The symptoms improved under lead lotion and belladonna and the internal administration of bismuth. Pneumonia of the left base came on, necessitating the administration of brandy. Next followed typical measles with Koplik and Filatow's spots. The measles lasted for six days and then pneumonia returned in the left base. A speedy desquamation followed. An erythema of one day's duration came on and finally herpes over the left groin and left buttock, as well as near the anus and on the anterior third of the penis. The prepuce was inflamed and required treatment. Further symptoms were gastro-intestinal catarrh with green clayey motions and protracted convalescence joined to slight bronchitis, although the child rapidly put on flesh and drank milk heartily. This child, as well as the other members of the family, had rheumatic symptoms. It should be stated that snuffles were present although no other signs of specific disease presented themselves. The teeth of the other members of the family were good and regular as to time. The father and mother were healthy.

Southfields, S.W.

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.

ST. GEORGE'S HOSPITAL.

A CASE OF EXTENSIVE PERICARDIAL EFFUSION ; OPERATION ; RECOVERY.

(Under the care of Dr. ARTHUR LATHAM and
Mr. H. S. PENDLEBURY.)

A MAN, aged 53 years, came under the care of Dr. Arthur Latham on Sept. 1st, 1902, at St. George's Hospital. He gave a history of good health until the early part of last March. He denied having had syphilis and asserted that he had always been a moderate drinker. In the early part of March he began to suffer from shortness of breath. This symptom gradually became more troublesome and the patient in consequence was obliged to give up work on March 28th. On April 4th the left pleural cavity was tapped and ten ounces of serous fluid were withdrawn. Further small quantities of blood-stained fluid were removed on May 23rd, July 22nd, and August 5th. During August the patient developed marked œdema of the legs and some distension of the abdomen. He also became jaundiced. When he attended at the hospital he complained of sleeplessness and of cold extremities. He was suffering from considerable dyspnoea, with slight cough and expectoration; the face was sallow and somewhat cyanosed; the pulse-rate was 76, the volume being small and the wave full though regular; the respirations were 24 to the minute; the temperature was normal. The legs were markedly œdematous and there was evidence of a considerable quantity of free fluid in the abdominal cavity. The apex of the heart could not be felt nor could it be located by the stethoscope, as no cardiac sounds could be detected; the area of cardiac dulness was much increased. The note over the left axillary base was dull, there was diminution of the voice sounds, and on auscultation distant tubular breathing was heard. Over the base of the left lung posteriorly the note was impaired, there was distant tubular breathing, and a few moist sounds could be heard. The urine had a specific gravity of 1028, was normal in colour, somewhat diminished in amount, and contained a very faint trace of albumin. On Sept. 3rd the patient was given a little chloroform by Dr. Ll. Powell. Mr. H. S. Pendlebury tapped the pericardial sac in the fourth costal interspace one and a quarter inches from the left border of the sternum and drew off 95 ounces of serous fluid which was dark brown in colour owing to the presence of a considerable quantity of methæmoglobin. No further evidence was obtained by a careful examination of the fluid. The patient slept well during the

night and felt much more comfortable on the following morning. The heart sounds could now be heard over the præcordial area but were still very faint. During the night 90 ounces of urine were passed. On the 8th the patient was comfortable and the œdema of the legs and the distension of the abdomen were considerably less. He was sleeping well and the coldness of his extremities had diminished. The pulse was of good quality and the wave could be easily felt. The heart sounds, however, were again becoming more distant and the cardiac dulness was again increasing, consequently Dr. Latham asked Mr. Pendlebury to drain the pericardial sac, which apparently had been distended with fluid for several months and was still secreting to an appreciable extent.

The operation was performed on Sept. 9th. Having decided to drain the pericardium for some time it was of the first importance to choose a procedure which would insure drainage from the lowest approachable part of the pericardial cavity. Consequently Mr. Pendlebury determined to perform the operation so clearly described by Dr. Cyril Ogle and Mr. Herbert Allingham in THE LANCET of March 10th, 1900, p. 693, with such modifications as might appear necessary. A vertical incision some four and a half inches long was made with its centre at the lower border of the seventh costal cartilage parallel with, and one inch from, the left border of the sternum. The skin and fascia were reflected inwards and outwards and the abdominal muscles were then detached from the seventh costal cartilage. The cellular interval, "costo-xiphoid space," containing the superior epigastric artery was then broken into, some of the muscular fibres of the diaphragm being torn. As the pericardium was distended it was easily brought into view, but as Mr. Pendlebury wished to have sufficient room to insert the fingers after opening it two inches of the seventh costal cartilage were first removed by cutting it through with bone forceps and disarticulating the fragment from the sternum. The internal mammary vessels were now exposed and held aside. Had it been necessary it would have been easy to secure them. More loose connective tissue, fat, and the triangularis sterni were gently pushed aside and the pericardium—tense and thick—was exposed. Owing to the conformation of the chest the wound was somewhat deep and to obtain more complete and convenient access to the pericardial contents after opening two inches of the sixth costal cartilage were likewise removed. The pericardium was incised where it bulged downwards through the torn cellular space and the cut edges were seized with clips. Some 20 ounces of blood-stained fluid, similar to that removed by tapping on Sept. 3rd, escaped. The incision into the pericardium was increased to allow of three fingers being introduced to examine as far as practicable the heart and parietal pericardium. These were found quite smooth and apparently normal. Unfortunately, the man's chest was very deep and it was not possible to explore thoroughly the back of the heart and pericardium, as can be done so readily in children after this operation. There were no adhesions to be felt and the fingers could be interposed between the heart and the diaphragm. A peculiar vibratile thrill was noticed on palpating the ventricles during systole. These manipulations had no harmful effect on the pulse; indeed, the escape of the remaining fluid had distinctly increased its strength and promoted its regularity. It was only possible to stitch one corner of the pericardium to the skin at the lower end of the wound; a tube was introduced and the upper three inches of the incision were united by silkworm gut sutures. The tube was removed on the fourth day after the operation as it was blocked with the clotted discharge. On the eighth day, the 16th, the stitches were removed, only a small sinus remaining where the pericardium had been sewn to the skin. This sinus did not completely heal till nearly three weeks afterwards, a little easily clotting fluid trickling away from time to time. Throughout convalescence the patient's temperature was normal. On the 16th the patient had improved to an extraordinary extent. He was sleeping well and was free from dyspnoea, there was hardly any œdema of the legs, and there was no evidence of the presence of fluid in the abdomen. The percussion resonance of the sternum was normal and there was no extension of dulness to the right of the sternum. The cardiac sounds could be heard distinctly and the position of the apex appeared to be normal, although the thickness of the patient's muscles made an exact localisation impossible. Towards the base of the left lung there was some impairment

of the percussion note, the vocal fremitus was increased, and the heart sounds were high-pitched, whilst near the vertebral column distant tubular breathing could be heard. The urine was acid and pale, the specific gravity being 1008; no albumin could be detected after Sept. 19th. From Sept. 29th to Oct. 8th the daily output of urea varied from 216 to 468 grains. The patient made an uninterrupted recovery, going into the hospital yard on Oct. 8th and to Bexhill on the 23rd. Writing on Jan. 22nd, 1903, he stated that he felt perfectly well and was able to do his work.

Remarks by Dr. LATHAM and Mr. PENDLEBURY.—The above case is of interest in view of the facts that so large a quantity as 95 ounces was removed by aspiration from the pericardial sac in one operation, that the pericardial sac was opened by means of a new method devised by Mr. Allingham and Dr. Ogle, and that the patient is now well and at work. The pleura was not seen at all during the operation and probably it may be taken that in cases where the pericardium is distended with fluid it is not likely to be seen. If it did come into view it could easily be held aside with the finger. It may be suggested that by beginning the incision into the pericardium at a level just above the base of the ensiform cartilage all danger of opening the abdominal cavity is avoided. Surgically speaking, it may be said that the operation is not difficult to do and only takes a little over 20 minutes. It would seem advisable, however, in cases where a large amount of fluid exists, to withdraw some before the actual operation in order to relieve a little the heart's embarrassment. Since writing the above we are permitted to mention that Mr. Allingham has performed the operation on two other cases with success.

Medical Societies.

CLINICAL SOCIETY OF LONDON.

Skin-sliding as a Means of preventing and removing Cicatricial Deformity.—A Case of Spinal Caries treated by Costo-transversectomy with Complete Recovery.—Prolapse of the Bowel and Prolapse of the Uterus treated by the Injection of Paraffin.

A MEETING of this society was held on March 13th, Mr. HOWARD MARSH, the President, being in the chair.

Mr. T. S. ELLIS (Gloucester) read a paper on Skin-sliding as a Means of preventing and removing Cicatricial Deformity. The process consisted of a daily dressing or massage by means of pinching up the skin around the edge of a wound or a scar and thus stretching or sliding the skin and subcutaneous tissues in the direction required. The process was devised by Mr. Ellis in the belief that when the skin in the neighbourhood of a cicatrising wound was made to slide freely and all adhesion of the cicatrix at the margin of the wound to the tissues beneath was prevented, the contraction of the cicatrix, acting on the skin, would draw it towards and over the area of the wound. Interstitial growth in the extended skin compensated for the extension it had undergone. For the effacement of a cicatrix of any kind (keloidal or other) not only was the attainment of freedom from attachment indicated but also such mobility and redundancy of skin around it as should, for a time, give freedom from tension. This indication might often be completely fulfilled by persistently sliding the adjacent skin towards the cicatrix and using the skin (made redundant) as a handle wherewith to lift the cicatrix from its attachment. Lantern slides were exhibited of a case of severe burn, which had occurred on Jan. 15th, 1902, to a child, aged 11 years, involving extensive destruction of the integument of the neck and chin, and the advantages of the treatment were described. Some calipers which Mr. Ellis had designed to aid the process were also exhibited.—Mr. A. E. J. BARKER recalled an investigation by a committee of that society on keloid which had come to the conclusion that keloid sometimes underwent spontaneous cure. He then referred to a case in which skin grafts had been followed by such rapid growth of keloid that it was thought to be sarcoma, though the subsequent history showed that it was not so.—Dr. W. H. B. BROOK asked what was the exact manner of picking up the skin and for what period of time it had to be picked up.—Mr. ELLIS replied that no knife was required.

Dr. W. H. B. BROOK (Lincoln) read a paper on a case of Total Paraplegia due to Caries of the Mid-dorsal Vertebrae, for which the Operation of Costo-transversectomy was performed with complete recovery. The patient, a youth, aged 17 years, was admitted into the Lincoln County Hospital on Sept. 22nd, 1902, suffering from angular curvature of the spine of a year's duration, for which he had worn a plaster jacket. During the previous four weeks there had been gradually increasing loss of power in the legs, with incontinence of urine. When admitted he presented well-marked angular curvature, the sixth and seventh dorsal spinous processes being the most prominent. There were no tenderness and no signs of any collection of pus. There was well-marked girdle sensation at the level of the epigastrium, with great impairment of sensation below this level. The legs could be moved but not well; the knee-jerks were exaggerated and there was incontinence of urine. For six weeks he was treated by extension applied to both legs, but his condition became steadily worse, paraplegia and incontinence of urine and faeces gradually became complete, and in spite of the greatest care bedsores appeared. A skiagram showed blurring in the region of the seventh and eighth dorsal vertebrae, confirming the diagnosis that tuberculous matter was present. On Nov. 8th the operation of costo-transversectomy, as described by Mr. J. Jackson Clarke, was performed, the right transverse process of the eighth dorsal vertebra being cut down upon and removed together with the head and neck of the eighth rib, so that access was obtained to the seat of the disease and the broken-down bodies of the vertebrae were carefully scraped away with a specially designed curved sharp spoon, care being taken not to wound the dura mater or the pleura. The wound was drained, injected with iodoform emulsion containing 1.40 per cent. carbolic acid, and tightly packed with iodoform gauze. The extension was continued. Sensation began to return on the following day and movement on the day after. At the end of three weeks sensation was perfect and movement was good, but it was seven weeks before the patient regained perfect control over the bladder and rectum. The drainage-tube was discontinued on Jan. 8th, the wound was healed by Jan. 25th, and on Feb. 15th the patient was able to sit up after having been fitted with a steel spinal support. He was now able to walk quite well.—Mr. JACKSON CLARKE related how he first came to perform the operation that Dr. Brook had so successfully repeated. In October, 1901, a patient, aged 45 years, rapidly developed total sensory and motor paraplegia from tuberculous disease of the seventh and eighth dorsal vertebrae. Mr. Jackson Clarke performed laminectomy and found that an abscess (formed by the destruction of the posterior parts of the bodies of the two vertebrae) was pressing backwards on the cord. To secure better drainage he performed costo-transversectomy seven days after the first operation. The result was most satisfactory and showed that the second operation would have done all that was required without the preliminary laminectomy. From this experience and that of three other cases Mr. Jackson Clarke came to the conclusion that the removal of the transverse process afforded the best means of access to the vertebral bodies in certain cases. When complete sensory and motor paralysis came on rapidly as in his first case the lateral drainage, whether by removal of a transverse process alone or in conjunction with the head and neck of a rib, should be done at once. When the symptoms were not urgent rest should be tried for some months before proceeding to operate. The main object of the operation was to open the abscess and to establish an aseptic sinus through which a few drops of carbolic solution or some other antiseptic could be injected daily for as long as might be necessary. No attempt should be made to scrape away caseous material or carious bone. The cord was often exposed by destruction of the bodies of the vertebrae and such interference would be highly dangerous. If the paralysis should not be relieved the subsequent performance of laminectomy was in no way interfered with by the lateral opening.—Dr. BROOK, in replying, expressed a preference for a straight spoon.

Mr. STEPHEN PAGET read a paper on Two Cases of Prolapse of the Bowel and a Case of Prolapse of the Uterus treated by the Injection of Paraffin under the Mucous Membrane. The first case was that of a man, aged 65 years, who in 1897 had undergone excision of the rectum for cancer. Ever since the operation he had suffered from prolapse of the bowel with loss of control and had been