found to be in the left lung, the whole of the interstitial tissue of which was charged with extravasated blood. No distinct cavity or large clot was found in the lung, nor was it possible to find the vessel which had given way, though several branches of the pulmonary artery were traced. The bronchial tubes and tubules were full of blood. No blood had escaped from the trachea into the mouth or into the pharynx.

The case seems to be one of those described by Niemeyer as causing death suddenly, before hæmoptysis can occur, by blocking up the bronchi with blood and so suffocating the patient. It is recognised by the author just named as a very rare form of disease.

Holloway-road.

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.

VICTORIA HOSPITAL FOR CHILDREN.

TWO SUCCESSFUL CASES OF OPERATION FOR CLEFT PALATE IN CHILDREN OF TWELVE MONTHS OF AGE; REMARKS.

(Under the care of Mr. H. H. CLUTTON.)

THE age at which operations for the cure of cleft palate should be undertaken has caused considerable discussion in the past, and there is still much diversity of opinion about it. The operation has been performed on a child of only four days old, but unsuccessfully, and it is not often attempted on children of twelve months old, and could only be successful in such cases as are here recorded. We agree with Mr. T. Smith's remarks:¹ "None but very general rules can be laid down as to the best time for operating, since each case must be judged on its own merits, and every surgeon will be guided by the results of his own experience." We would refer our readers to Mr. Clutton's remarks on the cases.

The first case (for the notes of which we are indebted to Dr. Moline, the medical registrar) was a girl of twelve months old, who was admitted in August, 1886. She was a healthy-looking, well-nourished baby, brought up by hand, as she could not take the breast. The cleft involved only the soft palate, and there was no other abnormality. On Sept. 2nd, the infant being under chloroform, the edges were pared and brought together with fine silk sutures. A lateral incision, chiefly through the pillars of the fauces, was made on each side to relieve tension. On Sept. 8th a few of the sutures were removed under chloroform. On the 15th the remaining sutures were removed in a similar manner. The palate was entirely healed and closed, with the exception of a small aperture near the hard palate. She left the hospital a few days afterwards. When seen again a few months later this opening had closed, and the line of union was scarcely perceptible, the uvula even having its natural form. The mother also said that the baby's cry had a much more natural sound than it had before the operation.

The second case, for the notes of which we are indebted to Dr. Wills, the house-surgeon, was a boy of eleven months of age, who was admitted on Jan. 17th, 1887. This was not such a healthy-looking child as the last, and was therefore kept in hospital on careful diet for a month before attempting any operation. With care the infant could take the bottle, but the food easily returned through the nose. The child had no other deformity, nor was there any history of this or any other abnormality in the family. The cleft involved the soft palate and a very small portion of the hard. The two halves seemed fairly thick, and not too far apart. On Feb. 10th, the child being under the influence of chloroform, Mr. Clutton pared the edges, and, finding that part of the cleft which involved the posterior edge of the hard palate

too fixed to be successfully brought together by the simple operation, made a lateral incision on each side close to the gum, and raised a muco-periosteal flap from the bone, by the method generally known as Langenbeck's. The whole cleft was then very easily united by fine silk sutures. The pillars of the fauces were partially divided with a pair of curved scissors, as in the previous case, to relieve tension, and the operation was concluded on Feb. 20th. The sutures were all removed under chloroform, when the palate was found perfectly united from one end to the other.

Remarks.—It is obviously a great advantage, if the voice is to obtain its natural sound, that the operation should be done at as early an age as possible. If, however, it fails, any subsequent operation is made more difficult. It is, therefore, of great importance that only the simplest cases should be undertaken at this early age; and even amongst these success will greatly depend upon the thickness of the divided palate which is to be united. A healthy child at twelve months of age may have the simplest cleft in its palate, involving only the velum, and yet the tissues on each side may be so thin as to give a very poor prospect of success after operation. The circumstances which induced Mr. Clutton to operate at so young an age in these two cases were—the simple character of the cleft, the abundance of the tissue on each side, which would afford a thick bond of union, and the healthy condition of the children. The nursing after the operation which the child is likely to obtain has also to be considered, for with constant crying success is impossible. These two children were scarcely out of arms during the ten days succeeding the operation, and the success that was thus obtained speaks volumes for the care and trouble which was devoted to them by the nurses at the Victoria Hospital.

LEEDS INFIRMARY.

RUPTURE OF BLADDER; OPERATION; DEATH FROM PERINEAL HÆMORRHAGE; REMARKS.

(Under the care of Mr. T. PRIDGIN TEALE.)

FREDERICK S—, aged twenty-five, was admitted on Dec. 6th, 1883, having been violently assaulted two hours previously. He had been kicked in the abdomen and perineum during a quarrel, and when admitted complained of pain in the lower part of the abdomen and of inability to pass urine. There was tenderness of the abdominal wall, with tension of muscles, but no visible bruising at either seat of injury, and the patient was under the influence of alcohol. The retention was relieved by a No. 10 catheter, a few drops of blood preceding the flow of urine. The catheterism was repeated twice at intervals of six hours. There was, moreover, such an absence of collapse or alteration of look, pulse, or temperature, that the nature of the case was not suspected by the resident staff. On the following morning he was seen by Mr. Teale, who, observing a tympanitic abdomen, with dulness of the flanks, and being told that the more recent catheterism had only drawn off an ounce or so of urine, suspected rupture of the bladder.

At midday, after consultation with his colleagues, who agreed in the diagnosis of ruptured bladder, Mr. Teale operated. Having first opened the perineum in the median line and introduced into the bladder an indiarubber drainage tube, cut short at the wound, and stitched to its edges, Mr. Teale opened the abdomen between the umbilicus and pubes. A large quantity of pale straw-coloured fluid was found, in which the intestines floated freely, and without any trace of inflammation or congestion. At first the rent could not be seen or felt, owing to the collapsed state of the bladder, but on injecting through the perineal drainage tube a weak solution of carbolic acid a vertical rent was detected in the posterior surface of the bladder, not far from the apex, and fully an inch in length. The rent was closed by six fine catgut sutures, so inserted as to bring the peritoneal surfaces into contact without perforating the mucous surface, and the abdominal wound was closed without the insertion of any drainage tube. There was more oozing of blood from the peritoneal wound than usual, and shortly after Mr. Teale left the hospital Mr. Robson was called to the patient, who explored and then plugged the perineal wound. Some hours after there appeared to be some fresh oozing of blood, and the man became alarmingly anæmic from loss of blood, and died the next morning at seven o'clock.

At the post-mortem examination, the rent in the bladder

¹ Heath's Dictionary of Surgery: art. Cleft Palate.

was found to be perfectly water-tight, and there was no peritonitis.

Remarks by Mr. TEALE.—The hæmorrhage from a simple median perineal wound was so unusual that one can only look upon it as an unfortunate coincidence, possibly the result of the kick in the perineum, of which no visible bruising gave warning. In another case of ruptured bladder, I should not think it necessary to insert the perineal tube, partly because the recent experience of others shows that such a course is not needed, and partly because it is a question whether on the whole suprapubic drainage would not be more satisfactory.

SAMARITAN HOSPITAL FOR WOMEN, NOTTINGHAM.

CASES OF ABDOMINAL SECTION; REMARKS.

(Under the care of Dr. TRUMAN.)

CASE 1. Parovarian cyst.—Jane S—, aged twenty-four, was admitted on May 19th, 1886. The menstrual periods commenced at the age of fifteen, and were painless until the last four or five years. The nature of her work requires frequent exercise of her strength in lifting heavy weights. Owing to pain in the lower part of her body she has been unable to go to work for the last six weeks.

On examination per vaginam, there was found a rounded swelling in the right lateral fornix, the size of a cocoanut, perfectly resistant and unyielding to pressure. Uterus pressed against the os pubis; its cavity not lengthened. The swelling felt solid, and it was suggested that it was due to a pedunculated myoma. In reference to this, Dr. Walter mentions the close resemblance of the physical signs, in a case of parovarian cyst, to those caused by a myoma attached to the posterior wall of the uterus. In the present case, however, the normal length of the uterine cavity, the absence of metrorrhagia, &c., pointed rather to the existence of a small ovarian cystoma.

An operation was performed on June 15th. In the right half of the pelvic cavity, and not at all rising above the brim of the pelvis, was a unilocular cyst, perfectly unadherent, and with a long narrow pedicle crossing over to the left side of the uterus. By aspiration were removed twenty fluid ounces of a perfectly clear and white liquid, of specific gravity 1006, containing neither fibrin nor albumen, but abounding in chlorides. The cyst was then drawn out, and the pedicle, three-quarters of an inch in diameter, secured by the Staffordshire knot and divided, when it was seen to spring from the *left* broad ligament, the cyst having fallen over into the *right* half of the pelvic cavity. The ovaries were healthy, and were not removed.

The patient made a good recovery, and was discharged on July 10th. She is in full work, and menstruation has been painless since.

CASE 2. Dysmenorrhœa.—Mary H—, aged thirty-two, was admitted on July 21st, 1886. The menstrual period began at fourteen. She has had severe dysmenorrhœa for eight or nine years, and was latterly dismissed from one of the metropolitan hospitals as incurable. The periods are regular, lasting seven days, with great loss, small clots being frequently observed. The pain never ceases in the intervals, but is intensified at the periods. The patient has great difficulty in walking a hundred yards, and this always increases the pain. She has been unable to work at all for the past two years, and is thus, much against her will, dependent on her friends for support. The situation of the pain is the left ovarian region, and this pain is increased if she lies on the left side.

On examination, the uterus was found slightly retroflexed. In the situation of the left broad ligament was a swelling the size of a walnut, freely movable, and exquisitely tender, nausea being caused when it was pressed between the two index fingers, one internal and one external. There was no tenderness. In the right ovarian region there was no pain except in the above-named spot.

On July 24th an operation was performed. The appendages were removed on both sides; the left ovary was enlarged and becoming cystic.

The patient was discharged cured on Aug. 24th. After a time spent in recovering her strength, she returned to work. She can now walk a couple of miles, and can work, if necessary, for fourteen hours a day. Although both ovaries were completely removed, there is a discharge of blood every month; this is unaccompanied by pain.

CASE 3. Hæmatosalpinx (?)—Mrs. H—, aged thirty-two, was admitted on Dec. 7th, 1886. Has had four children; no miscarriages. First labour ten years ago; forceps were applied for five hours and a half. She was in bed for two months afterwards. Ever since has had more or less pain in the right iliac region. Has also had four attacks previously to the present one; these attacks came on suddenly and kept her in bed for three or four months. Her last child, fourteen months old, is at the breast. For the last eight months Mrs. H— has menstruated regularly, and the periods have been longer than usual. A month ago she had sudden pain in right hip and pubic region, with vomiting and faintness; has been in bed since. Has had great difficulty in emptying the bladder.

On examination, the cervix was found jammed close to the pubic bone; the cervix was that of an unimpregnated uterus, but with a deep laceration. The right half of the pelvis was occupied by a tense, fluctuating tumour, continuous with a swelling above the pubes. This tumour stretched over to the left side, but the left half of the pelvis was not so closely filled up as the right. There was great tenderness to touch externally and internally. Temperature 100.2°. An operation was urgently needed on account of the partial blocking up of the urethra. This, however, had to be deferred; the woman was suckling, and the sudden weaning of the child made her very feverish. Pain was considerable, and had to be combated by opium. On re-examination on Dec. 29th, it was seen that the abdominal swelling was larger, and that, in addition to steady increase since the 7th, it had rapidly increased during the past forty-eight hours, and the woman was losing colour. There was marked dulness in the hypogastric region, and that mostly on the left side. The swelling felt per vaginam when first seen was principally on the *right* side; it was now on the *left*; and to the extreme left of this elastic swelling was felt a more resistant body.

The diagnosis was not very clear, but seemed to be one of three things: an ovarian cyst, with twisted pedicle, and consequent hæmorrhage into its cavity; an extra-uterine foetation; or a hæmatosalpinx, the latter accounting the more readily for the history of four preceding attacks, if small hæmorrhages be supposed to have taken place. It was evident that hæmorrhage was actively going on at the present time, and the operation was performed on Dec. 30th. The pelvic cavity exhibited the following condition of things. The left half was occupied by a large swelling, consisting mainly of blood clot. The uterus was enlarged about three-quarters of an inch in all three dimensions. Between it and the rectum was the tumour, semi-fluctuant, and from three to four inches in diameter; by its upper surface it was free, but by the other surfaces it was adherent. The wall of the tumour was formed of (1) a strong, thick, fibrous investment, so firmly adherent to the bowel that it had ultimately to be separated by the knife, and passing upwards to the left cornu of the uterus, where it showed a large, ragged rent, and (2) of a layer of plastic lymph, which limited the contents of the tumour. This layer broke down with a touch and blood clot escaped. The finger was passed round the tumour and adhesions were pretty easily broken down. The solid part of the tumour sprang from the left cornu, and apparently was the left ovary; it was ragged and torn, and contained a cavity two inches across. The rest of the tumour consisted of blood clots and dark fluid blood. The blood clots were of two kinds, fresh and red, and old and decolourised (fresh blood coinciding with fresh pain and swelling on the 28th and 29th). In these clots were found a membranous cyst, very thin, and about three-quarters of an inch in diameter, and two small bean-shaped bodies half an inch to three-eighths of an inch long. The clots were cleared away, and the part of the growth springing from the uterus tied and removed. That part of the fibrous investment that was adherent to the bowel was tied and divided, leaving a margin half an inch deep attached. The posterior surface of the uterus was left freed, but covered with a rough layer of lymph. A glass drainage tube was inserted to the bottom of the posterior cul-de-sac.

The case went on well. The drainage tube was removed on Jan. 3rd, and the patient discharged on Feb. 1st.

Remarks by Dr. TRUMAN.—A question arose whether this might not have been a case of early tubal pregnancy. Dr. Handford, physician to the Nottingham General Hospital, most kindly examined the relics for me. He says: "All the tissues, besides the clot, are so infiltrated and sodden with blood