PART III.

MEDICAL MISCELLANY.

Reports, Transactions, and Scientific Intelligence.

ROYAL ACADEMY OF MEDICINE IN IRELAND

President—SIR THORNLEY STOKER, M.D., F.R.C.S.I.

General Secretary—JAMES CRAIG, M.D., F.R.C.P.I.

SECTION OF PATHOLOGY.

President—JOSEPH O'CARROLL, M.D., F.R.C.P.I.

Sectional Secretary—PROFESSOR WHITE, F.R.C.S.I.

Friday, January 5, 1905.

THE PRESIDENT in the Chair.

Fractures of Os Calcis and Astragalus.

PROFESSOR BENNETT said—One reads in the present day the old assertions about fractures repeated as if they had not been put aside by the accumulated knowledge of the last century. I take this example from a book bearing the date 1900 :—"Fractures of the tarsal bones are always caused by direct violence (passing of a carriage wheel), falling of a heavy weight upon the tarsus." To put any addition to our knowledge of the fractures of the tarsus is a matter of interest in helping to wipe out the "always" from the passage I have quoted. Bad anatomy does not help us in this difficulty. "The astragalus is a peculiar bone, inasmuch as it articulates with four different bones and shows no point of insertion of any tendon." May not the horizontal division of the external lateral ligament be regarded as tendon? I regret that I am not able to state anything of the life history of the examples I now record, but I present them as I have them. The first of these is a left os calcis which Professor Dixon kindly gave to

me this session, because the portion of bone forming the articular surface in front of the sustentaculum tali is wanting. The specimen agrees in many particulars with the case of Legouest, figured in the Thesis of A. Ballenghien,^a and is wanting in the fact that the little piece of bone has not been preserved. My next two specimens concern the astragalus. Some five and twenty years ago I published a discussion on the supposed fracture of the tubercle of the astragalus, whether it be a fracture or not or a vestige of the ostrigonum tarsi.^b I have multiplied specimens of this kind, until now my series number eleven. Here I show a united fracture of the same region of the bone, without doubt a fracture well and truly knit, but how caused I cannot say. The anterior part of the tubercle with the groove for the tendon of the long flexor of the great toe has been broken and united with the minimum degree of deformity. The question which is most difficult of solution is—How did it get broken? By what force, direct or indirect? Lastly, I show a specimen which I am again very hard set to read. I put this by in spirit last summer, puzzling over it to find some solution of its mysteries. While the summer passed the spirit sped away, and when I came back to my work almost all my mysterious signs of fracture had gone. See how I got the specimen. A student in his first year had dissected the lower extremity to the last shred, and he had got the astragalus isolated neatly from the bones of the leg and from the tarsus, and, seeing me pass, asked me to look at “the fracture.” I agreed in his diagnosis. I said I could see no damage or trace of it in the bones of the leg or of the tarsus, and for some reason, being pressed for time, I was content to walk off with the bone. No one here would give me credence for my diagnosis of fracture had I not put the specimen in water a few days ago, and so repaired the damage of the evaporated spirit. Read the lesion as you like. A fracture it was, taking effect on that part of the head of the bone that rests on the calcaneo-scapoid ligament, and it has not passed to any deeper extent than the cartilage.

Cancer of the Œsophagus with Secondary Growth in the Heart.

DR. TRAVERS SMITH exhibited some of the thoracic viscera of a man, aged seventy, who had died under his care in the Whitworth Hospital of flat-celled cancer of the œsophagus. The

^a Thèse par A. Ballenghien. July 20, 1890. Page 126.

^b Journal of Anatomy. Vol. XXI.

growth had caused a very narrow stricture, and had grown by direct extension into the outer coat of the descending aorta. Numerous small secondary deposits were also found in the outer coat of the aorta, and the bronchial lymph glands were cancerous. Embedded in the wall of the left ventricle near the auriculo-ventricular groove was a secondary deposit the size of a large hazel-nut, which on microscopical examination, made by Dr. Earl, showed typical flat-celled arrangement. There were no metastases of the disease below the diaphragm with the exception of a cancerous deposition in a single lymph gland situated under the peritoneum on the anterior aspect of the stomach near the œsophagus, and nearer the lesser curvature than the great. Dr. Travers Smith laid stress upon the frequency with which this gland was affected in internal, especially abdominal, cancer. He also spoke of the difficulty in fully explaining how the secondary deposit in this case had reached the heart.

THE PRESIDENT said that an interesting point had been raised—namely, the dissemination backwards against the lymph stream. This must often happen also in various forms of tubercle. The particle must be supposed either to have gone against the stream or else it had been carried by the subclavian, returned by the vena cava, and going through the pulmonary system was deposited by the coronary artery in the heart.

PROFESSOR BENNETT said the same thing must occur in cancer *en cuirasse*, as the cancer certainly did not follow the lymphatic stream.

DR. LITTLE said that in cases of tubercular meningitis the original lesion was often found in the bronchial glands, so that in such cases the infection must also travel against the stream.

DR. TRAVERS SMITH briefly replied.

Hydrocephalus.

DR. O'CARROLL showed a hydrocephalic brain of a boy seventeen years old who had suffered for about six years from headaches and frequent sub-comatose attacks lasting a few days. The cranium was not much larger than normal, and was fully ossified. The ventricular cavities were considerably dilated, but not to the degree of thinning the brain substance excessively. The greatest thinning was at the lower anterior part of the lateral ventricle where the cortex was adherent to the underlying bone. During the last couple of months of the boy's life a colourless

watery fluid, recognised to be cerebro-spinal fluid, used to drip freely from time to time from the left nostril. No thickening or occlusion of the pial curtain descending from the cerebellum to the medulla was found. It was evident that the serous discharge from the nostril came from the left ventricle by way of the adhesion of the temporo-sphenoidal lobe to the body of the sphenoid.

It is to be noted that during life the boy had been sub-normal in intelligence, but by no means an imbecile; he had learned to read and write, and could perform simple mental calculations. He was of average height and weight, and the head was not abnormally large, but the sexual organs were poorly developed. The skin, of normal texture, seemed somewhat tightly drawn over the limbs as it ordinarily is on the outside of the thigh; but there was no scleroderma. There had been no ataxy. In walking his toes caught the ground now and again, and Babinski's toe-extension sign was present, while increased knee-jerk and ankle clonus were absent. There was no proof of hereditary syphilis; his birth had been instrumental. Dr. O'Carroll suggested that, as in other cases, hydrocephalus seems to depend on obstruction of the posterior outlet of the ventricles, this may have started in obstruction of anterior fissural outlets by an early basal meningitis of adhesive character, the outlet re-asserting itself recently in the nasal drip.

DR. EARL described the appearance of the brain on making a *post-mortem* examination. There were a number of points on the anterior surface of the temporo-sphenoidal lobes where the brain was adherent to the bone. Also at one point on the lower surface of the left temporo-sphenoidal lobe there was a thin piece of brain left adherent, a small hole resulting. The membrane over the roof of the fourth ventricle did not appear to be thickened. The ventricles of the brain were generally distended, and the foramen of Munro was much enlarged. The sella turcica was very large, as a result of the ventricular distension, not of any change in the pituitary body which was simply flattened out.

DR. TRAVERS SMITH said that Dr. O'Carroll deserved great credit for his diagnosis, as the diagnosis of chronic hydrocephalus was often very difficult in its early stages. He described a case which he believed to be chronic hydrocephalus in a girl aged eleven. She had a distressed, anxious expression, and was completely paraplegic. Knee-jerks were lost. Legs and practically the whole trunk were anæsthetic. Pupils were widely dilated. Pulse 60.

He did a lumbar puncture, and the cerebro-spinal fluid came away in a strong stream. It was clear, and contained no micro-organisms and practically no cells. He presumed that Dr. O'Carroll's case was one of hyper-secretion of the ependyma, and he wondered if it had anything to do with the immature sexual organs, the condition of the skin and subcutaneous tissues.

DR. MOORHEAD described a case of his own in which hydrocephalus had occurred after pyrexia, lasting for sixty days, in a man aged sixty-five. There was no obstruction to outflow, and there was increase of the subarachnoid fluid. The cerebro-spinal fluid was distinctly turbid, and he cultivated the *Bacillus coli communis* from it. He regarded the hydrocephalus as due to inflammation of the ependyma.

DR. NEIL also described a case in an infant, aged three weeks, from which he had removed twenty ounces of cerebro-spinal fluid through the occiput.

DR. O'CARROLL, in replying, said that although he had got no proof of syphilis in the case, he had perhaps suspected it as being the cause. He did not know whether the condition of the skin could be associated with pituitary mischief or not.

SECTION OF SURGERY.

President—SIR ARTHUR CHANCE, P.R.C.S.I.

Sectional Secretary—E. H. TAYLOR, F.R.C.S.I.

Friday, January 12, 1906

THE PRESIDENT in the Chair.

Remarks on Gastro-enterostomy.

MR. R. CHARLES B. MAUNSELL read a paper entitled "Remarks on Gastro-enterostomy, with description of a New Clamp." He advocated operation in gastroptosis and atonic gastritis in addition to the more commonly recognised indications. He considered that there should be no fixed rule for the site or form of incision in the abdominal wall or for the site of junction of the viscera, as the first would depend upon the amount of ptosis present, often lying partly below the level of the umbilicus on the left side, the junction of the viscera being made near the pyloric antrum, or at the most dependent portion of the stomach, according to the amount of muscular power present in the stomach

walls. A new form of clamp was described and shown; it was made somewhat on the principles of Carwardine's intestinal clamp, and held the parts neatly in position during the operation. A short *résumé* was then given of the various post-operative troubles and their treatment.

THE PRESIDENT expressed himself in favour of clamps, and recognised the advantages of those designed by Mr. Maunsell. In some of his cases vomiting did not occur at all after the operation. He referred to the advisableness of suturing the proximal loop of the jejunum to the meso-colon with a view to prevent subsequent internal strangulation.

MR. BLAYNEY was not in favour of clamps, as he considered their use endangered risk of post-operative hæmorrhage. He had not known of any case in which dispensing with clamps had led to any untoward result through the escape of stomach contents or prolongation of the operation.

MR. JAMESON JOHNSTON was in favour of clamps, and had not noted hæmorrhage in any of his cases. He considered it essential that the anastomotic opening should be free, and that the direction of the peristaltic wave in the stomach and jejunum should correspond. He admired the principles of Mr. Maunsell's clamps.

MR. WILLIAM TAYLOR had used clamps like those of Moynihan, but of a lighter build; he thought those of Mr. Maunsell were an improvement. He also thought hæmorrhage after gastro-enterostomy could be prevented if the sutures were properly introduced. He had seen one fatal case of vomiting due to the vicious circle.

MR. EDWARD H. TAYLOR had been rather startled by hæmorrhage in one case after gastroenterostomy, although he had used every precaution in the suturing process. At present his practice was, in making the gastric incision, to divide the muscular coats carefully and expose the principal vessels in the submucous coat, and suture them separately before incising the mucous membrane. In some of his cases vomiting had not occurred once after the effects of the anæsthetic had passed away, and he had observed that those who did best in this respect were those in whom there was decided pyloric obstruction. Where the pylorus was fairly patent one was more likely to encounter post-operative vomiting.

MR. W. S. HAUGHTON said he had sometimes experienced difficulty in making a sufficiently large aperture in the meso-

colon, and he would like to know if Mr. Maunsell considered it likely that the vitality of the colon would be dangerously affected by dividing some of the colic vessels. Instead of clamps on the stomach and intestine he used strong fixation sutures, which held the parts steadily in apposition and facilitated accurate suturing.

MR. KENNEDY said he had discontinued the use of the Murphy Button in gastro-enterostomy. He had met with two cases of hæmorrhage where gastro-enterostomy had been performed some months previously; both recovered, however, under ordinary treatment.

MR. MAUNSELL, in reply, said he had only meant to touch on a few points respecting the operation of gastro-enterostomy. His habit now was to suture the margin of the divided meso-colon along the line of gastro-jejunal junction. He always ligatured the larger vessels met with when incising the stomach. He did not think there was much likelihood of the peristaltic currents in the stomach and jejunum being reversed if ordinary care was taken. If he could not make the aperture in the transverse meso-colon large enough without tying vessels he tied them. The proximal jejunal loop should be long enough to enable it to be connected with the most dependent part of the stomach without tension. He considered that the vomiting was due chiefly to the anæsthetic.

Partial Gastrectomy for Pyloric Tumour.

MR. WILLIAM TAYLOR read a paper on the above subject.

The patient, a woman of sixty years of age, was exhibited in perfect health, free from stomach trouble of any description, able to eat anything and everything without the slightest discomfort. The history dated back for three years, during two and three quarter years of which she complained of ill-defined stomach trouble, to which she applied the term "weakness." During the three months prior to admission pain after eating became a very prominent feature of the case, but the pain continued after vomiting; in fact she was never free from pain during this period, but food greatly aggravated it. At times it was so severe as to compel her to press her stomach across the back of a chair or edge of the table; at other times she rolled upon the floor in agony. About two months before admission she noticed a tumour forming,

which increased very rapidly in size, and it was on account of this tumour and the severe pain and vomiting that she sought admission to hospital. On examination the tumour was found to be situated a little above and to the right of the umbilicus; it was hard, nodular, and firmly fixed to the anterior abdominal wall. There was no tenderness. The stomach was moderately dilated. The patient herself was greatly emaciated. Examination of the gastric juice showed a complete absence of free hydrochloric acid. The diagnosis of malignant disease was made on account of the age of the patient, her cachectic appearance, the rapid growth, the hard, irregular nature of the tumour, and the absence of free HCl. from the gastric juice. Exploratory laparotomy was performed when it was discovered that by excising portion of the abdominal wall to which the tumour was adherent the growth could easily be brought outside. This was accordingly done, and as the tumour presented all the naked eye appearances of malignancy, a partial gastrectomy was performed. The cut ends of the stomach were sewn up with two rows of silk sutures, The duodenum was freed by dividing the peritoneum over the right kidney and fixed by two rows of suture into the opening made in the posterior wall of the stomach, about one inch beyond the line of section. What was taken to be œsophagus during this procedure was subsequently found to be a constriction, due to the healing of an old-standing ulcer, which had contracted and produced an hour-glass condition of the stomach. This condition was immediately remedied by the performance of gastroplasty. Two enlarged glands were removed from the lesser omentum, and the abdominal wall repaired. The entire operation occupied exactly seventy minutes, and the shock was very slight. Recovery was rapid and uninterrupted, and she left for the Convalescent Home on the twenty-third day after operation.

Examination of gastric juice that day (January 12, 1906), seven months after the operation, showed that there was not a trace of free HCl., or, indeed, any other free acid to be found. The pathological report of the tumour demonstrated that it was apparently a mass of inflammatory material around an old-standing ulcer.

Mr. Taylor then discussed the question of the diagnosis of inflammatory tumours from carcinomata, after which he went

into the question of the operative treatment of gastric carcinoma involving the body or pylorus, and contrasted gastro-enterostomy with gastrectomy, both as regards the immediate mortality of these procedures and the average length of life after the performance of these respective operations.

The comparatively small number of cures after gastrectomy was attributed to the inability to make a diagnosis sufficiently early, and Mr. Taylor advocated strongly more frequent recourse to Mr. Moynihan's advice—viz., "that one should operate not to confirm but to make a diagnosis."

MR. MAUNSELL stated that the symptoms upon which he laid stress in the diagnosis of gastric cancer were absence of free hydrochloric acid, short duration of gastric symptoms and, in many cases, irregular pyrexia. In one case he had performed almost complete gastrectomy, but with fatal result. Quite recently he had operated on another case, and took away about half of the stomach, and the patient was making good progress. He thought that, short of cancer in the liver, every effort should be made to remove cancer of the stomach.

MR. JAMESON JOHNSTON considered that the growth should be removed if possible, as much more benefit was likely to ensue than after gastro-jejunostomy.

MR. HAUGHTON having also made some remarks, MR. WILLIAM TAYLOR replied, and the Section adjourned.

SECTION OF MEDICINE.

President—SIR WILLIAM SMYLY, M.D., P.R.C.P.I.

Sectional Secretary—F. C. PURSER, M.D., F.R.C.P.I.

Friday, January 19, 1906.

THE PRESIDENT in the Chair.

The Diagnosis, Treatment, and Pathology of Empyema.

A discussion on the diagnosis, treatment and pathology of empyema was introduced by Dr. W. G. Smith, Sir Thornley Stoker and Dr. Earl.

DR. NINIAN FALKINER submitted from the Registrar-General's statistics the following tabular statement of the ages of those whose death had been attributed to empyema in 1904, and of the associated conditions:—

TABLES I. and II. showing, for the year 1904, by age-periods, the diseases with which the deaths directly attributed to Empyema of 35 persons (29 males and 6 females) were associated.

I.—DISEASES (BY AGE-PERIODS) WITH WHICH 29 DEATHS OF MALES FROM EMPYEMA WERE ASSOCIATED.																				
CAUSES OF DEATH		TOTAL DEATHS	AGES AT DEATH																	
			Under 1 year	1	2	3	4	Under 5 years	5-	10-	15-	20-	25-	35-	45-	55-	65-	75-	85-	96 and over
Broncho-pneumonia	..	1	1	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..
Tubercular Phthisis	..	4	..	..	1	..	1	1	1	..	1	1	..	..	..	..	..	..	..	..
Tubercle of other Organs	..	13	..	..	..	..	..	..	1	5	4	1	1	1	..	..	..	..	..	..
Pleurisy	..	4	..	..	..	..	..	1	..	..	1	..	1	..	..	..	1	..	..	..
Appendicitis	..	1	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..
Not ascertained	..	6	..	..	..	..	..	..	..	..	1	1	..	1	3	..	..	..	..	..
II.—DISEASES (BY AGE-PERIODS) WITH WHICH 6 DEATHS OF FEMALES FROM EMPYEMA WERE ASSOCIATED.																				
Tubercular Phthisis	..	1	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..
Tubercle of other Organs	..	2	..	..	..	..	..	..	..	..	1	1	..	..	..	..	..	..	..	..
Pleurisy	..	1	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..
Not ascertained	..	2	..	..	..	..	..	..	..	..	..	1	1	..	..	..	..	..	..	..

From above Tables it appears that of 35 deaths which were directly attributed to empyema, 20 were upon further inquiry found to be connected with tuberculous disease, 5 with pleurisy, one with broncho-pneumonia, and one followed acute appendicitis. Regarding 8 deaths from empyema, no further information was obtained.

DR. WALTER SMITH opened the discussion. [His paper will be found at page 161.]

SIR THORNLEY STOKER introduced the discussion on the surgical treatment of empyema, and gave the results of his own experience as to various methods. [His paper will be found at page 170.]

DR. EARL read a short paper on the bacteriology of empyema. [It will be found at page 178.]

SIR JOHN MOORE read notes of two cases illustrative of the difficulties which attended the differential diagnosis of empyema, or pyothorax, and hypophrenic abscess. [This communication will be found at page 186.]

SIR ARTHUR CHANCE discussed the policy of surgery towards empyema, which, he said, was very simple. [His communication will be found at page 191.]

DR. A. C. O'SULLIVAN gave particulars of the opsonic power of the blood and pus from two cases of empyema.

DR. HAYES showed four cases illustrating the good effects after operation done up to ten years previously. He pointed out that formerly irrigation was always carried out, but this was never done now. He relied on puncture with a long needle as the best aid to diagnosis, and thought that the severe operation recommended by Sir Arthur Chance was unnecessary, as his cases showed that the thickened pleura had resolved.

SECTION OF OBSTETRICS.

President—R. D. PUREFOY, M.D., F.R.C.S.I.

Sectional Secretary—HENRY JELLETT, M.D., F.R.C.P.I.

Friday, February 2, 1906.

The PRESIDENT in the Chair.

Degenerated Uterine Fibroid.

SIR A. MACAN exhibited a specimen of degenerated uterine fibroid. He said that after opening the abdomen of the patient he found the tumour pedunculated, and with adhesions. On section the tumour gave evidence of being an ordinary fibroma. Pain had previously been complained of. This form of red degenerative change is said usually to begin in the centre of these tumours. They are liable to be coloured and to slough.

Sarcomatous Degeneration of a Myomatous Uterus.

DR. ALFRED SMITH exhibited a specimen of a myomatous uterus undergoing sarcomatous degeneration. The patient was about forty-five years old, married, but had no family. Her menses had ceased. Operating he found a mass of brown matter, which he took to be a polypus. He removed the entire uterus. Professor McWeeney's report on the specimen showed, apparently, a polypoid formation projecting from the mucous membrane of undoubted sarcomatous structure. The sarcoma tissue itself was undergoing mucoid degeneration in some places, otherwise the uterus was in an advanced stage of fibro-myomatous overgrowth. Slides demonstrating the sarcomatous changes were also shown under the microscope.

DR. HASTINGS TWEEDY considered that Dr. Smith's case showed the necessity for the early removal of all myomata.

DR. JELLETT suggested that in Sir A. Macan's case the red degeneration might have been the result of bacillary infection.

THE PRESIDENT instanced a case in which he removed a tumour from an unmarried woman, which underwent a dark, mahogany-brown discoloration, almost identical with that seen in Sir A. Macan's specimen, and in which the change was due to teleangectasis.

Carcinoma of Ovaries and Uterus.

DR. JELLETT showed two carcinomatous ovaries and a uterus removed from a patient aged forty-seven. The tumours were so fixed in the pelvis that at first sight their removal appeared impossible, but, on making a transverse incision from the centre of the usual mesial incision outwards towards the left anterior superior spine, it became possible to pass the fingers below the left ovary, and so to work across the pelvis to the right. The broad ligaments were so infiltrated that it was impossible to tie them, and the uterus was in consequence removed, hæmorrhage being controlled by two clamps passed upwards from the vagina. There was a large collection of very foul pus in Douglas' pouch, and from this an infection of the abdominal wound resulted. The patient, whose pulse at the end of the operation was 160, made an uneventful recovery, save for the wound infection. At the present time, six months after the operation, she states that her health has been good, and that she has gained in weight. On examination, however, it is probable that a return is taking place in the tissues round the rectum.

Double Pyosalpinx.

DR. JELLETT also showed a double pyosalpinx and the remains of an extra-uterine foetus removed from a patient who had been pregnant eighteen months before the operation, and who had believed that she had miscarried. No ovum, however, was seen at the time, and the condition of the removed foetus made it probable that it had been retained since the supposed miscarriage. The foetus was aged about $4\frac{1}{2}$ months.

DR. KIDD said the first case reminded him of one of sarcoma of the ovaries, in which the hæmorrhage was so profuse after removing one ovary that he decided to let the other alone.

THE PRESIDENT doubted the value of operation in such cases.

Sequel to an Attack of Eclampsia.

DR. J. SPENCER SHEILL then read a paper entitled "Sequel to an attack of Eclampsia." The patient, a young primipara, had had her left kidney removed three years previously for tuberculosis. She contracted eclampsia in March, 1905, when about five and a half months pregnant. She had seven seizures, which caused the death of the foetus. Her uterus was emptied by induction of labour, and her recovery was rapid and complete. She again conceived; and on examination early in July, 1905, was found to have been two and a half months pregnant. She was cautioned about her condition, and placed on milk diet. A little later, in spite of diet and care, she developed albuminuria, which, however, was successfully combated by appropriate treatment. Again, in December 1905, albumen made its appearance in the urine, this time permanently. Œdema now began to complicate the case. Although the most vigorous measures were adopted, on the 8th of last month (Jan., 1906), when she was within about a month of term, owing to the onset of symptoms which indicated the near approach of eclampsia, induction of labour was performed, and she was delivered in eighteen hours of a living child. A few hours later she had a typical eclamptic seizure, and was successfully treated. The points of particular interest are :—(a) Are there no methods by which we can with certainty abort threatened eclampsia? (b) Would it not be for the good of everyone concerned that this woman should be rendered sterile by the operation of tube tying?

THE PRESIDENT said he believed that when our efforts to relieve the patient's condition were only partially successful we should

take measures to empty the uterus, though eclampsia may come on before we have succeeded. He thought that in the second pregnancy of this patient he would have waited considerably longer before inducing labour.

DR. HORNE preferred to have the ovaries removed, and mentioned two similar cases of his own experience. When a patient had eclampsia once, the question was, was she not likely to have recurrent eclampsia. The second pregnancy of this patient should have been prevented for this reason. He believed the kidneys were the primary cause of the disease.

DR. SHEILL said that a dead foetus was a foreign body at best; and, therefore, to empty the uterus was the most natural thing to do. Noting eclampsia was imminent in the second pregnancy of this patient, he thought it safer to induce labour. Two lives in this case were in danger; but that of the mother was paramount. Both were saved. He would like to hear their opinion.—Should sterility be effected in a patient who is liable to attacks of eclampsia?

THE PRESIDENT said he would not render her sterile.

Card Specimens.

DR. R. A. FLYNN—(a) Ovarian tumour with twisted pedicle and hæmorrhage into cyst; (b) parovarian cyst.

PRIMARY SARCOMA OF THE LIVER ACCOMPANIED BY SYMPTOMATIC PRURITUS.

SALVINI reports the case of a man, aged sixty-seven, with a primary sarcoma of the liver. Three months before admission the patient was seized with a pain in the region of the liver, which was worse on pressure, and did not disappear in spite of all efforts. Three days afterwards he was attacked with a general pruritus, which was followed by the appearance of a papular eruption. The case presented, therefore, a clinical syndrome, described by Pepere in his work on the primary malignant tumours of the liver, to which was added a dermatosis, which the author describes as symptomatic of a profound lesion in the liver.—*Riforma Medica*, Jan. 20, 1906, and *New York Med. Journal*, Feb. 17, 1906.