dissection. The base was fixed to the deep fascia overlying the pectineus and adductor longus muscles. In separating the lower part from the surrounding structures a large artery was divided and ligatured. After the tumour had been removed the bleeding points were secured and a superficial branch of the anterior crural nerve, which was lying in the wound, was divided and a portion removed. The wound was washed out with a solution of chloride of zinc (forty grains to the ounce), and stitched up with alternate silk and catgut sutures. Iodoform dressings were applied. During the operation the pulse became weak, but the patient quickly revived on the administration of a brandy enema. About five hours after the operation the dressings were changed, as the blood and serous oozing had saturated them. The right foot and leg were rather cold, but the patient had no pain in the limb. At 7 P.M. his temperature was only 96° 6'. The tumour on removal was hollow, with thick dense walls, and nodules on its exterior of more recent growth; it was not connected with the psoas tendon. Microscopically, it showed fibrous tissue, both well developed and embryonic. It seemed to resemble what French writers call "adeno-lymphocele." The fluid contained in the cyst was clear and straw-coloured; some shreds and films of apparently coagulated lymph were adherent to the lining wall of the cyst.

20th.—The man passed a fairly comfortable night, dozing all the time. He had some pain about midnight, which was relieved by a subcutaneous injection of morphia. This morning there is slight pain behind the knee; the right foot is colder than the left, though it is fairly warm. Temperature normal.

21st.—Right leg and foot as warm as the left, and there is no œdema of the leg. Wound dressed yesterday; there was a good deal of serous discharge, mixed with blood. A drainage tube was inserted into the upper part of the wound, and the wound syringed out with 1 in 40 carbolic acid solution.

28th.—The patient has continued comfortable, but has had some pain in the calf of his leg. There has been some œdema of the leg, but this has now subsided. The leg and foot are warm. There is no discolouration of the skin. There is some suppuration in the wound, and the discharge smells rather badly. The temperature usually reaches 100° in the afternoon or evening.

29th.—Some of the stitches were removed yesterday, and the remainder to-day, and free exit given to the discharge. There were some shreds of slough visible in the wound, but the greater part is clean and looks healthy. The wound was syringed, and strapping applied to retain the edges of the wound in position. The tibial arteries cannot be felt. The leg and foot were covered with hot applications of lead lotion during the three days that the leg was œdematous (26th to 23th); cotton wool and a flannel bandage are now applied.

30th.—Boracic acid lotion applied as a dressing, a drainage tube placed in the upper part of the wound, and the patient told to lie on his right side; by this means the tendency to bag in the deeper parts of the wound was overcome. Strapping is still employed.

Jan 3rd, 1889.—Progressing very favourably. Wound dressed twice a day with boracic acid lotion; it looks healthy, but the discharge is thin and watery, and the shreds of slough are not all separated. He left the hospital on March 1st, having been up and walking about for some days before going out. There was at first some tendency to swelling of the leg, but this improved with the aid of a flannel bandage.

CASE 2.—J. S.—, aged twenty-three, a general labourer, was admitted into the Albert ward on Nov. 16th, 1888, and left on Feb. 6th, 1889. On admission he complained of a tumour in the upper part of his right thigh. This he had first noticed about twelve months before, when it was about the size of a hen's egg; it caused him no inconvenience or pain. It gradually increased, and about four months ago the growth became more rapid; but the patient suffered no pain, though the presence of the tumour somewhat impeded him in his work. He was treated seven weeks in the Barnstaple Infirmary, when a trocar was passed into the swelling, but no fluid withdrawn. The family history was good. He had not suffered from any particular illness, and had never had syphilis.

On examination of the tumour, it was found to be of a somewhat oval shape, about five inches in its long diameter and three inches and a half in its short diameter, situated

in the upper part of the adductor region of the right thigh. It extended over the upper third of the thigh, being limited above by the rami and tuber ischii, and was well circumscribed, lying beneath the gracilis and to a slight extent the adductor longus muscles. When these muscles were relaxed it was slightly elastic, but no fluctuation was detected, and the skin moved freely over it. The tumour was freely movable transversely, and was not apparently attached to the bone. When the muscles were contracted the tumour became hard and immovable, and did not protrude between the muscles. There were no enlarged glands to be felt. His general health was good, and he was not losing flesh. Urine normal.

On Nov. 23rd some fragments of the tumour were removed by means of a trocar and cannula. When examined under the microscope they were found to be typical specimens of spindle-celled sarcoma.

On the 30th, the patient having been placed under ether and fixed in the lithotomy position, Mr. Sydney Jones made a longitudinal incision over the tumour of about seven inches in length down to the gracilis muscle, which was closely connected with the growth and difficult to separate from it. On the separation of the gracilis the tumour was fully exposed. It was found to be encapsuled; removal was effected without difficulty, there being only a few adhesions at its upper part to the deep adductor muscles. The hæmorrhage being somewhat profuse, the bleeding points were caught with forceps and the vessels ligatured. Some portions of ragged tissue were then removed, and the wound washed out with carbolic acid lotion (1 in 40). A drainage tube was inserted beneath the gracilis, and the edges of the wound were then approximated with silk and catgut sutures. Antiseptic dressings and an anterior plaster-of-Paris splint to prevent flexion of the thigh were then applied, and the patient placed in a position to assist drainage. The temperature at night was 100° 6'.

The wound was dressed on Dec. 1st. The discharge was slight; there was some tension of the stitches. The temperature at midnight was 103° 2'. On the next day, the temperature continuing high, the wound was dressed and the stitches from the lower part removed. A large quantity of discharge escaped. The temperature fell slightly after this. The wound was now dressed daily. The tube was removed on the 3rd, and one of smaller size inserted. The discharge continued profuse and the temperature high. On the 10th two more tubes were inserted, and the edges of the wound approximated with strapping. On the 14th an abscess was opened in the lower portion of the posterior surface of the thigh. It appeared to be unconnected with the wound, and was quite superficial. It was treated with antiseptic applications after incision, and soon closed. After this the wound healed rapidly, and, the discharge diminishing, the tubes were gradually withdrawn. On Jan. 2nd, 1889, the dressings were changed to lead lotion, which was used for a short time, and then, under zinc ointment, the wound entirely healed, the patient leaving the hospital on Feb. 6th.

MARGATE COTTAGE HOSPITAL.

STRANGULATED INGUINAL HERNIA; REDUCTION EN BLOC;
OPERATION; REMARKS.

(Under the care of Mr. W. TREVES.)

THIS case is an example of one form of reduction *en masse*, the sac being pushed back out of the canal, with its contents in a state of strangulation. This is the variety to which Luke particularly drew the attention of the profession, and occurred in the more usual manner—that is, by the forcible efforts of the patient himself. It is almost unknown in inguinal hernia of the acquired form. Mr. Birkett described a second variety, in which the neck of the sac is ruptured, and the contents forced through the rent between the peritoneum and abdominal wall, the strangulation continuing. Two other forms are described: in one the neck of the sac is completely detached, and the contents of the hernia thrust into the space between the peritoneum and the abdominal wall; in the other the contents of the hernia are reduced into a second sac or diverticulum extending from near the neck of the first. In all these the symptoms persist, and it is necessary to operate.

J. T.—, aged forty-eight, was admitted on Nov. 18th,

1888. The patient stated that he had suffered from rupture for some years, that it came down occasionally, that he had always been able to get it back again, and that he wore a truss. On going to bed on Nov. 16th, his rupture came down, and was attended with severe pain. He made three attempts to return it. At the third attempt it went back, but the severe pain continued. He had suffered from continued pain, vomiting, and retching, with confined bowels, and had taken no food.

On examination, the testicle was found lying against the left ring; it had, it was stated, disappeared, but had come out again; the rupture had been reduced, but above Poupart's ligament was a swelling the size of the fist, and all the symptoms had continued with unabated severity.

On the day of admission (Nov. 18th), at 6 P.M., nearly forty-eight hours after the strangulation, the inguinal canal was laid open, and the distended sac could be felt through the canal. It was seized with a large pair of Spencer Wells' forceps, and an endeavour was made to drag it down through the ring, but without avail. A section was then made through the abdominal wall over the swelling, in a line between the epigastric artery and the middle line, commencing about an inch above Poupart's ligament, and extending upwards for about three inches. The sac, being then exposed, was opened, and about a foot of congested but not irrecoverable gut exposed; the neck of the sac was found lying towards the median line, and about one inch from the same. The stricture was in the neck of the sac; this was divided, and the gut returned; the neck was then transfixed and ligatured with silkworm gut in two halves, and the sac cut away. The opening was closed with deep and superficial sutures of silkworm gut.

The man made an uninterrupted recovery, with radical cure of the hernia. He was kept in bed for three weeks.

Remarks by Mr. TREVES.—In cases of reduction *en bloc* similar to the above, all the older writers recommend that the canal be opened and an endeavour made to drag back the sac through the abdominal opening; this, if the hernia has been reduced by great force, is manifestly impracticable without free enlargement of the opening, and, in fact, without the making of an abdominal section in an exceedingly unsuitable place. In similar cases it would probably be better, as Mr. F. Treves advised in this instance, to make the abdominal section direct.

Medical Societies.

PATHOLOGICAL SOCIETY OF LONDON.

Diffuse Calcification of Liver.—*Bilharzia.*—*Gastric Cancer.*—*Hepatic Cirrhosis.*—*Osteo-arthritis.*—*Unilateral Interstitial Nephritis.*

AN ordinary meeting of this Society was held on April 16th, the President, Dr. W. H. Dickinson, being in the chair.

The PRESIDENT, before the commencement of the business, alluded, in a few well-chosen remarks, to the loss the Society had recently sustained by the death of its first President, Dr. C. J. B. Williams, who, during his long life, had contributed many valuable additions to pathological knowledge.

Dr. NORMAN MOORE read the report of the Morbid Growths Committee on Mr. Hutchinson's case of Crateriform Ulcer of the Face. The microscopical characters established the view that it was a squamous-celled carcinoma; the deeper part of the growth showed tubular processes somewhat like sweat glands, and it was possible that the neoplasm might have arisen from these structures.

Mr. TARGETT showed a specimen of Diffuse Calcification of the Liver, which was removed from a man aged sixty-two, who died in the Exeter Hospital. It was presented to Guy's Hospital Museum by Dr. Davy. There had been a tumour in the epigastric region for seventeen years, which was very hard but not tender, and did not interfere with his work as a farm labourer. Four months before death he developed an empyema on the right side, for which he was treated in the hospital. At that time the abdomen presented a swelling of stony hardness in the epigastric region, which moved with respiration, and appeared connected with the liver. There was no ascites, but the veins over the upper part

of the abdomen and the lower part of the chest were enlarged and varicose. There was no jaundice until two days before death, which resulted from facial erysipelas. The clinical report was very incomplete, and the condition of the urine was not mentioned; but at the post-mortem examination the kidneys looked normal, though much enlarged. The spleen was four or five times its usual size; the liver was firmly adherent to all the surrounding parts; after removal it weighed 66 oz. The left lobe was very much enlarged, and was the cause of the epigastric swelling. The capsule was much thickened, and the substance of the liver so hard that it had to be sawn into sections. The greater portion of the organ was then found to be replaced by fibrous tissue, which was infiltrated with calcareous deposits, composed of carbonate and phosphate of lime and a large proportion of organic matter, but did not contain cholesterolin or bile acids. Microscopic examination of the least affected parts of the liver showed changes like those of monolobular cirrhosis, and there were many groups of small round cells in the strands of fibrous tissue. One striking point was the amount of new tissue in the centre of the lobules spreading out between the rows of liver cells. The other parts of the liver were decalcified and examined, but they showed little more than fibroid tissue. There was no caseation; no gummata or evidence of parasites could be found. He considered that the thickening of the capsule, together with the amount of fibrous tissue in the interior of the organ, were suggestive of the primary change being syphilitic, but there was none of the cicatricial contraction so commonly found in old syphilitic livers. The clinical history did not mention syphilis or alcoholism. The specimen was referred to the Morbid Growths Committee.

Mr. BOWLBY exhibited the urinary organs and parts of other viscera removed from two cases of Bilharzia. The first patient was an Arab, who was admitted into the hospital at Alexandria under the care of Dr. Mackie. The man was suffering from severe cystitis, with foul blood-stained urine. On examination, the bladder was found to be greatly thickened, and felt as though it contained a malignant tumour. In the urine the ova of the bilharzia worm were found. Perineal cystotomy was performed to relieve the patient's sufferings, but he died a fortnight later. At the post-mortem examination numerous female bilharzia worms were found in the portal vein, thirty-seven of which, together with the urinary organs and portions of the lungs and spleen, had been sent by Dr. Mackie to Mr. Bowlby. The bladder was contracted and thickened. The mucous coat was covered with a shreddy mass of finely fibrillated villous growth. The ureters were dilated, with thickened walls, and the mucous membrane was covered by phosphatic deposit. The kidneys were in a state of suppuration. Under the microscope the thickening of the bladder wall was found to be due to an interstitial overgrowth of fibrous tissue, and the mucous membrane had been destroyed and was replaced by young fibrous tissue. There were numerous ova imbedded in the wall of the bladder. The walls of the ureters were filled with ova, some of which could be seen in the mucous membrane where it had not been destroyed. The kidneys showed the changes due to nephritis, and contained numerous ova. The lungs were semi-solid; several ova scattered through them. The second patient was a boy, seventeen years of age, from whose rectum Dr. Mackie removed a tumour (exhibited). The patient had suffered from rectal pain and the passage of blood. The tumour consisted of a diffuse papillomatous growth, which under the microscope was found to consist of a loose, richly cellular, fibrous tissue, in the interstices of which were numerous ova.—Dr. STEPHEN MACKENZIE said the opportunity of studying the general pathology of this disease was rare. He asked what was the origin of the coagula and fibrous threads often seen in the urine in these cases. Were any parent worms found in the bladder? They nearly always inhabited the bloodvessels. The ova in the alimentary canal were said to have lateral spines, while those in the urinary tract had terminal ones.—Dr. MOORE had found both lateral and terminal spines on ova in both situations.—Mr. BOWLBY, in reply, said that the processes were composed of young fibrous tissue in a state of disintegration. The parasites were only found in the portal vein.

Dr. GOODHART related a case of Cancer of the Stomach following gastric ulcer in a man aged thirty-one. Two years before his death he was attacked by dyspepsia, his stomach was dilated, and he vomited nearly everything