of the hand, but there was general wasting and weakness of the forearm muscles. The contracture of the flexors was so marked that a diagnosis of ischæmic contracture was made, although no definite hardness of those muscles was detected. Very great improvement resulted from treatment by gradual stretching on plaster slab and metal splint, coupled with treatment in the physio-therapeutic department, and complete cure was anticipated.

The second case was that of a boy, aged 9, who sustained a fracture of the lower end of the right humerus in December, 1921. No history of the treatment then received was available. He was admitted to the Hospital for Sick Children in January, 1922, with typical ischæmic contracture of the right forearm. There was flexion of the wrist and interphalangeal joints with some hyper-extension of the metacarpo-phalangeal joints, all of which were stiff with only a small range of painful movement. The long flexors of the hand were just acting but there was no power in the interossei. The general nutrition of the hand was very defective and the skin purple. Sensation to cotton-wool was lost over the whole hand on both aspects and to pin prick over the same area except over the hypothenar eminence and the ulnar side of the dorsum. Radiograms showed an old supracondylar fracture in very bad position. Only 10° of movement from 90° to 100° were possible at the elbow-joint; there was a scar apparently from a deep pressure sore on the anterior aspect of the forearm. Treatment on the same lines as that adopted for the other case had produced considerable improvement; but there was still anaesthesia in part of the median nerve distribution, and the median intrinsics remained almost completely paralysed; while movements at all the joints were defective, and there was only slight power in the long flexors. Mr. Fairbank invited opinions as to whether or not the median nerve should be explored.

Mr. W. R. BRISTOW thought exploration of the median nerve should certainly be carried out with the object of obtaining a return of the valuable median sensation in the hand. The physiological division of the nerve was probably in the region of its muscular branches to the pronator radii teres and long flexors, so that little could be done to secure a return of muscular power. Mr. Bristow also showed sections illustrating the differences in the changes which took place in muscle: (a) in a peripheral nerve lesion, and (b) in ischæmic contracture.