A NOTE ON A CASE OF FIBROMA OF THE SMALL OMENTUM.

By J. JACKSON CLARKE, M.B. LOND., F.R.C.S. ENG.,
ASSISTANT SURGEON AT THE NORTH-WEST LONDON HOSPITAL
AND AT THE CITY OF LONDON ORTHOPÆDIC HOSPITAL.

IN the Transactions of the Royal Medical and Chirurgical Society for the year 1900, Mr. Pearce Gould has recorded a case that is not only remarkable in itself but also lends a reflected interest to a case that I communicated to the Pathological Society of London in the year 1892. Since

FIG. 1.

The tumour and the liver and the cardiac end of the stomach (A) seen from the front.

Mr. Pearce Gould, in the record of his case of sarcoma of the gastro-hepatic omentum, has fully quoted the pathological account of my specimen as well as the comments that I made upon the surgical anatomy of the tumour, the only reason

FIG. 2.

The liver, the stomach and duodenum, the pancreas, and the tumour seen from behind. The structures in the right border of the small omentum have been exposed by dissecting away the posterior layer of peritoneum. A = stomach; B = pancreas; C = duodenum.

that I have for bringing the subject forward again is that I may remove a defect from the record of my case as it now stands in the place above referred to. Mr. Pearce Gould has drawn attention to this defect by expressing regret that in my account no details of the alteration in the position and shape of the stomach and duodenum or any exact account of the state of the portal vessels and common bile-duct are given. It is fitting to state that these details were included in sketches that I exhibited with the tumour before the Pathological Society of

London. With these sketches before me I can now state that the stomach was of an elongated and narrowed form, the greater part of it lying obliquely behind the tumour. This elongation of the stomach resulted in the pylorus being at a much greater distance from the cardiac orifice than is normally the case. The pylorus lay behind the growth, a little to the right of its median line and about the junction of its lower and middle thirds. From the pylorus the duodenum passed first upwards, then to the left, and finally downwards, completing three-fourths of a circle. The opening of the common bile-duct into the duodenum was situated vertically above the pylorus in the middle of the horizontal portion. The common bile-duct, the hepatic artery, and the portal vein were elongated and lay behind the upper half of the tumour near its right border. The main arterial supply of the growth was an offshoot of the gastro-duodenal branch of the hepatic artery. There was a hepatic branch of the superior mesenteric artery which ran up behind the portal vein to the liver.

Portland-place, W.

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.

WESTMINSTER HOSPITAL.

A CASE OF PYÆMIA AFTER ABORTION IN WHICH THE PERICARDIUM AND THE LEFT PLEURA WERE OPENED AND DRAINED; DEATH.

(Under the care of Dr. W. A. WILLS and Mr. W. G. SPENCER.)

DRAINAGE of the pericardial cavity is still an extremely rare operation, though several of those that have been described have been very successful. It is now generally recognised that it is very difficult to aspirate the pericardium on account of the tendency manifested by the heart to float towards the sternum when the patient is in the recumbent posture. The following case illustrates the importance of ascertaining the nature of the micro-organism present in a case of septicæmia or pyæmia, for we have no reason to think that anti-streptococcic serum would be of any avail in infection due to a staphylococcus. For the notes of the case we are indebted to Mr. H. Hallilay, house physician.

A married woman, aged 24 years, with six children, was admitted into Westminster Hospital on April 4th, 1901, under the care of Dr. de Havilland Hall and during his absence came under the charge of Dr. Wills. The patient was in her usual health until a fortnight before admission. She then was attacked by malaise, joint pains, and feverishness, and took to her bed at once. She was three months pregnant and at the end of the first week of her illness she had a miscarriage. She had had no vaginal discharge before, but after the miscarriage a discharge came on and lasted for about a fortnight. She was admitted as suffering from acute rheumatism with pericarditis.

She was a stout, somewhat florid woman. Her temperature was 103° F. There was considerable dyspnoea. Her face was livid and the *alæ nasi* were working. She was sweating freely but there were no joint pains. There were evident signs of pericardial effusion, the præcordial dullness extending to the left just beyond the nipple line and upwards to the upper border of the third costal cartilage. The impulse was feeble and diffuse. There was a distinct pericardial rub heard at the left margin of the sternum over the base of the heart and the heart sounds were muffled but clear. From the angle of the scapula to the base of the left lung there were dullness, whiffy tubular breathing, and bronchophony, with some increase of vocal fremitus, pointing to pneumonic consolidation of the left lower lobe. Elsewhere over the lungs there were no abnormal physical signs. The pericardial effusion did not