She made an uninterrupted recovery in about ten days. Strange to say, abortion did not result, as might have been expected from the indirect action on the uterus.

AN UNIQUE DISLOCATION OF THE FOOT, AND OF THE ASTRAGALUS.

BY JOHN R. HAM, M.D., DOVER, N. H.

I was called on April 25, 1892, to S. W., the proprietor of a portable steam-mill, who, while sawing logs, came in contact with a piece of shafting which was revolving at the rate of six hundred times a minute.

He may not have made more than one revolution when his clothing gave way and he was rescued. I found the malleoli widely separated and projecting; the foot forced directly upwards and firmly wedged between the tibia and fibula; the depth of the foot from the extremities of the malleoli was obliterated; and the movements of the foot gone. There was no fracture, nor was there any external wound.

Under strong extension and counter-extension the foot was finally loosened and pulled down from between the bones of the leg, which came together with an audible snap when the wedge was removed.

I now discovered a complete backward dislocation of the astragalus, which lay between the tendo-Achillis and the posterior surface of the tibia.

The reduction of this bone was a much more difficult matter, but after half an hour's effort aided by two strong assistants in extension and counter-extension, and when on the point of despair as to a successful issue, I succeeded in slipping the bone in place.

Ether was not used because it was not on hand and, the patient being three miles from the city, it was not thought best to delay in the reduction.

Reports of Societies.

OBSTETRICAL AND GYNECOLOGICAL SECTION OF THE SUFFOLK DISTRICT MEDICAL SOCIETY.

GEORGE HAVEN, M.D., SECRETARY.

REGULAR meeting, Wednesday, January 13, 1892, the President, Dr. C. M. GREEN, in the chair.

ANATOMICAL SPECIMENS.

DR. C. P. STRONG: I have here a very small cyst of the broad ligament which I removed this morning, and which is interesting for one or two reasons. The patient was a girl of twenty-two, who had always been perfectly well except that she had menstruated only about once in eight or nine weeks, — irregular in that respect. Until eleven weeks ago she had not known what it was to be ill at all. Then she was upon her feet a good deal, and commenced to have pains in her left side which constantly increasing, had made her an invalid so that she had spent most of her time in bed since I saw her for the first time about three weeks ago, and then made out a cyst of some kind. I thought it was a small dermoid back of the uterus. I advised operation on her at once without any treatment because the family were dependent on her efforts to earn money. I operated to-day and found this cyst lying in the broad ligament. This ovary

which was also removed, was very much larger than now appears, due to a large cyst in its interior which has been ruptured. The tubes were apparently perfectly normal.

Another interesting point is that the broad ligament of the other side is similarly affected, the only difference being that on the right side the cyst growing in exactly the same location was about the size of an American walnut. The right ovary contains numerous small cysts, but as I did not see any reason if the cysts were opened and their walls destroyed that they would grow again, under the circumstances I thought it best to run the risk of a second laparotomy at some future date and allow the ovary to remain. That ovary was considerably enlarged. I laid open the cyst and thoroughly cauterized its interior wall.

The point of interest aside from the condition of the tube and the parts on the other side being similarly affected, was the great amount of disability arising from the presence of these cysts, and the fact that they had come on so suddenly. There were no adhesions, nothing to account for the great pain from which she certainly did suffer.

THE PATHOLOGY, DIAGNOSIS AND TREATMENT OF PELVIC INFLAMMATIONS.¹

DR. J. R. CHADWICK: There are so many starting-points for inflammation in the pelvis that it is hard to speak of the diagnosis and go over the whole ground. What we have to consider generally are pelvic peritonitis and pelvic cellulitis. While the symptoms do not vary essentially between the two, my experience would teach me that they vary somewhat in degree, that is, that a pelvic peritonitis gives rise to much more violent symptoms than pelvic cellulitis. The symptoms briefly may be said to be first a chill followed by pain, constant and lancinating, and fever with, on the second or third day, more or less metrorrhagia with some distention of the bowels, sometimes a diarrhoea, not regularly. Those, I presume, would be accepted as the symptoms that are generally present.

In peritonitis of course the location of the pain in the early stage is characteristic of the part where the inflammation originates. From that point of origin the disease may spread indefinitely. Of course it involves more or less all the organs which are invested with peritoneum, habitually starting, as the pathology to-day I suppose would say, in a large number of cases from inflammation of the tubes, originating undoubtedly often from hematocoele, and, as I believe, originating sometimes from traumatism; that is, I cannot satisfy myself that the cases are all attributable to the introduction of germs, though I know that is held by many.

In regard to the diagnosis, we have had the symptoms of the physical conditions. The most striking is the induration which is felt through the roof of the vagina, especially the posterior cul-de-sac. I should say, before going further, that in my experience the pelvic peritonitis is the common disease. Pelvic cellulitis is extremely rare, a statement that is in opposition to what most of our older books held. I have not found one case of cellulitis to one hundred of peritonitis according to my diagnosis. The induration which is felt by the vagina is of course limited in the case of peritonitis to the peritoneal cavity, that is, it

¹ See articles by Drs. Fitz and Cabot on pp. 491 and 493 of the Journal.