exception. On the other hand, where the foot-plate remained, there was practically no change from preceding tests. In one case of removal from both ears the hearing remained perfectly good for five months, and was then somewhat dulled after a head cold, which closed the Eustachian tubes and caused marked retraction of the membrane. After inflation of both middle ears through the catheter the hearing was restored in one and partially so in the other. This would seem to show that the cicatrix over the oval niche was driven into the window by the closing of the tubes, and acted as an obstruction. It is proposed to remove, under cocaine, a piece of membrane from one side, with the object of contracting the cicatricial drum. By this it is hoped to counteract the tendency of the cicatricial membrane to sink into the fenestra.

In conclusion, I wish to emphasize the importance of a careful differential diagnosis in each case before advising the operation.

Clinical Department.

SOLID TUMOR OF OVARY.

BY J. COLLINS WARREN, M.D.

SOLID tumors of the ovary are said to be exceedingly rare. According to Greig Smith, "Of all tumors of the ovary probably not more than three per cent. are solid; most of them are malignant sarcoma or cancer; true myoma has been found; pure fibroma is almost unknown."

The following case seems, therefore, worthy to be placed on record:

J. R., domestic, single, forty-three years of age, entered the hospital November 2, 1892. For the last twelve years she has suffered from epileptic seizures, which she describes as "giving warning," and affecting the right side mainly. Her general health has otherwise been good. There is no history of any injury to her head. Her mental condition is slightly below par. Catamenia have been regular, but ceased two months ago. She first noticed some soreness of the abdomen on bending over about four months ago, but not until two months ago did she notice any enlargement. She has not had any pain, but has experienced a feeling of weight and dragging when walking about.

The patient is poorly nourished, and there is a slight suggestion of cachexia in the face. On examination, the abdomen was found to be somewhat distended with ascitic fluid, and a large, very hard, and nodulated tumor was felt extending three inches above umbilicus and down to the pubes. It was quite movable and could be pushed readily from side to side in the ascitic fluid.

On vaginal examination the uterus was found to be small, movable, and not connected with the growth. The hymen was well developed. The lungs and kidneys were normal. There was a slight presystolic murmur, but the heart's action was otherwise good. The tumor was regarded as probably of a malignant nature and possibly attached to the omentum. It was, however, thought advisable to perform an exploratory operation.

Laparotomy was accordingly performed on November 11th. An incision was made below the umbilicus, about four inches in length, which disclosed a hard

nodular mass of an opaque whitish color floating in ascitic fluid, about two quarts of which escaped. The incision was enlarged by the scissors to two inches above the umbilicus and with some manipulation the tumor was brought out through the wound, and was found to be attached to the left broad ligament. The pedicle was long and thin and was easily tied with a Staffordshire knot. The tumor on removal was found to be about the size of an adult head and to weigh eight and one-half pounds. An examination of the other ovary showed it to be about twice its normal size and hard and nodular, resembling somewhat in this respect the diseased ovary.

The patient made a good recovery, the temperature not rising above 100° F., although the evening of the operation she sat up in bed and had several epileptic seizures during her convalescence. The stitches were removed on the thirteenth day, the union being perfect. The catamenia appeared on November 28th, immediately after one of the seizures. Having been satisfactorily fitted with an abdominal belt, which I apply to all cases of laparotomy, she was discharged December 6th in excellent condition.

The following is the report of the microscopical examination of the tumor by Dr. W. F. Whitney: "A large lobulated growth (size of the head), firm, not covered by peritoneum and united to a fragment of the Fallopian tube. Microscopic examination showed it to be made up of fibrous tissue, with here and there a few bundles of unstripped muscular fibre. Fibro-myoma."

There were no cysts in any part of the tumor.

A REMARKABLE DEFORMITY OF THE PELVIS, IN CONSEQUENCE OF FRACTURE OF THE SACRUM.

BY BARTON COOKE HIRST, M.D., PHILADELPHIA.

A WOMAN brought in to the gynecological ward of the Philadelphia Hospital, on December 16th, gave the following history:

Age thirty-two. Has had six children, the last, three years ago. Three months ago, during a menstrual period, she fell from a third-story window striking with an unbroken fall upon the brick pavement of the yard below. One leg was broken, the skull, she thinks, was fractured, and some injury, she believes, was inflicted on the backbone. Since the fall she has not menstruated, and has suffered severe pain in the lower abdomen, which, however, of late has steadily decreased. She was transferred to our department from the surgical ward after her head injury and the broken leg had been repaired. An examination of the pelvis gave the following result: The uterus is in good position, movable; behind and to the right is a mass that gives me the impression of a diminishing, encysted hamatocoele. Directly the finger enters the vagina, a peculiarity of the posterior pelvic wall attracts attention. The coccyx and lower sacrum are much higher than they should be in the pelvic cavity, and they project forward at a right angle to the rest of the sacral bone, so that they encroach, to an extraordinary degree, upon the antero-posterior diameter of the pelvis. An external examination shows a transverse fracture of the sacrum at the level of the posterior inferior spinous processes of the iliac bones, a dislocation of the lower fragment inward, and a firm bony union of the two fragments at a right angle. From the seat of fracture to the tip

of the coccyx, the pelvimeter measures seven centimetres. From the tip of the coccyx to the lower edge of the symphysis pubis the measurement is seven and a half centimetres. Thus the antero-posterior diameter of the pelvic outlet is reduced three and a half centimetres or almost one and a half inches, for the backward displacement of the coccyx in labor, that increases this diameter from nine and a half to eleven centimetres, has become impossible. I believe, therefore, that should this woman again become pregnant a symphysiotomy or a Cæsarean section would be necessary for her delivery, most likely the latter.

Out of 13,200 fractures reported from nine large hospitals in this country and in Europe, but 0.8% were fractures of the pelvis; and in this small proportion, fracture of the sacrum figures as the least frequent of all injuries to the pelvic bones. When one considers that almost all grave injuries to the pelvis end fatally, the rarity of a pelvic deformity in a woman of childbearing age dependent upon a united fracture of a pelvic bone may be appreciated. In a rather cursory search through obstetrical literature I cannot find anything just like this case.

Medical Progress.

RECENT PROGRESS IN ORTHOPEDIC SURGERY.

BY E. H. BRADFORD, M.D., AND E. G. BRACKETT, M.D.

(Concluded from No. 26, page 622.)

CONGENITAL LUXATION.¹¹

KARWESKI reports five cases of congenital luxation, one spontaneous following scarlet fever, and eight of paralytic luxation.

Following Hoffa's suggestion in 1890, Karweski operated upon a child three years of age. In four other children whom he operated upon, all being girls, the oldest was eight, the other three, and two were four; all of unilateral luxation. In none of the children of from three to four did he find muscular contraction mentioned by Hoffa and Lorenz; and traction in bed previous to the operation, carried out for two weeks, did not give any results. The section of the muscle was also useless. The cotyloid cavity was found abnormal, presenting a surface which was almost flat, and the head and neck were distorted in a measure. In operating he divided the capsule, the flaps were drawn apart and after the reduction were stitched together tightly over the head, presenting a point of resistance for the traction of the head. The external incision was that of Langenbeck. The treatment after the operation consisted in the application of plaster-of-Paris bandage, which reached as high as the axilla. At the end of three weeks passive motions were made. At the end of eight weeks permission was given for the patient to walk with traction apparatus fastened to a leather corset. There was no suppuration in any of the cases.

The ultimate result was good in all the five cases.

A SPLINT FOR USE AFTER OPERATION ON THE HIP-JOINT.¹²

A device is shown, for use particularly after excision of the hip-joint, which allows turning of the patient in

bed without disturbing the relation of the leg to the trunk of the patient. The apparatus consists of an elliptical-shaped band of steel connected with the bottom of the traction-splint in such a way that when the patient is rolled upon the well side, the foot is raised and rolled outward and in the same degree as is the hip, so that there is no motion in the hip-joint by turning the patient on the side or on the face. The apparatus is fastened to an ordinary long splint, either a Taylor or any form of traction apparatus.

PSEUDO-ARTHROSIS OF THE HIP AFTER COMPLETE CURE OF SEVERE HIP-DISEASE.¹³

Several cases of this rare affection are mentioned. The only diagnosis to be made is from congenital dislocation. These patients are able to walk without much limp, provided the tubercular process has healed. Several of them have a walk which resembles very much that of unilateral congenital dislocation. The only question is the question of diagnosis, and the diagnosis lies between that and congenital dislocation. Unlike the ordinary result of hip-disease, they have often most excellent motion at the hip-joint. Surgical intervention, such as resection is of no advantage, the result being no better than the conditions in which the patients are. They walk readily without much limp. The limp can be modified in a measure by the use of the shoe with a high heel.

A REMOVAL OF APPARATUS IN THE COURSE OF TREATMENT OF HIP-JOINT DISEASE.¹⁴

Dr. Schaffer has given his opinion from a large number of observations, and concludes that the duration of the disease is, as a rule, about four years, and that during this time a latent tuberculosis may become active by trauma.

The attempt at leaving off mechanical treatment must always be tentative, and the splints be reapplied if symptoms reappear.

The examination of a joint under ether he does not think advisable, as more force than is necessary is liable to be used.

In determining whether the brace shall be omitted, two symptoms are of particular value: One is the gait and the attitude of the patient in walking; and second, the character of the resistance of the joint to motion, indicating the resistance of muscular contraction. Pain is not a valuable symptom; and the presence at any time during disease of suppuration is not of value, as many of these cases have a shorter course than many without suppuration. The symptoms on which the conclusions are made for leaving off treatment in the disease are: (1) The disappearance of the characteristic attitudes; (2) the disappearance or the modification of the muscular spasms.

OBLIQUE OSTEOTOMY OF THE FEMUR FOR DEFORMITY FOLLOWING HIP-DISEASE.¹⁵

A case is reported in which there existed a marked degree of deformity following old hip-disease. The operation was done through an incision on the outer side of the femur and the section by the osteotome made from before backwards so that the lower fragment impinged upon the upper. It is claimed by this that perfect apposition is maintained during healing and that the result is thus more certain.

¹¹ Menard: *Revue d'Orthopédie*, November, 1892.

¹² Karweski: *Centralblatt für Chirurgie*, September 10, 1892, No. 36.

¹³ British Medical Journal, 1891, vol. II, p. 993.

¹⁴ Dr. Newton Schaffer: *New York Medical Journal*, November 28, 1891.

¹⁵ Terrier and Hennequin: *Revue de Orthopédie*, vol. I, 1892.