

the eye forwards and outwards. The iris was slightly discoloured; the pupil was large and acted very slowly to light. There was a slight deposit of semi-transparent lymph on the anterior capsule of the lens. The fundus was slightly hazy. The veins were extremely swollen and dark, with peculiar constrictions, which gave the appearance of a string of sausages. The disc was slightly congested and the edges slightly blurred. Vision = $\frac{6}{60}$. There was pulsation of the retinal veins. A loud, intermittent, blowing noise could be heard with the stethoscope on the whole of the right side of the head, being most marked over the orbit and temple. On pressure on the internal carotid the noises nearly ceased. The patient was kept in bed for some days. The pain slightly decreased, but otherwise there was no improvement. On Nov. 6th the internal carotid was tied. The noises at once ceased; there has been no pain since. The exophthalmos

into the cavernous sinus. 3. The communication must have been at first small and gradually become larger, as the protrusion of the eyeball increased for three weeks, and as there was no history of a sudden violent pain or sudden intense noise. 4. The vision was fairly good; there was no marked papillitis. This proves that there must have been a free anastomosis between the central retinal vein and the inferior ophthalmic veins. 5. There was no pulsation except when the patient bent the head. This is the second case of pulsating exophthalmos which has come under my notice; the first case is recorded in the Transactions of the Ophthalmological Society, vol. ix.

Bradford.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF EMPYEMA OCCURRING IN A VERY YOUNG CHILD.

BY MALCOLM MACKINTOSH, M.D. GLASG.

THE child in question was a female aged four weeks and four days who was found dead in bed beside its mother at an early hour on the morning of April 5th last. The parents are healthy, and the baby, who was born at full term after an easy confinement, showed no sign of anything abnormal. It was fed at the breast and never had any difficulty in taking its food easily and naturally. The mother noticed nothing worthy of remark until the evening before the child died, when she observed that it gasped several times in a way that she had not noticed before; but on referring to the nurse she was told that in all probability it was due to "wind," and the matter was allowed to drop. Post mortem the brain and abdominal organs were found to be free from disease, but on opening the thorax the cause of death was soon discovered. The left pleural cavity was full of pus, and the lung was represented by a small hard mass situated at the posterior part of the chest, which seemed to me never to have expanded at all. The amount of pus present was about eight ounces. It is a very interesting question as to whether the disease was present before birth or was a subsequent development.

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A CASE OF SPERMATOCELE.

BY T. W. CARMALT JONES, F.R.C.S. EDIN.,

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ON Dec. 14th, 1894, a man consulted me about a swelling connected with his left testicle. He was twenty-four years of age, and the swelling was first noticed when he was thirteen or fourteen. There was a feeling of weight and some pain, especially at night, and in bed the feeling of weight worried him. He had worn a truss for double inguinal hernia since the age of seven constantly. The swelling did not interfere with cycling, rowing, or wrestling, but he always wore a suspender. He had not gone in for gymnastics. There was no history of a blow, though he used to play football. On examination there was a tense sausage-shaped swelling, apparently in the left cord, projecting for about an inch above the testicle, with a smooth rounded upper end; lower down the swelling became indistinct at the back of the testicle, but below and behind there was again a smooth round-ended swelling projecting below and behind the testicle. No sense of fluctuation could be made out as the tumours were so tense; but on percussion the impulse was distinctly conveyed from one end to the other. The scrotal skin was very thick, and I could not see any light through the tumour. I diagnosed either an old hydrocele or a hæmatocele, and advised tapping. On Dec. 16th I drew off two ounces and a half of opaque, milky-looking fluid with a yellow tinge; it looked exactly like egg and milk, but on standing the yellow colour disappeared and the fluid became slightly brown. After the tapping the whole swelling disappeared alike above, behind, and below the testicle. The



gradually decreased, and the patient made an uninterrupted recovery. She was kept in bed for three weeks. For the first few days there was slight pain on swallowing. Peculiar constant whistling noises were heard for four weeks in the right ear. On Jan. 15th, 1895, the vision was $\frac{6}{12}$. There was very slight swelling of the upper lid, and no exophthalmos. The movements of the eye were normal, except for some slight difficulty in turning the eye outwards. The retinal veins were still much swollen and rather dark. The disc was normal.

This is undoubtedly a case of so-called pulsating exophthalmos, and caused by anastomosis of the internal carotid and the cavernous sinus. These cases, of non-traumatic origin, are more common in women and between the ages of thirty-five and forty-five. There are several rather interesting points in this case to which I will briefly refer. 1. There was no history of a blow or fall, no confinement or serious illness, and no arterio-sclerosis or heart disease. 2. There was intense pain for seven days before the noise was heard or the eye began to protrude. The pain was evidently caused by an aneurysm of the internal carotid, which increased in size for seven days and then broke

child was sent to Mr. Wyatt Wingrave for examination, and his report was as follows: "Report upon a specimen of fluid received from Mr. Carmalt Jones, Dec. 18th, 1894.—Quantity: two ounces and a half. Colour: café-au-lait, opaque. Reaction: alkaline. Specific gravity, 1032. Odour: faint; stale. Ash. Microscopic: (1) spermatozoa (dead), about 5000 in 1 c.mm.; (2) large nucleated round cells undergoing fatty degeneration; (3) fatty spheres about 3μ to 15μ in diameter; (4) granular pigmented spheres 10μ to 40μ in diameter; (5) small irregular granular masses 2μ to 5μ in diameter. Organic matter: fat in abundance, hæmatin, serum albumen, and nucleo-albumen. Inorganic: chiefly phosphates and chlorides. Coagulation could not be induced except by heating. There were no crystals of either cholesterolin, spermin, or hæmatin. On extraction with ether some free cholesterolin crystals were obtained. The fluid is evidently derived from a cyst connected with the testicle which has formed some association with the blood. Judging from the presence of pigment, it has been gradual in formation." The last time I saw the patient was on Jan. 16th, 1895. I could find no signs of refilling in the cyst; there was a great deal of thickening about the cord and testicle; he had had no pain, the sense of weight had entirely disappeared, and he had not worn a suspender for more than a week.

Sherborne-lane, E.C.

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.

UNIVERSITY COLLEGE HOSPITAL.

A CASE OF STRANGULATION OF THE VERMIFORM APPENDIX IN AN INFANT SIX WEEKS OLD; REMOVAL OF THE VERMIFORM APPENDIX, WHICH WAS SUPPURATING; RECOVERY; REMARKS.

(Under the care of Mr. BILTON POLLARD.)

HERNIA of the appendix vermiformis has been observed both in the inguinal and femoral varieties of hernia—reducible, incarcerated and irreducible, and strangulated. Brieger¹ collected 41 cases of this form of hernia; 20 were inguinal, 15 femoral, and as regarded 6 the variety was not stated. In 6 the appendix was normal. Operation was performed in 26 cases, 16 being cured, 2 cured with fecal fistula following, and 5 died; in 3 the result was unknown. In the earlier cases the result of operation was not so favourable as in the more recent, probably because the condition is now better known, although sometimes very hard to diagnose, and the appropriate treatment adopted. Drs. Bull and Coley² give 6 additional cases in children—2 strangulated, 3 irreducible, and 1 reducible; 1 strangulated and 1 irreducible case died, the patient in the former case being only eight weeks old and almost moribund at the time of operation. The symptoms in strangulation of the appendix vary somewhat extensively, both as regards duration and severity. In a case of strangulation in a femoral sac described by Bayer³ they had commenced eighteen days before admission, and were chiefly local swelling and radiating pain; in another case there was constipation with some degree of prostration, but no vomiting. These are what may be called the dangerous cases, as on account of the absence of urgent symptoms the patients or their friends refuse operation until local or general peritonitis or perforation of the appendix has ensued. The length of the appendix varies from one inch to nine inches and a half, and it is not surprising that it is not sometimes found in the sac of a hernia in children, for its development in them is occasionally unexpectedly out of proportion to that of the adult, whilst its mobility may allow it to slip about. For the notes of this case we are indebted to Mr. Douglas Drew, surgical registrar.

A male infant aged six weeks was admitted on Jan. 22nd

on account of an inflamed, irreducible swelling which occupied the right groin and the right side of the scrotum. The latter had been enlarged since birth. The mother first noticed it when the child was fourteen days old. She pushed the lump up and it disappeared at once. On Jan. 19th the lump appeared again. It was larger than before, and the child became very restless. On the 20th the mother gave it a dose of castor oil, which acted freely the same day. It vomited after the castor oil, the swelling became much larger and harder, and the skin became red. In the evening of the same day the child was brought to the hospital and hot fomentations were applied. On the following day an attempt was made to reduce the swelling under chloroform. Something was felt to go back, but there was no slip or gurgle, and the swelling was not visibly reduced in size. The child vomited once during the day, and the bowels acted twice. Next day (the 22nd) it was, as stated above, admitted. The skin of the right side of the scrotum was red and œdematous. The right inguinal canal and the right side of the scrotum were occupied by a hard and very tender swelling, which was irreducible. Mr. Pollard operated. The tissues were thickened and inflamed. The tunica vaginalis contained a little fluid, and both it and the testicle were inflamed. The vermiform appendix occupied the funicular portion of the sac. It was red, and its middle third was considerably enlarged. A ligature was applied on the proximal side of the swelling. A circular incision was then made round the upper part of the appendix. Only the serous and muscular coats were divided. These were then retracted from the central mucous tube, and the latter was tied with a fine silk ligature at the highest point exposed. The mucous membrane was then divided below the ligature and the appendix was removed. The serous and muscular coats, being released, projected well beyond the ligature. They were inverted by three Lembert's sutures, which were tied over the end of the stump. A second series of Lembert's sutures were inserted, and as they were tied the central tube of mucous membrane was displaced upwards into the cæcum. The stump of the vermiform appendix was reduced into the abdomen, the neck of the hernial sac was ligatured and divided, and the operation was completed in the usual manner, the wound being entirely closed. The child's temperature rose after the operation to 101.6°F. It fell to normal on the following day and continued so afterwards. The wound healed by first intention and the child was discharged on the eighteenth day after the operation. The parts removed at the operation consisted of one inch and a half of the vermiform appendix. At a distance of half an inch from its tip there was an oval fluctuating swelling measuring half an inch in length and containing pus, which lay altogether external to the mucous membrane. The latter was thinned by ulceration opposite the abscess.

Remarks by Mr. POLLARD.—Strangulation of the vermiform appendix is rarely observed. In December, 1890, when operating for the radical cure of a right inguinal hernia, I found the vermiform appendix adherent to the back of the sac and was obliged to excise it preparatorily to ligaturing the neck of the sac. In this case there were severe local signs of strangulated hernia, but the absence of intestinal obstruction seemed to negative the idea that the hernial swelling was composed of intestine. I have met with two cases of strangulated hernia of the ovary which were diagnosed by the local signs of severe strangulation being unaccompanied by intestinal obstruction. Such a diagnosis was in this case out of the question owing to the sex of the child. Strangulation of omentum was a possible explanation of the appearances, but the rapid development and the severity of the local signs of strangulation were opposed to that view. The true explanation was only discovered at the operation. The method of removing the appendix which was employed in this case and in the earlier one already referred to appears to be worthy of remark. The appendix is sometimes simply ligatured and excised—indeed, the possibility of inverting the stump of the appendix and closing it with Lembert's sutures has been denied. It is, I believe, almost impossible to invert the mucous coat, but the serous and muscular coats are very movable and can be readily turned in over the central mucous tube, which is simply displaced upwards as the sutures are tied. By performing a sort of circular amputation and dividing the mucous coat at a higher level than the sero-muscular, as was done in these cases, the inversion of the latter layer and the apposition of serous membrane to serous membrane are

¹ Sajous' Annual of the Universal Medical Sciences, 1894, vol. iii., p. 23.

² Ibid.

³ Centralblatt für Chirurgie, 1876, p. 689.