Family history.—The father and mother were born in Ireland. The father died at the age of 37 years from pneumonia. The father had four sisters, all of whom came to the United States, where they married and reared large families. The paternal grandmother reared a family of 14 children and each of her seven sisters married and bore children. The mother, now 64 years old, married at the age of 25 years, bore these three daughters, and is exceptionally well preserved. There is no history of any of her sisters or relatives having been afflicted with abnormality of the organs of reproduction. The great-grandmother had four sisters who married and each bore children.

CASE 1.—Miss X., aged 22 years, complexion fair, eyes blue, hair and eyebrows heavy brown, features perfect (decidedly feminine), height 5 feet 9½ inches, weight 136 pounds, a clerk, was born in Philadelphia. She had always enjoyed perfect health, except for an attack of diphtheria at the age of 17 years. She first consulted me for cardiac palpitation and general weakness; at which time the diagnosis was secondary anæmia, probably induced by overwork and too close confinement. Following treatment her erythrocytes increased from 3,200,000 to 4,600,000 per cubic millimetre; the hæmoglobin from 72 to 88 per cent.; while the leucocytes remained at approximately 10,000 per cubic millimetre. I was informed that menstruation had never been established and was further told that two older sisters, one 33 and one 27 years of age, had likewise never menstruated. Six months later Miss X. again consulted me for secondary anæmia which yielded promptly to treatment. Both this woman and her sister, Case 2, experienced periodic attacks of tenderness of the breasts, but I was unable to get any definite history as to the intervals between such attacks. Case 3 noticed her breasts to be unusually sensitive for some months after her marriage but could not recall that these attacks were at or near the time she vomited blood. In 1904 I suggested to the mother that a vaginal examination should be made, which was accordingly done with the following findings. There were but few light hairs surmounting the mons Veneris and the labia were normal. The clitoris was of normal size and appearance and possessed the sensation normal to this organ. The mucous membrane of the vulva and vagina was lubricated with a mucous exudate and was normal in every respect. The vagina permitted the introduction of three fingers for its entire length of three and three-quarter inches. At a point corresponding to the normal position of the cervix the vagina terminated as a closed sac, but the calibre of the vaginal canal remained uniform throughout. By bimanual examination it was impossible to detect any uterus, nor was it possible to induce pain or to elicit tenderness by firm pressure in the ovarian regions. Vaginal examination by the use of a speculum showed the vagina to terminate abruptly. There was no intimation of a cervix uteri, nor were there indentations, scars, or fissures in the vaginal wall.

CASE 2.—Miss J., aged 27 years, complexion fair, brunette, features fine and decidedly feminine, temperament hysterical, height 5 feet 4 inches, weight 120 pounds, occupation housework, was born near Philadelphia. She had the ordinary diseases of childhood, including scarlet fever. Her health had been perfect until the age of 23 years, since which time she had suffered at intervals from facial neuralgia. Most interesting in connexion with this case is that at puberty (13½ years) she developed a tumour of the abdomen which grew steadily for a period of two and a half years. Both the patient and her family claimed that her abdomen became so markedly distended that they consulted three physicians, each of whom made a vaginal examination and reported that they were unable to find the cervix uteri. The tumour developed mostly on the right side of the abdomen and, according to the mother's description, reached to the lower border of the right costal margin. Once each month during the existence of this tumour she had profuse hæmorrhages from the nose and upon three occasions she vomited a small quantity of blood. At the age of 16 years she noticed that her abdomen was decreasing in size and by the twentieth year the tumour had apparently disappeared. There had never been vaginal hæmorrhage. Vaginal examination revealed essentially the same conditions described in the report of Case 1 of this series, except that the hair of the pubic region was heavy and black and the labia majora were decidedly thicker (hypertrophied). The length of the vagina was two and five-eighths inches. The hymen was intact and displayed a central opening.

CASE 3.—Mrs. K., aged 33 years, brunette, a widow,

married at the age of 25 years, height 5 feet 5½ inches; her weight at the time of marriage was 120 pounds; and her present weight was 234 pounds. She had enjoyed good health, suffering only from the diseases of childhood. At puberty she experienced most of the changes common to that age, and had periodic attacks of nose-bleeding until the age of 22 years, the nasal hæmorrhages occurring about every 26 days, and at this time she suffered from temporary enlargement of the glands of the neck, particularly those below the angle of the jaw, and from a mild sore throat. During the first year of her married life she vomited blood twice and gained 22 pounds in weight. She had never had bleeding from the vagina and stated that her sexual relations were perfectly congenial. Vaginal examination disclosed practically the same condition as described under Case 1, except there was no evidence of a previously existing hymen, the vagina was four and one-eighth inches long, and the pubic region was covered with black hair.

CASES 4 AND 5.—I have learned through the courtesy of the late Dr. H. C. Bacon of two women, about the age of 40 years, cousins, now married, and neither of whom ever menstruated. These women were decidedly feminine in stature and in sentiment, while in both sexual congress was accompanied by the normal sensations. In both of Dr. Bacon's unreported cases vaginal examination showed the external genitalia and the vagina to be normal and an absence of the uterus.

Philadelphia.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTE ON A CASE OF RUPTURE OF THE ROOT OF THE LUNG WITHOUT INJURY TO THE CHEST WALL.

BY HELEN CHAMBERS, M.B., B.S. LOND.,
CLINICAL PATHOLOGIST TO THE ROYAL FREE HOSPITAL.

WITH reference to the case of extensive rupture of the trachea with complete detachment of the left bronchus published in THE LANCET of Dec. 1st, 1906, p. 1509, the following case of a somewhat similar injury may be of interest.

A well-nourished girl, aged five years, whilst crossing the road and carrying another child slipped and fell forwards. The wheel of a large four wheeled van passed over her back. She was brought in dead to the casualty department of the Royal Free Hospital. At the post-mortem examination superficial abrasions of the skin and slight bruising on the back suggested that the wheel had passed obliquely from the right shoulder downwards to the left, crossing the spine at the level of the twelfth dorsal vertebra. There were no other external signs of injury except a few abrasions on the upper limbs and in the left temporal region. There was no surgical emphysema or pneumothorax. The left pleural cavity contained eight ounces of blood. The root of the left lung had been torn across. The tear resembled an incised wound and extended through the main bronchus and vessels, including all the structures of the root except a thin strand of pleura and a nerve. The lung was lying almost free in the pleural cavity. The left lung showed a laceration in the upper lobe parallel to, and about one inch above, its lower border. It was half an inch deep at the upper end and at the lower end extended completely through the lung substance, exposing the pleura on the posterior surface. The tissues at the margins of the laceration showed only slight bruising. The right pleural cavity contained three and a half ounces of blood. The root of the right lung was uninjured. The apex of this lung was nearly completely torn off, being attached posteriorly by a strand of lung tissue. The rest of the lung showed some bruising. Both lungs were of normal size. The trachea was uninjured but contained some blood-stained fluid. There was slight extravasation of blood in the posterior mediastinum. The pericardium was normal. The heart was empty and firmly contracted. The left ventricle was slightly bruised on the anterior surface. The spleen

showed a shallow laceration. The other abdominal viscera were normal. There were no fractured ribs or injury to the spinal column.

The chief feature of this case is the extensive injury to the lungs, including complete detachment of one of them, in the absence of any fracture of the ribs or spine.

Mortimer-street, W.

NOTE ON A CASE OF ANGIO-NEUROTIC OEDEMA OF THE LARYNX.

BY CHARLES BIRCH, M.R.C.S. ENG., L.R.C.P. LOND.,
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BERKS.

THIS case is of interest, I think, from the following points of view. In the first place, the recorded cases of angio-neurotic oedema of the larynx are, so far as I can discover, few in number. Secondly, it is of interest from the point of view of diagnosis. And, thirdly, the resemblance in some respects of the symptoms caused by this condition and bronchial asthma.

The patient was a boy at Clayesmore School, aged eight years. He went to bed on Oct. 11th apparently in his usual state of health. At 12 o'clock he woke up and called to the nurse, who slept in a room adjoining the dormitory in which the boy was sleeping. He complained of a tickling in his throat and pain on swallowing. The temperature was 99° F. As there was nothing in his condition to cause the nurse any alarm she gave him something hot to drink and he went off to sleep. At 2 A.M. the nurse was wakened up by hearing a choking sound. She went and looked at the boy. He was breathing rapidly, looked flushed, and his temperature was 102°. He complained of his throat hurting him. He vomited but complained of no abdominal pain. He was moved out of the dormitory into a room by himself and I was sent for.

At 4 A.M. I saw the boy. He was then in a most alarming condition. His face was pale and cyanosed and he was tossing about in bed struggling for breath. The alæ nasi were working. There was stridor on respiration, suggesting laryngeal obstruction. The respirations were 28, the pulse was 140, and the temperature was 102°. There were considerable over-action of the respiratory muscles and sucking in of the intercostal spaces. On auscultation of the chest there were no adventitious sounds. On examining his throat there was a very little general inflammation of the tonsils, soft palate, and back of the pharynx. No enlarged glands could be detected in the neck. It struck me that this was probably the beginning of a case of diphtheria. I therefore immediately injected 2000 units of diphtheritic antitoxin into the abdominal wall. I took a swab from the throat for examination and gave him a teaspoonful of vinum ipecacuanhæ; this gave him considerable pain to swallow and shortly made him vomit. Not being at all satisfied with the case I asked Mr. N. H. Joy, the medical officer to Bradfield College, to come over and consult with me. He saw the patient about 8 A.M. and formed the opinion that it was probably an early case of diphtheria. The boy was isolated. During the day the breathing gradually got easier and the cyanosis and restlessness passed away. At 6 P.M. he was breathing quite comfortably; he could swallow liquids without trouble, his face was flushed, and he was sweating considerably. The temperature was 102°. The tonsils were now a good deal swollen, but there was no change in the appearance of the pharynx.

On the following morning, after a good night, the patient was apparently in his usual state of health, though his temperature was still raised. The swelling of the tonsils had subsided. Another swab was taken from the throat; both this one and the one taken on the previous day turned out to be negative. There was no cough or discharge from the throat or nose throughout the attack. His recovery was uninterrupted.

I am afraid that the diagnosis of this case was based chiefly on the elimination of other diseases and conditions which could give rise to the signs and symptoms met with in this case. With regard to diphtheria there was no trace of any membrane. The result of the examination of both swabs was negative. And although there were half a dozen boys sleeping in the same dormitory there have been no cases of diphtheria either before or after. Since the beginning of the term the village has been "out of bounds" for the school, so that there was no chance of this boy

having been exposed to any infection that the other boys had not been exposed to.

The condition of this patient when I first saw him in some ways resembled a person in an attack of bronchial asthma; the chief differences were: instead of the chest being fixed there was excessive movement, the high temperature (it was 102° and only became normal at the end of the second day), and the absence of all expectoration. Nevertheless, I think there is probably a close connexion between the condition described and bronchial asthma. If we follow the theory of Traube, that the attack (of asthma) is due to the swelling of the bronchial mucous membrane, it is quite reasonable to expect that a swelling (oedema) of the trachea or larynx would give rise to signs very similar to those seen in bronchial asthma. As a matter of fact, this patient has a fairly strong family history of asthma, both his maternal and paternal grandfathers having suffered from this disease.

Whitechurch, Reading.

Medical Societies.

OPHTHALMOLOGICAL SOCIETY.

The Pupillary Membrane.—Sarcoma of the Choroid.—Total Avulsion of Iris with Retention of Vision.

A MEETING of this society was held on Dec. 13th, 1906, Mr. PRIESTLEY SMITH, the President, being in the chair.

Mr. E. TREACHER COLLINS described the macroscopic and microscopic appearances of an Adhesion of a Persistent Pupillary Membrane to the Cornea in the Eye of a Cat, and compared these with four other recorded cases of a similar nature. It was suggested that they might be divided into three classes with the following characteristics: (1) A cicatrix of a perforating ulcer of the cornea, with the pupillary membrane attached to the scar (Wintersteiner); (2) a cornea in all respects normal, except for a defect in the endothelium on its posterior surface at the seat of attachment of the pupillary membrane (Collins, Ballantyne); and (3) a cornea in all respects normal, except for an absence of Descemet's membrane and its lining endothelium at the position where the substantia propria and pupillary membrane become blended (von Hippel). The case, the subject of this communication, came under the third heading. In Class 1 the cause of the adhesion was undoubtedly inflammatory in origin. In the cases belonging to the other two classes there was an absence of all signs of past or present inflammatory changes, and in some of the eyes there were other congenital malformations which could not be inflammatory in origin. The balance of evidence in them would seem to be strongly in favour of the abnormality being due to an arrest of development, in Class 2 the arrest occurring in the differentiation of the mesoblastic tissue posterior to the hyaline layer of Descemet's membrane into endothelium and pupillary membrane, and in Class 3 the arrest occurring in the formation of a partition of the hyaline layer and the differentiation of the mesoblastic tissue between the lens and surface epithelium into two parts.

Mr. L. V. CARGILL and Mr. M. S. MAYOU described a case of a Flat Sarcoma of the Choroid. The patient, a man, aged 61 years, was first seen in August, 1904, when he complained of failure of sight of the left eye. At the outer side of the macula was a patch looking like an area of choroido-retinitis. The retina had an oedematous appearance and at the lower border of this area were some dark choroidal pigment spots, with other spots less pigmented; the patch was not definitely elevated but there was a scotoma corresponding to it; the vision was $\frac{1}{8}$. The right eye was normal. In spite of warning the patient did not show himself for a year and then the retina was partially detached, with much pigment along the border of the detachment. Vision was $\frac{2}{4}$. The use of Leber's transilluminator rendered the diagnosis of tumour certain. He was not again seen until March, 1906, when he had secondary glaucoma. Tension was + 2 and the vision equalled perception of light. The eye was removed and a funnel-shaped detachment of the retina was present. In the outer half of the globe there was a flat, darkly pigmented growth. In the region of the ora serrata it was raised and tended to spread in a