stead of being the size of an olive, however, it proved to grow larger behind, and was found to extend back to the neck of the jaw. It was quite easily separated by means of the finger and blunt dissector, and when delivered was considerably larger than a hen's egg.

The patient made a good recovery.

Dr. Whitney reports as follows: "An irregular oval tumor about five centimetres in long diameter, dense, opaque, whitish, with here and there bluish-white areas quite transparent. On microscopic examination it was seen to be composed of irregular glandular areas, interspersed with tissue having a more or less hyaline matrix filled with irregular star and elongated cells. Adeno-chondroma, probably of parotid."

CASE II. Mrs. C., about thirty-five years old, a patient of Dr. Hitchcock of Rockland, Me., was operated upon on September 29, 1895. She had had a slowly growing tumor of the fauces for some years, and it had at last become so large that it seriously interfered with speech and deglutition. On examination a mass was seen projecting from the left pillar of the fauces extending nearly across the mouth and resting on the tongue—hard, somewhat nodular, and covered with smooth mucous membrane. Having seen the first case, the diagnosis in this was an easy matter.

Ether was administered with difficulty, owing to the size of the tumor, which so nearly filled the mouth. A gag having been placed in the mouth, an horizontal incision was made through the mucous membrane well down to the tumor, and the handle of the knife was used to push back the soft parts covering it. The tumor was then seized with vulsellum forceps, and the finger was used to enucleate it. A few sweeps of the finger, and it was free and delivered. There was very slight hemorrhage, and the wound was packed with iodoform gauze. The recovery was uneventful.

The tumor was a firm, heart-shaped mass, about two and a half inches in longest diameter. Dr. Whitney reports that microscopic examination shows it to be made up of hyaline cartilage with masses of proliferating gland tissue scattered through it, and evidently originating in the parotid.

In both these cases, when the finger was in the bottom of the wound, the neck of the lower jaw, the external carotid and the transverse processes of the cervical vertebrae could be plainly felt.

Cartilaginous tumors of the parotid generally appear as external swellings in front of, or below the ear, or even on the cheek near the mouth, when they start from one of the small portions of the gland that are sometimes found well in front of the seat of the gland. How, then, can we account for their presence in the mouth, and covered by the soft palate? It must be remembered that one of the deep processes of the gland is situated in front of the styloid process, and passes into the back part of the glenoid fossa behind the articulation of the lower jaw. A tumor starting at this point would meet with less resistance in growing forward and into the mouth than outward towards the face.

Bosworth, in "Diseases of the Nose and Throat," says, "we find but seven instances reported in medical literature of a fibrous tumor developing in this region" (fauces). These seven cases he reports in full; and on reading them, one finds that nearly all of them correspond almost exactly to the two cases reported above; and as the diagnosis of fibroma was made in nearly every case from gross appearances it seems highly

probable that most, if not all, of them were really tumors starting from the parotid, and some of them being enchondromata and not fibromata.

Clinical Department.

A CASE OF FRACTURE OF THE UPPER END OF THE HUMERUS JUST BELOW THE TUBEROSITIES, WITH DISLOCATION OF THE HEAD OF THE BONE INTO THE AXILLA.¹

BY GEORGE H. MONKS, M.D.

A MAN of about fifty fell down stairs, striking heavily on his left shoulder. He had evidently sustained considerable injury to his shoulder, and was taken to the City Hospital at once. The external appearances about the shoulder were those of dislocation of the humerus. Ether was therefore administered by the house-officer, and an examination made. It then became evident that the head of the bone was broken off from the shaft, and displaced into the axilla, where it could easily be felt and moved about. Its fractured surface rested against the thorax. While the patient was still under ether I was sent for, and reaching the hospital soon after, I tried by manipulation to return the fragment to its proper place again, but without avail. It was therefore decided, after consultation with Dr. D. W. Cheever, to allow the man to come out of ether, in order to explain to him the exact condition of the shoulder, the necessity for operation, etc., and, after having obtained his consent, to cut down upon the head of the bone, and again attempt reduction.

The next day, therefore, the man's consent having been obtained, ether was again given and an incision made into the axilla down to the displaced head of the bone. The fragment was freely movable, but by combined manipulation it could not be returned to the glenoid cavity. The fragment was therefore drawn out through the wound and a tendon, which was apparently the only structure to which it was attached, was divided and the fragment removed. [This tendon, as was proved later, was that of the subscapularis muscle, a fact which explains why the head was drawn inwards into the axilla, and could not be returned to the glenoid cavity.] The forefinger was then inserted through the rent in the capsular ligament into the shoulder-joint, but no other fragment could be found—only the roughened end of the shaft. The axillary wound was then stitched with silkworm-gut. All did well for two days, when abdominal distention appeared, as well as other serious symptoms; and the man died four days after the operation.

An autopsy was made by Dr. Councilman, but the cause of death could not be determined with certainty. There was nothing about the seat of fracture to suggest a cause, and the wound in the axilla was apparently healing by first intention.

The shaft of the humerus was removed and cleaned, and *also one small fragment* (the greater tuberosity). The head of the bone, which had been excised at the operation five days previously, was then fitted to the fragments removed at the autopsy, and the specimen as a whole carefully examined. There were two main

¹ Specimen shown and case reported at the meeting of the Surgical Section of the Suffolk District Medical Society, December 4, 1895. ;

fragments in addition to the shaft. The larger fragment consisted of the rounded head of the bone and the lesser tuberosity, while the smaller fragment comprised only the greater tuberosity.

It is, of course, impossible to explain with any certainty the way in which this combined fracture and dislocation occurred. The most probable explanation is, however, that the man's shoulder struck the ground in such a way that the bone was first fractured, and then dislocated. The head of the bone (fragment A) was probably driven out, through the rent in the capsule, by the shaft, after which the shaft returned to its normal position leaving the head of the bone in the axilla. The head, as already stated, could not return

to the joint because of the contraction of the subscapularis muscle which was attached to it. [The arrow indicates the direction in which this fragment was drawn by the contraction of the subscapularis.]

The greater tuberosity (fragment B) presumably did not follow the rest of the bone in its excursion into the axilla, but was probably pulled upwards and backwards by the supraspinatus, infraspinatus, etc.—a fact which perhaps explains why this fragment was not discovered at the time of the operation when the joint cavity was explored.

Whatever the mechanism may have been, however, the case seems to be a sufficiently rare one to justify its publication.

ANOTHER CASE OF SPIRAL FRACTURE OF THE HUMERUS FROM TORSION.

BY F. H. McNAUGHT, M.D., DENVER, COLO.,
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The reports in the JOURNAL of similar cases (March 21, 1895, and January 9, 1896) lead me to report the following case:

W. P., weight one hundred and sixty pounds, aged thirty-six years, engaged in the form of sport mentioned (turning wrists), his antagonist being a powerful negro, weighing one hundred and eighty pounds. As they struggled with their left arms, the patient's humerus broke with a loud "crack," and his arm hung

helpless at his side. Examination showed a spiral fracture, oblique from about the centre of the bone upward and outward. There was a suspicion that a fragment had separated in the fracture somewhat as in Dr. Monk's last case, but this could not be positively ascertained.

Dr. J. N. Hall, who assisted me in the dressing, kindly called my attention to the cases mentioned above, and suggested that this one should be placed on record. The patient is doing well at present, and both he and his antagonist state most positively that they have tried the trick for the last time.

A CASE OF PERITONISMUS.

BY EDGAR GARCEAU, M.D.,
Surgeon to Out-Patients Free Hospital for Women, Boston.

Mrs. H. P., seventeen years old, was a Syrian by birth who had been in this country but a short time. She was of slight build and of dark complexion. Her general appearance and her manner suggested the exceedingly neurotic type, not the effusive, exuberant, fidgety kind, in which the constant explosions act as a safety-valve to an irritable nervous system, but the more serious, self-contained, repressed, still-water-runs-deep variety which belongs to nervous women of a certain intellectual force, and which manifests itself by sudden tempestuous outbursts, which relieve the nervous system temporarily and leave the patient apparently, as placid as before.

Her menses began at thirteen years of age, were always painful, but were regular. She was married at fourteen, and had two children in quick succession; both labors were instrumental, and she was ill for a long time after the birth of each child. Pain in the back, bearing-down sensations, leucorrhea and other symptoms of lacerated cervix and perineum soon developed and she was a nervous wreck when she first came under observation. After some preliminary treatment she was sent to the Free Hospital for Women, where the cervix and perineum were repaired. While under ether a careful examination was made which showed that both ovaries and tubes were free from disease. She was discharged from the hospital perfectly well. She went home and was quite comfortable for four months. Then, without any special warning, she began to have fever and chills, and was completely prostrated; coincident with this the menses appeared, and were unusually painful. When the period was over, she still continued to suffer pain and was very wretched, the chills and fever continuing. On examination the uterus was found to be immovably fixed in the pelvis, and the pelvic roof tense and hard as a board; the ovaries and tubes could not be palpated and the abdomen was tympanitic and tender to a degree; the temperature was 101°, and the pulse rapid. A diagnosis of pelvic peritonitis was made, caused probably by double salpingitis, and she was recommended to go to the hospital. She declined to do this.

Exactly one week later she came to the out-patient department apparently perfectly well. The uterus was of normal size and shape, and was freely movable, and bimanual examination was done without exciting the least pain. Both ovaries and tubes were easily palpated and were found to be free from disease, and perfectly normal in every respect. The abdomen was