be freely and thoroughly excised, but that in addition a clean sweep should be made of its lymphatic connexions. It is unnecessary in this article to enumerate the pathological considerations which have led to the adoption of this principle, but it is very necessary to examine the question as to how far the principle has been applied to the practice now employed.

First, as regards anatomy. It is a matter of fact that efferent lymphatic vessels run from the axillary glands through the apex of the axilla into the posterior triangle, and after forming connexions with the glands therein finally enter the thoracic duct on the left side and the right thoracic duct on the right side. Moreover, superficial lymphatics from the skin covering the mamma track up over the clavicle to these same glands in the posterior triangle.

Now, to examine the practice. It is laid down that in primary malignant disease of the breast the axilla should be cleared out (after removal of the breast), whether the glands be visibly infected or not. Why? Because the fact that they are not affected macroscopically is no proof that they are not affected microscopically. And yet, in the face of the anatomical facts quoted above, it is not the usual custom or practice to go further. If it is wrong to assume that the axilla is free from disease because it shows no sign to the naked eye or finger, it is equally wrong to assume that the posterior triangle has escaped. If it is right and peremptory to clear the axilla, it is also right and peremptory to clear the posterior triangle. Still more is it inconceivable how the triangle can be left untouched if the axillary glands are found to be clearly affected at the time of operation.

It may possibly be objected that it is not feasible or is difficult to clear the posterior triangle. To this it can be replied that by a flap operation done a week or ten days after the primary operation a clean dissection can be made of the whole posterior triangle, that it is not difficult, and that it is quite feasible. A flap formed by a long incision down the sterno-mastoid muscle meeting an incision along the clavicle is detached as far back as the anterior border of the trapezius; this exposes the triangle, and the contents can be systematically removed with a little care and patience. By such means the acknowledged principle would be carried out as far as is possible, and if the principle is right it seems incumbent upon the surgeon to strive to apply it thoroughly in practice and not to be content with stopping half-way. It is not suggested that this is the best method of operating, and inasmuch as two cases only have been so treated, and those comparatively recently, no results of value can be produced. It is hoped, however, that this article will serve to ventilate the question as well as to point out that at present the practice appears to directly clash with the acknowledged principle.

Brighton.

BRITISH MEDICAL TEMPERANCE ASSOCIATION.—

A meeting of the British Medical Temperance Association was held on Wednesday, Dec. 11th, at the London Temperance Hospital, when a paper was read by Dr. C. R. Drysdale on Therapeutics without Alcohol, in which he contended that alcohol was of little, if any, use in the treatment of disease. Sir B. W. Richardson, who presided, said that, in conjunction with the late Dr. Farr, he had found that more people were killed by alcohol than by phthisis. The discussion was continued by Dr. Norman Kerr, Mr. Hazel, Dr. Paramore, and Dr. Ridge, and a vote of thanks was accorded to Dr. Drysdale.

INFIRMARY MEDICAL SUPERINTENDENTS' SOCIETY.

The December meeting was held at the infirmary of St. George's-in-the-East on the 14th inst., Mr. J. R. Lunn being in the chair. Dr. M. M. Bowlan (medical superintendent of St. George's-in-the-East) exhibited cases of Extensive Ulceration of both Feet; Suppuration of Knee-joint cured and perfect movement regained by draining and free irrigation; Congenital Heart Disease; Pityriasis Rubra; and Jaundice associated with Rupial Eruption. The question of a uniform diet for all workhouses within the metropolitan area was discussed and approved of, Mr. Walter Burney (Greenwich) pointing out that those houses which adopted a more liberal diet were favoured with the company of the professional workhouse loafer, who was a pest to society and made these institutions unendurable to the respectable poor. Various other administrative matters were discussed, and a vote of thanks to Dr. Bowlan for his interesting series of cases terminated the proceedings.

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.

MIDDLESEX HOSPITAL.

ACUTE PERFORATION OF AN ULCER OF THE STOMACH;
LAPAROTOMY; RECOVERY.

(Under the care of Dr. W. PASTEUR and Mr. HENRY MORRIS.)

THIS case makes the eighth record of operation for perforation of simple ulcer of the stomach that we have published in the Mirror of Hospital Practice during the course of the present year. It was, however, the first of the series to be subjected to operation, and has probably been already referred to, although not previously published. It is a very important case, because it shows distinctly the local symptoms which may be present soon after perforation has taken place, at the stage, in fact, when morphia is so often given and much valuable time lost in consequence of the masking of symptoms which that drug produces. The absence of rigidity of the abdominal muscles when the girl was first seen, although there was already a loss of the liver dulness, should be especially noted; it was not long before this rigidity or "guard action" was found, but that it may be absent at first is an important observation. In the seven other cases referred to life was saved by operation in four cases, and in a fifth it was prolonged until the eleventh day. In all but one the perforation was of an ulcer on the anterior surface of the stomach. The fact which comes out most prominently in these records is the importance of early operation. The successful results were gained when there had been intervals of six, nine, nine, and thirteen and a half hours between the first symptoms and the operation, and death ensued when the intervals had been fourteen, nineteen, and nineteen and a half hours. This is a most striking fact, more strongly emphasised as the patient who only lived for ten days was the one operated on fourteen hours after the commencement of the symptoms. In the larger number it was possible to suture the opening in the stomach, but in one the tissues around the opening gave way, and it was necessary to excise the edges in order to reach healthy parts for the sutures. In one case a tube was passed into the stomach through the opening. For the notes of this case we are indebted to Mr. W. E. Huddleston, house surgeon, and Mr. John Murray, surgical registrar.

A young woman aged twenty-four years, single, presented herself at the out-patient department of the Middlesex Hospital on March 10th, 1894, at 3.30 P.M. She had enjoyed good health until two years ago, when she became subject to indigestion, which, however, had only given trouble during the preceding six months. The chief symptom was epigastric pain very soon after taking food and lasting for some two hours. During the previous three months there had also been sickness after food, sometimes on several successive days, and for the last six or eight weeks the patient had not touched meat or potatoes on account of the pain which followed. On one occasion, some four months previously, she vomited a small quantity of dark blood. The bowels had never given her any trouble. She had been under treatment for dyspepsia during the last few weeks. The patient was in her usual health on the morning of the 10th, and took boiled haddock at her midday meal (12.30). At 2.30 p.m., as she was hurrying upstairs, she was suddenly seized by a strong "drawing" pain in the lower abdomen. This rapidly increased in area and intensity, and by the time she reached the hospital, an hour later, had spread over the whole abdomen. She managed to walk to the hospital, about a quarter of a mile, but was doubled up with pain and felt faint. There was no vomiting. Her appearance when first seen did not in any way suggest the nature of her illness. As she lay on a couch in the out-patient room, with slightly flushed cheeks, without pinching of features or anxiety of expression, answering

questions readily in a clear voice, there was little to suggest acute perforation of the stomach. Physical examination of the abdomen, however, left little room for doubt as to the true state of things. There was slight uniform distension of the abdomen; the abdominal wall was quite flaccid, and gentle palpation could be borne without much pain. The percussion note was everywhere tympanitic and the liver dulness was completely obliterated. The patient was at once removed to the wards, and when seen again an hour later her condition had already changed considerably for the worse. The face was now anxious and somewhat pinched, the abdominal wall had become rigid and acutely tender, the girth at the umbilicus was greater since admission by more than one inch, and pain was rapidly becoming more acute. At 6.30 P.M.—just four hours after the first onset of symptoms—Mr. Henry Morris operated. A median incision four inches long was carried from the costal angle towards the umbilicus. After dividing the superficial structures the peritoneum bulged up into the wound, and on being nicked allowed a quantity of offensive gas to escape. When the peritoneum was divided the distended colon presented in the wound. This was returned into the cavity, flat sponges were introduced, and the wound enlarged downwards to the umbilicus. On drawing the stomach up into the wound a perforation the size of a No. 12 catheter was brought into view. It was situated close to the pylorus on the anterior surface near the greater curvature. The ulcerated portion of the stomach was invaginated by means of eight Lembert sutures of No 2 silk, a second row of sutures being placed more superficially to strengthen them. The peritoneum was thoroughly irrigated with a 1 in 400 carbolic solution at 105° F., and the pelvis sponged out as dry as possible. The various peritoneal pouches were similarly dealt with. Much lymph was removed from the surface of the liver. The abdominal wound was closed with nine thick silk sutures, and the ordinary dressing applied. During the irrigation of the peritoneum the pupils became widely dilated, and there was a tendency to failure of respiration. Much difficulty was experienced in maintaining respiration for an hour or two after the operation. At 9.30 P.M. breathing was of the Cheyne-Stokes type, the pulse had improved considerably, and the temperature was 98°. On March 11th the patient had slept five hours and a half during the night. She complained of pain on respiration. There was no sickness. The temperature was 99.8°. She was ordered to take nothing whatever by the mouth; a morphia suppository was to be repeated if necessary, and a rectal tube to be passed frequently. On the night of March 11th the patient was sick twice and again four times on March 12th. The vomit was watery and bile-stained, but contained no blood. At 4 P.M. she was ordered one teaspoonful of hot water every hour. The pulse was 116, the temperature 99.6°, and the respiration 26. On March 13th there had been no more sickness. She was ordered two teaspoonfuls of hot tea and milk every hour. On March 14th a simple enema was administered. Her diet consisted of six ounces of tea and twelve ounces of hot water in the twenty-four hours. Nutrient enemata were ordered to be given every four hours. On March 15th urine was passed naturally for the first time. One teaspoonful of prepared meat juice every two hours was ordered. On March 18th the patient was improving steadily. The stitches were removed on this day. Two ounces of arrowroot every five hours were ordered. On March 22nd progress was uninterrupted. There was some distension, which was relieved by a rectal tube. On March 24th the wound was nearly healed. The patient left the hospital cured on April 7th. She came again to the out-patient department more than twelve months after the operation complaining of pain after food, which rapidly yielded to simple remedies. She stated that she had been perfectly well and strong ever since leaving the hospital.

Remarks by Dr. PASTEUR.—This case illustrates many points which have been emphasised by subsequent experience. The early recognition of the nature of the case and the prompt resort to operative procedure doubtless contributed in no small measure to the recovery of the patient. The diagnosis was made within one hour of the onset of symptoms, and before five hours had elapsed the perforation had been closed and the peritoneum thoroughly cleansed. The importance of an early diagnosis is self-evident, and with increasing knowledge of these cases this should become more and more easy of attainment. The value of "obliteration of the liver dulness" in this instance was manifest.

Had this not been recognised when the patient was first seen the difficulty in making a diagnosis would have been much greater. The history and the mode of onset were, it is true, suggestive of the true cause; but in view of the complete absence of the pinched look of the face, of the tense, tender abdomen wall, and of all signs of general collapse, one might well have hesitated to give an opinion on the spot and felt disposed to watch the case awhile before making a definite diagnosis. I am doubtful, however, whether delay, even in such circumstances, could be justified. Personally, if in doubt at the outset of a case of this kind I would rather urge a patient to run the comparatively trifling risk of an exploratory incision than allow the time to pass by when an operation might have cured an otherwise necessarily fatal accident. Two other factors also doubtless contributed to the favourable result—the one, the good general condition of the patient, and the other the almost complete absence of the initial collapse which is so often met with in these cases. This last is probably a point of considerable importance in estimating the chances of success in any given case.

CHRISTCHURCH HOSPITAL, NEW ZEALAND.

INTERESTING SURGICAL CASES IN THE WARDS.

(Under the care of Dr. COURTNEY NEDWILL.)

WE are pleased to be able to bring before the readers of THE LANCET the notes of the following cases of successful surgery in the hospital of Christchurch. Hydatid disease is very common in the colony of New Zealand, and cysts have been met with in all the various internal organs. We can only suppose that the thyroid has escaped implication to the extent shown by Dr. Nedwill because of its comparatively small size. With regard to the size of stones which have been removed from the bladder by the suprapubic route during the life of the patient, we published in THE LANCET the account of a case under the care of Mr. Milton,¹ who extracted a stone, now in the museum of the Royal College of Surgeons of England, which weighed thirty-four and a half ounces by suprapubic cystotomy from the bladder of a fellah aged sixty. The man lived two months and a half and then died from kidney disease. Even this is exceeded by the case referred to in Ashhurst's "International Encyclopædia of Surgery," of which we have been recently reminded by Sir G. M. Humphry,² where a surgeon removed a stone weighing forty ounces and a half. The man did not survive more than eight days. It is to be expected that extraction of the larger stones should be more frequently followed by a fatal result, as their long sojourn in the bladder will have caused more extensive changes in the kidneys. When small ovarian tumours are attached by long pedicles they are difficult to diagnose from movable kidney, wandering spleen, and tumours of the omentum or intestine, or uterus. When larger, and there is likewise a considerable amount of free fluid in the peritoneal cavity, difficulty arises in another way, as it is often quite impossible to determine the exact nature of the growth, whether it is cystic or solid, &c., and the only way to make certain is to perform abdominal section. Those experienced in abdominal examinations can frequently make a shrewd guess, but short of operation there is little to help in the diagnosis between a moderate-sized sarcoma of the ovary, with multiple growths in the peritoneum, and a multilocular ovarian tumour of similar size one of the cysts of which has been slowly filling the peritoneal cavity with fluid after its unnoticed rupture.

CASE 1. Hydatid cyst of the thyroid gland.—A girl eight years old was admitted on July 1st, 1895, on account of a tumour occupying the central part of the thyroid gland. Her mother said she first noticed a lump in her child's throat about three years previously. During the last three months the child had had great difficulty in breathing, especially at night, frequently starting up in bed, throwing her hands about, and appearing as if she would be suffocated. After her admission she had several severe attacks of dyspnoea. On July 3rd she was placed on the operating table and an attempt made to anaesthetise her which had to be abandoned

¹ THE LANCET, Sept. 16th, 1893.

² THE LANCET Nov. 30th, 1895, p. 1342.