wards. The sterno-hyoid muscle was pulled over to the left, but the sterno-thyroid and omohyoid, which were thinned out over the tumour, were divided, and the right lobe fully exposed. It was then slowly dissected out in its capsule, bleeding vessels being ligatured as they were divided. The chief difficulty in the removal of the tumour lay in the number and immense size of the bloodvessels supplying the gland. Of these the superior thyroid artery and vein—the latter being quite the size of the finger, and the former proportionately large—the middle thyroid vein, and the inferior thyroid vessels were the largest, and were all ligatured in two places, and divided between the ligatures. After they had been divided, and the gland freed of all its connexions except the enlarged isthmus, this structure was also ligatured and divided, and the right lobe then removed. A huge cavity remained, bounded posteriorly by the carotid sheath throughout its whole length, while below the pleura could be seen rising with each inspiration. The larynx and trachea were flattened out and twisted over to the right side. The wound was washed out with boracic acid lotion and its edges brought into accurate apposition by sutures of silkworm gut, a drainage-tube inserted, and a dressing of iodoform gauze and absorbent wool applied. The operation lasted nearly three hours. There was very little hæmorrhage considering the magnitude of the operation, and the amount of shock was small.

On April 19th the temperature was 100° F., and on the 20th 101°, but it was never above normal afterwards. The wound healed by first intention, and the cavity had entirely closed on the seventh day after the operation, when he was allowed to get up for the first time. He went home a week later, with instructions to return in three weeks' time, it having been thought, from the microscopy of the portion removed, that there was evidence of malignancy.

He returned again on May 27th. He had been in capital health since the previous operation, and had had little if any difficulty in swallowing, even solid food, or of breathing. On May 31st the left half was removed in precisely the same manner as the right half had already been dealt with. On this side, however, the superior thyroid vessels were much smaller and the inferior larger. The recurrent laryngeal nerve was seen underneath the tumour and avoided. The wound was treated in the same way as before. On June 6th all the sutures were removed, and on the 7th the drainage-tube, which had been shortened half an inch daily. The man went home on June 14th quite recovered, the circumference of the neck being then fourteen inches and a half.

Pathology.—Section of the right lobe showed it to be an ordinary bronchocele, with colloid degeneration; there were, however, two masses, each the size of a walnut, which showed a different structure. They were rounded, distinctly marked off from the neighbouring tissue, soft, and more highly vascular. In one a small cyst was found. Microscopically, they showed an alveolar stricture, the fibrous tissue bounding the spaces being small in amount, with numerous bloodvessels. The smaller alveoli were filled with small cubical cells, whilst the larger showed colloid degeneration in the centre, with similar cells around. These masses were evidently of a carcinomatous nature. The left lobe was similar to the right in structure, but showed no evidence of malignant change.

Remarks by Mr. PEPPER.—This is an interesting example of a tumour remaining stationary or only increasing slowly in size for many years, and then suddenly taking on a more active growth, as the result of its undergoing malignant change, which is the more likely if the patient has reached adult life. The rapid increase in size and the pressure effects rendered operative interference necessary. The larger lobe of the tumour was first removed in the hope that the symptoms would disappear, and that the enlargement would prove to be due to simple hypertrophy; but microscopical examination showing its malignant nature, it was resolved to complete the extirpation. Although total excision of the thyroid for simple hypertrophy may not be defensible (save for relief from pressure) on account of the possible development of myxœdema, there can be no doubt that in cases of malignant disease the more immediate danger from the nature of the growth renders the operation advisable. At the present time the patient is in excellent health, and no signs of myxœdema have appeared. As the areas of malignant growth were circumscribed, and the lymphatic glands free from infection, there are grounds for hope of immunity from recurrence. For the clinical notes of the case I am

indebted to Mr. Knox, house-surgeon, and for the pathological report and photograph from which the drawing was made to Mr. Crowle, surgical registrar to the hospital.

LONGFORD INFIRMARY.

THREE CASES OF ABDOMINAL SECTION; RECOVERY.

(Under the care of Dr. MAYNE.)

WE publish below the notes of three cases of successful operation on the abdomen for conditions of varying character: in one the patient suffered from tubercular peritonitis; in another the peritonitis was secondary to an ovarian tumour; and in a third there were many and firm adhesions remaining from a peritonitis, the result of tapping a cyst some time before. Of these, the effect of the operation in the case of the patient suffering from tubercle of the peritoneum is the most interesting. We have already drawn attention to the fact that this condition has often simulated ovarian tumour, and many operations have been undertaken for the relief of patients supposed to have been suffering from the latter when the symptoms were caused by tubercle. The evidence as to the value of operative treatment in tubercle of the peritoneum is so very conclusive of improvement (if not of cure) in the majority of patients submitted to it, that it is not possible to agree with the unfavourable opinion of Spaeth.¹ König gave at the recent congress at Berlin a series of 131 cases in which operation had been done for tubercular peritonitis; of these, no less than 107 were left in a satisfactory condition when they were last reported, 84 were said to be quite cured, and 30 were well two years after the operation. We would refer our readers to our remarks on cases of this nature, and their treatment, as exemplified by patients under the care of Mr. Keetley.²

CASE 1.—E. H—, aged twenty, was admitted on March 3rd, 1889, suffering from an attack of tubercular peritonitis, which commenced several weeks before. The abdomen was greatly enlarged and distended with fluid, very painful, and on the left side between the ribs and the crest of the ilium, and about five inches in breadth, there was dulness, which might have been mistaken for a tumour; but careful examination left no doubt of its being caused by disease of the peritoneum. Her features were pinched, and there was a well-marked hectic flush. Severe diarrhoea and night sweats were very troublesome and distressing to her. Temperature 103.2°; pulse 140, very weak. She was ordered daily eight ounces of port wine, egg-flip, beef-tea, jelly, milk and lime-water; for medicine she had quinine, pepsine, and bismuth, and when necessary hypodermic injections of atropine and morphine in combination; applied over the abdomen cod-liver oil and belladonna. This treatment was continued for some days, but without any satisfactory result, the temperature varying from 103° to 104.2° during the time. The patient having been told that an operation would afford her the only chance of recovery, she replied, "I came to hospital believing I must die and place myself entirely in your hands." On the 13th, having been put under the influence of chloroform, an incision about five inches long in the usual site was made. The abdomen having been opened, a large quantity of fluid escaped. The intestines were bound down to the posterior wall of the abdominal cavity, and they occupied a very small space, several bands of lymph appearing to tie them down; these were carefully broken. The dull space referred to was next carefully examined, the peritoneum found greatly thickened and studded with tubercles, several patches having commenced to suppurate. While Dr. Mayne's hand was in the abdominal cavity, about six gallons of water, which had been boiled and allowed to cool to a temperature of 105° F., were poured into it, and during the process some more of the adhesions carefully broken down. The hand was then removed and all the water that would be allowed to flow away, but no attempt was made to empty the cavity. The wound was now closed and the patient put to bed and given a hypodermic injection of ether; as she seemed very weak, some brandy was also given. About two hours afterwards vomiting occurred, and continued during the night. At ten o'clock the temperature was 104.2°; pulse 140, weak and compressible.

¹ Deutsche Med. Woch., No. 20, 1890.

² THE LANCET, vol. ii. 1890, p. 1028.

She was given morphine and atropine hypodermically, and each alternate hour two tablespoonfuls of beef-tea with two teaspoonfuls of brandy, and a sherry glassful of champagne. The following morning she expressed herself as better, but extremely weak and sore where the wound was; temperature 103°. She steadily improved, the temperature on the morning of the 22nd being only 99°. She left the hospital on April 2nd, and has since been for several months at service as house and parlour-maid, and is now a strong healthy-looking girl.

CASE 2.—K. W.—, aged fifty, was admitted into hospital on July 6th, 1889, suffering from an attack of peritonitis. On examination an ovarian tumour, which occupied the right side, was found. Having been kept quiet and under the influence of opium she speedily recovered from the symptoms of peritonitis. On the 14th, chloroform having been administered, Dr. Mayne operated, and removed a large polycystic tumour of the right ovary, which was very adherent to the peritoneum (left ovary healthy). Having washed the cavity of the abdomen out with water, which had been boiled and allowed to cool to a temperature of 105° F., the wound was closed and dressed, and the patient placed in bed. Temperature 99°. Hypodermic injection of morphia and atropine was given. Next morning the temperature was normal, and never rose. The only complaint she had was that the surgeon would not open the dressing and look at the wound, which was done on the 21st, when it was found perfectly healed and the stitches removed. She left the hospital on Aug. 2nd, nineteen days after the operation, and has since been in good health.

CASE 3.—M. C.—, aged eighteen, of strumous appearance, was admitted on July 11th, 1889. On the 14th, chloroform having been administered, a tumour (which was monocystic, and sprang from the left ovary, had a short pedicle, and was very adherent) having been removed, and the abdomen washed out with water, as in the previous case, the wound was closed and dressed, and the patient put to bed. The pulse being weak, she was given some brandy and a hypodermic injection of morphine and atropine. Temperature 99.3°. There was slight vomiting during the evening. She was given another hypodermic injection of morphine and atropine. At ten o'clock next morning the temperature was 99°, and continued at this until she went home on Aug. 3rd. This patient had been tapped before coming to hospital. With the exception of having had a slight cold she has been in good health since the operation.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

The Treatment of Strangulated Hernia when the Intestine is Gangrenous or Ulcerated.

AN ordinary meeting of this Society was held on March 24th, the President, Mr. Timothy Holmes, in the chair.

Mr. C. B. LOCKWOOD read a paper on the Treatment of Strangulated Hernia when the Intestine is Gangrenous or Ulcerated, of which the following is an abstract. The communication was based on the analysis of cases of hernia in which the intestine was gangrenous or ulcerated, collected from the records of St. Bartholomew's Hospital, and upon the details of two others in the author's own practice. The St. Bartholomew's Hospital cases were treated in the manner laid down by Sir William Lawrence—namely, "by a free incision of the mortified part, in order to unload the distended intestinal canal, or, if the gut should have already given way, to divide freely the integument and sac, and to leave the subsequent process of cure entirely to nature," the stricture being also divided, if necessary, for the proper flow of fæces. Four of the thirty-five St. Bartholomew's Hospital cases recovered, three of them completely; one had a fistula eight months after the operation. These patients only recovered after repeated operations, and the details of their cases were given. Thirty-one (88.57 per cent.) of the St. Bartholomew's Hospital cases died and both of the author's cases. One of the latter had no proper relief from the opened bowel, although there was a free passage, and the other fatal cases showed that this was not at all unusual. The causation of the absence of relief was discussed and illustrated with

cases, and the conclusion was arrived at that the usual operation could not be depended upon to give relief. Next the other causes of death were examined into, and it was shown that intra-peritoneal or subperitoneal fæcal extravasation might occur, or that the gangrene or ulceration might continue to spread to the bowel within the abdomen, or septic peritonitis might spread from the sac to the rest of the peritoneum. Should these dangers be escaped, the patient incurred the risk of dying of inanition. All of these accidents were illustrated from the list of fatal cases. The alternatives to performing the usual operations were next given, and the statistics of treatment by clamp, secondary suture, and of primary resection and suture were mentioned. The conclusion was in favour of primary resection and suture, and the *rationale* of the procedure was briefly described.

Mr. MAYO ROBSON sent a communication from Leeds bearing on the subject of the paper. He agreed that primary resection was the best treatment to pursue in these cases, and he had twice carried out this method successfully within the last two years. The first case was that of a middle-aged woman, who had a small hernia which had been strangulated for eleven days. The gut became gangrenous, and he resected the dead portion and brought the intestine together with Lambert's suture. The second case, in a woman aged sixty, was one of strangulated femoral hernia. A large portion of gangrenous omentum was removed, and the necrotic bowel was resected as in the other case. The bowels were open on the third day, and there was no abdominal trouble. He held that this treatment was far more satisfactory than the old method, and the conditions were different from those existing in cases of resection after fistula, for there was no difficulty in getting the two tubes of gut to fit.

Mr. BRYANT was surprised to find that the mortality of this affection was so terrible; he certainly thought that there was a larger percentage of recoveries; at least he could recall a good many cases which got well. In considering the question of resection it should be remembered that the bulk of the cases of gangrene occurred in femoral rather than inguinal hernia. He had looked up thirty-one cases from the records of Guy's Hospital, and twenty-six were femoral, four were inguinal, and one umbilical. It followed that the operation would have to be done on small herniæ with narrow necks, and it would be difficult to enlarge the incision freely. The majority of cases which presented themselves were almost moribund before they were operated on, and the surgeon as a rule felt himself justified in doing only that which would preserve life, and was not able to resort to a grave operation. It might perhaps be done where there seemed to be a reasonable chance of recovery, in those instances where the bowel was almost but not quite gangrenous. He held that in these cases the gangrene did not extend upwards, but was a gangrene *per se* following on the long blood stasis. In the cases he had collected there was not one instance of fæcal extravasation, and in only one was there peritonitis other than local. All the patients died collapsed from want of power. It should be remembered that there was often firm union between the neck of the sac and the injured intestine, and hence, if an attempt were made to draw down the gut, the result might be only to tear away the gangrenous portion. In order to draw down the intestine it would be necessary to incise very freely the neck of the sac, and this would be difficult in femoral hernia. The incision in some cases would have to be so free that the result would be literally to perform a laparotomy. In young patients with a hernia in the inguinal region of congenital character and with acute gangrene, the plan suggested by the author would be the best course to pursue. In conclusion, he held that the treatment could only be applied to a very small number of cases, and for the majority the old form of treatment would be adhered to. Sir William Lawrence had recommended that as much as possible of the gut should be returned towards the neck of the sac, so as to leave as small a spur as possible after the gut had sloughed away. He could recall two of Mr. Cock's cases which were treated in this way, and which got well. That these patients did not die from obstruction was evident from the fact that in ordinary cases of strangulated hernia seven, fourteen, or twenty-one days might elapse before the bowels were open, and yet no symptoms of obstruction ensue.

Mr. BENNETT said that the treatment described was no doubt the ideal one, but it was not always easy to adapt an