enlargement presenting a rather large quantity of albumin in the urine while lying in bed which disappeared after they had been up for several hours. The albuminous urine was often high coloured, and, like the urine of backward pressure in cardiac disease, lithatic. In all my three cases the night urine was sometimes found to become free from albumin.

It is, of course, necessary that the bladder should be emptied of urine when the patient gets up, otherwise an admixture of the albuminous urine, excreted while in the recumbent position, with the normal urine of the erect position will occur, and the patient may be thought to have continuous albuminuria. The existence of this hypostatic albuminuria, if the term may be used, should be borne in mind when dealing with cases where, as in hospitals, the sample of urine provided for examination is taken from the whole amount passed in the 24 hours or is that passed early in the morning while the patient is in bed.

While the albuminuria is probably due to the mechanical pressure of the spleen on the left renal vein in the recumbent posture, the occurrence of this intermittent or hypostatic albuminuria is very far from constant in cases of splenic enlargement. In this it resembles albuminuria from chronic venous engorgement induced in other ways, as, for example, in the backward pressure of mitral disease. It does not depend on the size of the spleen, for hypostatic albuminuria may be, and, indeed, usually is, absent when the spleen is very large, and may be present, as in two of my three cases, where the spleen is relatively smaller. It is possible that its occurrence or absence may depend on some difference, such as elongation, in the condition of the suspensory peritoneal ligaments of the spleen which thus determine or prevent direct pressure on the left renal vein. On this point there is as yet no anatomical evidence. It is also conceivable that the appearance of albuminuria is dependent on an underlying want of vitality or nutrition in the kidney which, though not sufficiently marked to induce albuminuria under ordinary conditions, does so when chronic venous engorgement is superadded. This is to some extent supported by the observation that in one of the more recent cases albuminuria disappeared from the night urine after the patient had been some time in the hospital, and had somewhat improved under treatment; subsequently after a slight attack of influenza the night urine again contained albumin.

It appears that the appearance of albuminuria in the recumbent position and its disappearance in the erect position is not absolutely constant even in those individuals with enlarged spleen in whom its presence has been noticed; but its temporary occurrence in three cases justifies the suggestion that it may not be so very infrequent.

This hypostatic albuminuria is the reverse of what usually occurs in cyclical albuminuria, but it is possible that there may be some cases of cyclical albuminuria in which albumin appears when the patient is lying down and disappears when he is up. I have not yet met with a case, but the possibility of such an event is suggested by Edel's³ recent observations that a weak pulse and the appearance of albumin in the urine in cyclical albuminuria are related, and that if, by regular muscular exertion, such as marching or hill-climbing, always stopping short of fatigue, the heart's action is strengthened, the urine becomes free from albumin, lighter in colour, and more copious.

Upper Brook-street, W.

³ Münchener Medicinische Wochenschrift, 1901, Nos. 46, 47 (Abstract, Brit. Med. Jour., 1902, vol. i., epitome No. 63).

A TOWN COUNCIL MUDDLE AT BULAWAYO.—At a meeting of the Bulawayo Town Council held on Jan. 20th, mention was made by the sanitary inspector of a case of typhoid fever the source of the infection of which could not be traced. The mayor stated that the advisability of appointing a medical officer of health would be discussed at a subsequent committee meeting. The disposal of slop and other contaminated water was also discussed. The chief sanitary inspector was asked to draw up a plan for dealing with the water, but it was eventually decided to postpone the matter. It is little more than a month ago since the Bulawayo Town Council decided, in pursuance of a "scheme of retrenchment," to abolish the office of medical officer of health as well as those of the town clerk and the town engineer. The chief sanitary inspector (acting town clerk) has resigned and the muddle thus created will certainly not help forward the health of the town.

REMOVAL OF A SARCOMATOUS TUMOUR FROM THE TAIL OF THE PANCREAS OF A CHILD FOUR YEARS AND EIGHT MONTHS OLD;

SECONDARY GROWTH IN THE PORTAL VEIN.¹

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THE following case seems sufficiently interesting and rare to be put on record.

The patient was a female child and was born on March 9th, 1894. Her father and mother are both alive and well; they have one other child, a healthy girl, born in 1897. One of the patient's grandfathers was said to have died from an internal cancer at the age of 65 years. The patient had whooping-cough when she was three weeks old. It was not known that she had suffered from any lung trouble. The bowels were very constipated whilst she was under immediate observation. There was no albumin in the urine, which was scanty (sometimes only 12 ounces in 24 hours), and deposited urates, its specific gravity being usually about 1030. An abdominal swelling was first noticed in April, 1898, and Dr. R. L. Guthrie sent the patient to a well-known surgeon who diagnosed a tumour of the left kidney but advised that no operation should be performed. Dr. Guthrie asked me to see the patient in May of the same year. She had then an obvious swelling in the upper part of the left side of the abdomen. It was firmly held in the position of a renal tumour, but the attachments seemed sufficiently lax to allow of the growth being shelled out of its bed. The patient was, however, extremely emaciated and anæmic, having a cachectic appearance which seemed to contra-indicate surgical interference, and I therefore agreed with the opinion and advice already given.

Dr. Guthrie treated the child with iron and laxatives, and in October, 1898, he asked me to see her again. She then had improved very much in her general condition, had quite a good colour, and was not thinner. The tumour had increased in size, but not to any great extent. It distended the hollow of the left loin, pushing the lower ribs upwards and forwards, bulging the side outwards, extending across the abdomen as far as the outer edge of the right rectus muscle and downwards to below the level of the anterior superior iliac spines. The greatest girth of the body was 23½ inches a little above the level of the umbilicus. On palpation the mass was smooth and elastic. It could be grasped between a hand in front of the abdomen and the other hand behind the loin, and although it was firmly held, there was still a slight mobility of the tumour, sufficient to make me think that I could remove it. There were some easily felt glands in both axillæ and in both groins, but they were not enlarged. The veins over the upper part of the abdomen were distended. No disease of the heart or lungs was detected. In view of the greatly improved condition of the child's general health I told the parents that she had a tumour of the kidney and explained that an operation would involve extreme risks. I also told them that I knew of only three cases in which after the successful removal of a tumour of this kind from a child the patient had survived more than a few months.² On the other hand, I pointed out that death must occur soon if nothing were done. It was decided to accept the risks of an operation.

On Nov. 4th, 1898, chloroform was administered and the tumour then seemed decidedly more mobile. I opened the abdomen through the upper part of the left linea semilunaris, and exposed the growth, with the splenic flexure and adjacent portions of the colon fixed in front of it. The most convenient place to open the retro-peritoneal space, in which the tumour lay, was above the transverse colon, and when the peritoneum in that situation was divided I had no difficulty in separating the tumour from the connective tissue in which it was loosely imbedded. Some firm adhesions to the lower end of the spleen were separated and the new

¹ A paper communicated to the Pathological Society on Feb. 18th, 1902.

² The patient in one of these cases, which was published by myself in the Transactions of the Clinical Society of London, 1894 and 1895, is alive and well, more than nine years after the operation.

growth was then easily drawn out of the abdominal cavity, the tail of the pancreas being dragged out with it. The tumour was then only attached to the pancreas and it was impossible to separate them without cutting through pancreatic tissue. In doing this large vessels were divided, but hæmorrhage from them was easily controlled by liga-

FIG. 1.

Tumour removed from the tail of the pancreas. The figure is about half the actual size of the tumour which measured five inches in its longest diameter. No. 2836A, Royal College of Surgeons of England Museum.

attempt an investigation of the nature and connexions of this second abnormal condition. I therefore ligatured all bleeding points, having much trouble in securing those on the spleen. I washed out the abdominal cavity with warm sterilised salt and water, leaving as much as possible inside, when the wound was sewn up, with a view to counteracting the shock of the operation, which, however, was not survived by the patient.

At the necropsy, which was conducted by Dr. Cuthbert H. J. Lockyer, caseating glands were found near the bifurcation of the bronchi and in the anterior mediastinum. There were extensive old pleuritic adhesions on the right side. There was no sign of peritonitis or of union of the lips of the wound. The peritoneal cavity was full of fluid (the salt and water introduced at the operation), which at first flowed away clear, but that from the loin pouches was deeply blood-stained. The kidneys were healthy and were normal in position. Part of the transverse colon was separated from its attachments, its meso-colon having been completely divided, and the omentum had been removed from all but the left one and a half inches of the stomach. The left pleuro-colic fold was intact. The spleen had a wound on the lower end of its inner surface one and a half inches long. The left half of the pancreas was absent, its cut surface presenting many ligatured points. There was a smooth encapsuled growth situated in the gastro-hepatic omentum with the bile-duct and some vessels in front of it. The neck of the gall-bladder, and the transverse fissure of the liver were above it. The foramen of Winslow was behind and the new growth seemed to be connected with the head of the pancreas below, the connexion between the two being much constricted.

The parts were sent to the Royal College of Surgeons of

FIG. 2.

Under surface of the liver, parts of the stomach, duodenum, and gall-bladder and the divided portal vein greatly distended. In dividing the vein the tumour also was divided into two unequal parts, the larger of which, nearer the liver end of the vein, was found to be quite unattached and has been removed; a considerable portion of the remaining part of the tumour is also obviously unattached. The vein was not occluded; a bristle is seen passing by the side of the tumour through the lower portion of the vessel. (Half size.) No. 2836B, Royal College of Surgeons of England Museum.

tures. No ureter was seen during the operation. There was a second new growth, of about the size of a bantam's egg to the right of the cavity from which the tumour had been removed. I thought that this was a collection of glands affected by malignant disease, but the patient was in such a serious state of collapse that it was out of the question to

England and when they had been dissected it was found that the mass in the lesser omentum was a new growth inside the portal vein and widely distending it. Mr. Shattock has examined the tumours and both are fibro-sarcomatous in structure. The specimens are preserved in the museum of the College and the accompanying illustrations (Figs. 1 and 2),

which are reproduced from photographs taken by Mr. H. George, give a very faithful representation of their appearance.

Although the nature of the tumour removed in this case was doubtful even at the end of the operation the conditions found at the post-mortem examination of the body showed that it certainly had grown from the pancreas, from which it had been noted that the chief blood-supply of the new growth came; a larger portion of pancreas had been removed than I thought when operating. The differential diagnosis between an enlarged kidney and a tumour of the tail of the pancreas may be quite impossible. Once before³ I operated on a tumour having almost exactly the same relations as in this case to the tail of the pancreas and to the surrounding structures, and I was assisted in mistaking the tumour for a renal enlargement by three of the most experienced men in London. I removed a cystic tumour, having to divide the pancreatic tissue as in the case now recorded. In that case I examined the parts during the operation and found the kidneys and spleen in their normal positions. The patient made a good recovery, is still alive, and has had no further trouble from the tumour or from the operation. In neither of these cases was there any difficulty in arresting hæmorrhage from the pancreatic tissue, although in the first case there was much trouble in finding a bleeding point. In the present case it did not seem to me that there was any great difficulty in arresting hæmorrhage from the torn spleen by pressure or even by ligatures except that it was very far from easy to expose the parts to view. But the presence of an obstruction in the portal vein and the fact that towards the end of the operation the patient was in a state of extreme collapse render observations on this point of little value in this case. It is obvious that no operation could have cured the patient, but it was not possible to discover the smaller secondary growth until the larger one was extracted. I was right, however, in considering that the tumour diagnosed was removeable. If there had not been a secondary growth there would have been a very fair prospect that the patient might have done well, and I regret that I did not recommend operative treatment when I first saw the child.

Portman-street, W.

GENERAL REMARKS ON ASYLUM DYSENTERY AND ITS TREATMENT BY INJECTIONS OF PERMANGANATE OF POTASH.

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At a time when attention is being directed to irrigation of the bowel as a successful method of treating dysentery and allied conditions mainly in the light of experience gained during the South African campaign, it may be of interest to give a few details of the treatment of this troublesome complaint by means of injections of permanganate of potash.

Asylum dysentery, or so-called "colitis," has of late years been a source of much anxiety in many of the institutions for the insane in this country. The subject has been fully and lucidly dealt with by several able writers, but beyond mentioning the stock remedies the question of treatment has occupied a subsidiary place. The main object of the numerous workers, in what threatens to turn out a somewhat unprofitable field of research, would seem to be the elucidation of the causation and spread of this vexatious and recurring complaint. At a recent meeting of the Epidemiological Society the whole subject was re-discussed in all its bearings, and the two points on which there seemed to be a general agreement were the spread of the complaint by the removal of patients from one institution to another and the infectious nature of the disease as evidenced by its occurrence among patients sleeping in dormitories. While dysentery has been more common in asylums of late years than formerly, it must not be supposed that it is a new complaint in these institutions. There are records and particulars of its occurrence in asylums long

before the present-day ideas of germs, bacilli, &c., were promulgated. Numerous as have been the attempts to trace the origin and spread of dysentery in asylums no very clear or definite ideas have yet been arrived at. Overcrowding, sanitation, ventilation, and so on, have respectively been penalised, but there is no consensus of opinion why dysentery should have become a troublesome complaint in a latter-day nineteenth-century asylum, and that, too, where none of the causes already mentioned exist. Defects in sanitary arrangements would be sufficient, but often none exist, and the attempts to associate the disease with a certain well-known system of warming and ventilation have completely failed. As regards overcrowding there are numerous instances of its appearance where overcrowding did not exist. At the same time, where there is congestion of space, if not actual overcrowding, the conditions are favourable, and if there is associated with these the unnatural craving for warming dormitory space I am of opinion that a fair explanation is offered for the occurrence of many cases of dysentery. In round numbers three-fourths of asylum patients are physically hale and hearty and should not, and do not, require artificially warmed space after 8 P.M.

During the autumn of 1899 and the spring of 1900 dysentery appeared in the Dorset County Asylum, and while the cases were not numerous, yet they were sufficient in number to cause inconvenience and anxiety. Starting on the female side, the cases were of the usual well-known type and character and the number of severe attacks were in about the usual proportion. After a time, and when there were no cases in the women's wards, cases began to appear on the male side, and these, if fewer in number, were more severe than among the women. At this time the ordinary therapeutic remedies were employed and in a few cases injections of a solution of nitrate of silver were tried, but the results were most discouraging. As far as practicable the cases were isolated and the complaint disappeared from our midst, only to reappear again in the winter of 1900. It was during this second outbreak that the use of injections of permanganate of potash was resorted to. As soon as the case was diagnosed to be one of dysentery the lower bowel was washed out night and morning with a weak solution (from two to four grains to the pint) of permanganate, the instrument used being an ordinary enema syringe. The motions rapidly lessened and seldom had the treatment to be prolonged beyond the third day. In every one of the cases—and several of them were severe—the patients recovered. Not only was the treatment successful, but by the early and judicious use of the injections the outbreak was cut short. At the time doubts were entertained as to the value of the treatment, but after a further experience these doubts were removed and now every case of a dysenteric nature or of severe diarrhoea is treated by this method. In each instance recovery has followed the treatment. Apparently the permanganate acts in its double capacity of a disinfectant and a styptic. In the more severe cases milk as an article of diet was found to be unsatisfactory. It was not only rejected but it increased the intestinal irritation. This, I believe, is not an uncommon experience. The main article of diet used was a mixture of special beef-tea and specially prepared rice, together with a liberal allowance of port wine. To ensure success the treatment should be commenced early and thoroughness is an essential precaution. In one case only after the permanganate treatment had been adopted has there been an opportunity of examining the bowel post mortem. This was the case of a demented melancholic who had a very severe attack of dysentery from which she made an excellent recovery. The injections were continued for five days and the patient was quite convalescent in three weeks. Soon afterwards she developed acute double pneumonia to which she succumbed. At the necropsy the mucous membrane of the rectum showed numerous healed ulcers, so different from the ulcerated congested state of the bowel in fatal cases from dysentery. Two classes of patients—the tuberculous and the general paralytic—invariably give bad results. The reason is too evident to need any explanation.

While my experience of the permanganate has not been extensive I think it has been sufficient to warrant the results being made known and I am hopeful that this short paper may be the means of inducing others to try the treatment as opportunity occurs.

Dorchester.

³ Transactions of the Medical Society of London, 1898.