keeping well away from the diseased structures; I then dissected off the entire floor of the ulcer, keeping my knife well under the disease, so as to make sure of removing all the diseased tissues. Having applied pressure forceps to a few bleeding points, I dressed the wound with dry antiseptic dressing without strapping or sutures, allowing it to granulate; this it did most satisfactorily, and in a little time was well and the scar not particularly noticeable, so that he was able to resume his occupation. I had the advantage of constantly seeing this man for some years after, and there was no sign of the disease returning.

CASE 2.—A boy aged eight years was admitted into the Shirley Children's Hospital in December, 1884, with a large patch of lupus on the left cheek $2\frac{1}{2}$ in. by $1\frac{1}{2}$ in. He had been under treatment for some time, both private and hospital, before applying to me. I first tried local and general treatment, but as this failed to afford any prospect of cure, and the disease continued to spread, I decided to treat it after the same manner as the first case, and with the kind assistance of my colleagues, Dr. C. G. Beaumont and Mr. Chamberlain, I made a deep incision round the ulcer, keeping well away from all traces of the disease. This done, I dissected off the floor, as in the previous case, and treated it in every way the same, and the result was entirely satisfactory; the wound healed, and the resulting scar was not very perceptible. So far as I could afterwards learn, there was no return of the disease.

I do not publish these cases with any wish or intention of claiming priority for the operation, but to confirm Mr. Bidwell in the good results which he claims for the proceeding. No doubt the skin grafting may be of some advantage; but I do not think it is essential to the success of the operation, which I consider far preferable to the old plan of scraping, as there is more control over the diseased structures and a better chance of thoroughly removing them. Of course, the great point is to get well beyond the disease and not be afraid of removing too much; and, like all operations of the kind, the sooner it is done the better for the patient. Had I noticed the papers to which Mr. Bidwell refers I should have mentioned these cases before; but they must have escaped my attention, as I have no recollection of having seen them.

Wellington, Salop.

EPITHELIOMA OF THE TONGUE IN WOMEN.

BY CHAUNCEY PUZEY, F.R.C.S. ENG.,
SURGEON, NORTHERN HOSPITAL, LIVERPOOL.

As a contribution to the statistics of epithelioma of the tongue attacking women¹ I send a short note of two cases upon which I operated in the summer of 1892. Curiously, both patients were admitted within a few weeks of each other, and they are the only cases occurring in women which have come under my care during twenty years of hospital work.

CASE 1.—The patient, a woman aged fifty-three years, had the left side of the tongue (posterior position) extensively affected with epithelioma, and several of the submaxillary glands of the same side were enlarged. She was in a very feeble condition from pain and starvation, but urgent in requesting operation. On June 20th, 1892, I removed the left lateral half of the tongue close to the hyoid bone. Very little blood was lost, but the patient was so weak that removal of the glands was deferred. For some hours after operation it seemed doubtful if she would rally; but after that she made a rapid recovery. A few weeks later the submaxillary region was thoroughly cleared out. For two or three months she improved remarkably, but then disease recurred in the glands at the back of the neck and the case soon ended fatally.

CASE 2.—The patient, a stout, ruddy, healthy-looking woman aged fifty-nine years, was admitted a few weeks later. She had a large epithelioma involving the middle portion of the right lateral half of the tongue and slightly invading the floor of the mouth, but without glandular enlargement. On July 29th, 1892, I removed the right lateral half of the tongue, close to the hyoid bone. She made a rapid recovery. Twelve months later I heard that everything was perfectly satisfactory, and so it continued until the end of last autumn, when disease recurred somewhere in the submaxillary region (I did not see her) and she died last Christmas. The operation had given her two years of comfort.

¹ Vide THE LANCET, March 2nd, 1895.

The operation in both cases was that generally known as Marrant Baker's, and the only other point to which I wish to refer is that there was throughout the whole period of the healing of the wound in both cases complete absence of fetor, which I attribute to the hourly painting of the whole wound with glycerine of borax.

Liverpool.

FAT EMBOLISM FOLLOWING FREE INCISION OF THE FEMALE BREAST FOR DIFFUSE SUPPURATION.

BY SURGEON-MAJOR A. F. FERGUSON,
BOMBAY MEDICAL SERVICE.

THE patient, a healthy female twenty-two years of age, came to the Civil Hospital, Shikarpur, on April 7th, 1894, in great pain and looking very much worn out by intense suffering. The left breast was enormously swollen, red, and exquisitely tender, with a doughy elastic semi-fluctuant feeling uniformly throughout. The tenderness was so great that chloroform was necessary for examination. A free incision was made in what appeared to be the most likely situation. There was great hæmorrhage, but only a small quantity of pus. The excision was extended, but still no collection of pus was reached; the finger was introduced and passed through the gland, which was spleen-like in consistence, and the fingers could easily be pushed through it; but still only a small quantity of pus escaped, and it seemed to be equally distributed throughout the gland. A drainage-tube was inserted and a suitable dressing applied. The pain continued and the suffering seemed great. Morphine was given pretty freely, but she was very restless nevertheless. On the next day she looked extremely anxious and worn out, and the breathing was oppressed. The drainage-tube was removed, and some milky, oily-looking fluid escaped with it. There had been a good deal of bleeding, but only slight purulent discharge. The dyspnoea rapidly increased, and at 5 P.M. the following note was made: "The breathing is very much oppressed and 30 per minute, the face cyanosed, the pulse running, and patient unconscious." She died at 11 P.M. A post-mortem examination was obtained with great difficulty, and during its performance the relatives were outside clamouring for the body, so it was necessarily very superficial. The lungs were much congested, a great portion of the left approaching red hepatisation. Portions were kept and hardened. The kidneys could not be obtained, nor could the other organs be carefully examined under the circumstances. Sections of the lungs, stained with perosmic acid and mounted in Farrant's solution, were shown at the Indian Medical Congress at Calcutta. They show the capillaries and smaller vessels blocked with fat, and globules of fat in the blood in the larger vessels.

Mhow, Central India.

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.

UNIVERSITY COLLEGE HOSPITAL.

A CASE OF TUMOUR OF THE LUNG; REMARKS.

(Under the care of Dr. G. V. POORE.)

PULMONARY growths of a malignant character are usually secondary to disease in other parts. Probably in the large hospitals sarcoma of the lung secondary to bone disease of similar nature is most frequent, whilst in the infirmaries the disease is usually secondary to a scirrhus growth which first showed itself in the breast. This case is a most instructive one of primary sarcoma of the lung—a condition which, as this case demonstrates, is extremely difficult of diagnosis until evidence of compression of intra-thoracic veins or the appearance of tumours elsewhere affords additional aid.

Many cases which are recorded of primary growths of the lung are doubtful, for careful search does not appear to have been always made for a possible primary growth in other parts; here the examination was complete and conclusive. For the notes of this case we are indebted to Mr. A. M. Watts, house physician.

A man aged twenty was admitted to University College Hospital on Dec. 12th, 1894. He stated that on Oct. 8th of the same year he noticed, on getting up to go to his work in the morning, that he was very short of breath and felt cold all over. He had been quite well previously, but the symptoms were so severe that he took to his bed at once and sent for medical advice. He remained in bed till the end of the month, when, feeling better, he got up and went about for a fortnight, but did not resume his occupation. One morning about the middle of November, while out walking, he was suddenly seized with a severe aching pain in the middle of his back, which caused him to double up. He immediately returned home and took to his bed, stopping there till he entered the hospital. Since the middle of October he had suffered from pain in the left side, which was worse on coughing. For a week—a month before the date of his admission—he expectorated sputum stained with blood. He had been treated during his illness with poultices, blisters, &c. He had had influenza three years before, but no other illnesses. He said that he had always been delicate. There was nothing noteworthy in the family history. On his admission it was found that he had a slight cough, but no expectoration; he had some dyspnoea on exertion; there was no cyanosis; the respiration was 40 per minute. On examining the chest it was noticed to be poorly covered, long, and narrow, and that the intercostal spaces were better marked on the right side than on the left, which side hardly moved at all on respiration. Below the third rib on the left side there were absolute dulness on percussion and loss of vocal fremitus of breath sounds and of voice sounds. In the second left intercostal space there was distant bronchial breathing with egophony, the percussion note being impaired very much. In the first left intercostal space the percussion note and breath sounds were normal. Behind there were on the left side, below the spine of the scapula, very diminished vocal fremitus and dulness on percussion, with faint bronchial breathing and very weak voice sounds. In the left supra-spinous fossa the percussion note was impaired and the breath sounds were weak, but bronchial in character. The physical signs over the right side of the chest were normal, except that the heart could be seen beating over the second, third, and fourth spaces on the right side internally to the right nipple line, with the heart's apex beat in the fourth space midway between the right nipple line and the right border of the sternum. The impulse was somewhat heaving in character. On listening at the apex a well-marked systolic murmur was heard, which was only conducted inwards as far as the middle of the sternum. There was nothing abnormal in the urine, he had a fairly good appetite, and his bowels were regular. There was no oedema anywhere, and there were no dilated veins and no enlarged glands. As the patient had all the signs of an extensive effusion into the left pleural cavity, an attempt was made on the day after his admission to aspirate the chest in the sixth space in the mid-axillary line. An ordinary bottle aspirator was used with a moderate-sized needle; but as nothing but a little blood was drawn off the needle was again inserted on the same day, this time just internally to the angle of the left scapula, with the same result. The blood drawn off contained nothing but corpuscles. The temperature was 100·2° F. on his admission, and varied between that point and 98° for the next few days, and after that kept below 100° for some days. Soon after admission he was noticed to have a slight prominence of the chest wall in the left mammary region, which gradually became more marked, and on comparing a tracing of the chest wall taken on Jan. 12th, 1895, with one taken a month previously a considerable difference could be noticed in the size of the left side of the chest, especially in the anterior part. His general condition altered very little during this time; the temperature chart from Dec. 23rd to 30th showed an evening rise of nearly 101°, with a morning fall to normal, but from the latter date till his death his temperature did not rise above 100°, and after Jan. 1st or 2nd it never rose above normal. His pulse during the whole time he was in the hospital was rapid, on an average 120 to the minute, with the respiration 30 per minute. On Jan. 3d

an exploring needle was again introduced (this time into the left side of the chest in front), but with a negative result. On the 15th some oedema of the chest wall in the left mammary region was noticed, which gradually increased. About this time, also, some dilated veins were noticed in the left axilla, and both external jugular veins were found to be distended; there was also some distension of the veins of the forehead at this time. From the 15th till the time of his death the patient passed very small quantities of urine, which was of high specific gravity and contained a trace of albumen on two occasions, but at other times was normal. On the 29th some oedema of the lower part of the back on the left side was noticed, that on the front of the chest being more marked; there was also some on the left side of the face. He now could only lie on the left side, being unable to breathe in any other position. On Feb. 2nd a small, rounded, almost fluctuating swelling was found just over the anterior surface of the head of the right humerus; it was painless, and the skin over it showed no signs of inflammation. On puncturing the tumour a little blood escaped, which on microscopical examination was found to contain cells of a sarcomatous nature. The dulness on percussion, loss of vocal fremitus, &c. now extended over to the right as far as a line drawn downwards from the middle of the right clavicle to the right nipple, and then to the costal margin, the heart's apex beat being just to the left of the right nipple in the fourth space. The signs were limited to the left side behind. From this time the patient became rather rapidly worse, the oedema increasing and the dyspnoea being more marked; he, however, apparently did not suffer any pain and slept well. The growth at the head of the humerus increased slowly in size, and another small tumour was found on Feb. 10th just below the left scapula, attached to a rib. He became delirious on the evening of the 18th, and died the next morning.

At the post-mortem examination the diaphragm on the left side was found to be very much depressed by, and the whole of the left side of the thoracic cavity filled with, an extremely soft growth; it was dark-brown in colour and enclosed in a capsule formed apparently of thickened pleura, which was firmly attached to the chest wall everywhere. At the upper and anterior part of the tumour, and continuous with it, was found a layer of collapsed lung about half an inch thick, seven inches long, and four inches wide at its upper part and narrower below. The heart and pericardium were displaced to the right, as was also the right lung. The two former were healthy, but the right lung contained a small growth about the size of a marble on its posterior surface. The liver contained a few small growths about the size of peas scattered through its substance. All the other organs were healthy. There were no enlarged glands, except one in the anterior mediastinum. Microscopic examination of the tumour showed it to be a round-celled sarcoma, which was rapidly degenerating.

Remarks by Dr. POORE.—The great interest of this case consists in the impossibility of diagnosis in the early stages. The history was that of an acute onset, and the physical signs on admission were those of effusion into the left pleura. Even after the failure of aspiration, which necessarily aroused one's suspicion as to the true cause of the trouble, it was hard to believe that such failure was not due to some mechanical condition—such as profuse and oedematous adhesions—which prevented the flow of the fluid from the pleura. The physical signs were uniform in character, and there were no patches of dulness and resonance or of diminished and increased vocal fremitus, such as are common in growths in the lung. The necropsy, which revealed a soft pulsatous tumour uniformly distending the visceral pleura, fully accounted for the physical signs during life. There was a history of very slight hæmoptysis, but this was never repeated and merely gave rise to the suspicion that there was tubercle as well as fluid. When, towards the end, there appeared marked oedema of the chest and marked distension of the veins on the left side of the face and chest, and this without any rise of temperature, the diagnosis became almost certain, and with the appearance of the soft tumours on the neck of the humerus and one of the ribs one felt quite sure as to what would be found post mortem. It is interesting to note that the weight of the patient, which was 6 st. 11 lb. on admission, fell to 6 st. 7½ lb. on Dec. 22nd, 1894, and rose to 7 st. 2½ lb. on Jan. 14th, 1895. The last weight recorded (on Jan. 22nd) was 7 st.