plied every day. She returned in a week, said she had followed out my instructions as to rest and the daily application of pledgets, with the result that for the last one or two days she had been going about the house without being troubled with hæmorrhage. She had gained flesh and colour, and was in every way stronger. The tumour, though present, was certainly diminished. She has been seen by me once or twice since, and says she feels quite well, has had no more hæmorrhage, is doing her every day work, and does not intend to see a doctor again unless a fresh hæmorrhage attacks her.

Remarks.—Varicose and enlarged veins in the region of the vulva and in the vagina are of common enough occurrence during pregnancy, and at times give rise to serious hæmorrhages during or after parturition; but I have never seen, nor can I find recorded in any volume of obstetrics or gynaecology with which I am acquainted a similar condition of dilated veins in a subject sixty-five years of age, who was, as far as one could judge from examination, perfectly healthy, and who certainly presented no other signs of varicose veins in any other part of the body. No tumour was found in the pelvis, either per vaginam, per rectum, or on abdominal palpation, which might have accounted for this varicosity, and I must confess I am at a loss to explain its occurrence. The rupture and consequent hæmorrhage are easily accounted for by the extra pressure in the venous system, acting on what was evidently a weak part in the wall of the dilated vein. The sudden hæmorrhage with the almost cancerous cachexia presented by a patient of her age, the mother of ten children, might easily have led one to suspect malignant disease of the generative organs.

Queen Anne-street, W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A PROPOSED MODIFICATION OF MOORE'S TREATMENT OF ANEURYSM.

By W. E. STEAVENSON, M.D. CANTAB., M.R.C.P.,
ELECTRICIAN TO ST. BARTHOLOMEW'S HOSPITAL.

THE papers read before the Royal Medical and Chirurgical Society on April 12th on the Treatment of Internal Aneurysms by the Introduction of Steel-wire into the Sac, and the subsequent discussion thereon reported in THE LANCET of April 16th, have suggested the following modifications and additions to the operation:—That the wire used should be soft iron wire, instead of steel, of No. 29 gauge according to the Birmingham scale. That the introduction should be accomplished by means of a perforated needle fitted to a handle similar to that used for the operation of staphyloraphy, as suggested by Mr. T. Smith. That the wire should not, as in the latter instance, be previously wound upon a reel or bobbin, but should be paid out from a tolerably large coil or skein so as to reduce the chance of kinking. The amount of wire to be used will vary in accordance with the size of the aneurysm. That the perforated needle should be a straight one made of ivory, and much longer than those ordinarily employed for cleft palate.¹ That the needle should be introduced to such a depth that the point would be well within the aneurysm. When sufficient wire has been introduced, it should be cut off near the hank or coil from which it was paid out; the handle detached from the needle; the needle left in the aneurysm with the end of the wire protruding from it. That the wire should then be connected with the *positive* pole of a strong galvanic battery; a sponge, or tin and amadou plate electrode, moistened in salt-and-water, should be attached to the negative pole and placed on some indifferent part of the body. That the circuit should be closed, and a current of from fifteen to twenty milliampères passed through the aneurysm until it became consolidated, or for thirty minutes. The pad connected with the negative pole should be moved to different parts of the body when found necessary, so as to avoid any particular spot becoming blistered or sore. That at the con-

clusion of the operation the remaining piece of iron wire protruding from the needle should, if not already detached by the decomposition which had taken place in the sac, be pushed through the perforated needle by a blunt trocar into the aneurysm, and the small puncture hole closed by a piece of strapping. The introduction of soft iron wire into the sac of an aneurysm would be a great additional advantage in the employment of electricity over the usual method of galvano-puncture. When attached to the positive pole of a battery, coagulation would be encouraged within the aneurysm, and the wire itself would undergo decomposition with the formation of chloride and oxide of iron, which would, in addition, exercise their own specific coagulating properties.

It was mentioned by Dr. Pringle in the discussion already alluded to that the clot resulting from electrolysis is distinctly softer than an ordinary clot. If this be so, it is no doubt partly due to its rapid formation, and it would no doubt shrink and consolidate, and possibly become as firm as any other clot when of a similar age. In the operation now suggested, the clot produced by electrolysis would have a long and extensive origin, and be entangled in innumerable positions by the coils of the iron wire. Another probable reason why the coagulum formed by electrolysis "appears very frequently not to be stable, but to be liable to melt down again into the blood stream,"² is because needles attached to both poles, or to the negative pole, have been used. Around the negative pole the blood is coagulated into a yellow friable alkaline mass, composed to a great extent of gas bubbles, which very quickly breaks down. Around the positive pole the clot is smaller, firmer, and darker in colour, and has an acid reaction. From the physical laws of electrolysis, and from the experience already obtained, it would seem probable that a combination of Moore's treatment of aneurysm with that by galvano-puncture, as here sketched out, would offer a very fair chance of a successful result.

Welbeck-street, W.

ASPIRATION OF THE URINARY BLADDER.

By A. WILKINSON, M.D.

HAVING seen Mr. G. Buckston Browne's letter in your issue of Feb. 26th, also the report of and discussion on a paper read by Mr. W. H. Bennett at a recent meeting of the Medical and Chirurgical Society on a case of rupture of the urinary bladder which terminated fatally as a direct result of aspiration above the pubes, I am induced to send you the notes of a case in which the bladder was aspirated by this method sixty-nine times in immediate succession by myself and assistant alternately.

The patient, a large fat man, aged sixty-seven, had been an invalid three years owing to brain mischief, and during that time was gradually getting worse. His intellect was so far impaired that none of his statements could be credited, but, as far as could be ascertained, he had had some difficulty in micturition, but no actual retention till Sept. 3rd, 1885, the date of my first visit. The history, condition, and symptoms—aphasia and paresis—pointed to cerebro-spinal disease; but an enlarged prostate, fully the size of a tennis-ball, undergoing some active change, probably inflammatory, was the immediate cause of the retention. The bladder was greatly distended, and the urethral passage narrow, tortuous, and painful. With considerable difficulty a No. 5 gum-elastic catheter was passed, and about thirty ounces of urine drawn off. This was repeated on the 4th and again on the 5th, but from the latter date to Oct. 16th, as no catheter could be passed, supra-pubic aspiration was resorted to, sometimes once a day, more often twice. The punctures were made with a fine needle corresponding in size to No. 19 wire. The natural route to the bladder was still occluded, and aspiration having been performed fifty-four times, on Oct. 16th I punctured above the pubes with Pearce's trocar and cannula with the view to establish a permanent outlet. The cannula was tied in, but owing to the patient's interference, he twice pulling it out, that course was abandoned. The aspirator was again brought into use, and continued until the 25th, when I succeeded in passing a No. 3 soft catheter, to which an exhaustor was attached, and the

¹ Messrs. Coxeter, of Grafton-street, have made me such a needle.

² See Mr. Timothy Holmes' Lectures on the Surgical Treatment of Aneurysm. (THE LANCET, Sept. 7th, 1872, p. 326).

urine drawn off. The catheter was tied in, but removed by the patient in his demented condition. On the morning of the 27th about a teaspoonful of pus suddenly gushed from the urethra, and on passing the catheter about four ounces came through it, fairly conclusive that prostatic abscess had been the cause of the retention. Catheters gradually increasing in size were passed from day to day, until No. 10 could be easily introduced even by the patient's attendant. In this case the urinary bladder was aspirated above the pubes sixty-nine times in succession. All the punctures were made within an area about the size of a crown-piece, the most recent being as far removed as possible from the previous one. Small subcutaneous shot-like indurations followed the punctures, but soon disappeared, leaving no ill effects. The urine, which at no time contained sugar, after three or four aspirations became excessively large in quantity, being secreted at the rate of five ounces an hour, often more, and subsided to its normal amount when the aspirations were discontinued. The patient residing at a distance of nearly four miles, and the urine being so large in quantity, over-distension was not an unfrequent occurrence, but notwithstanding this unfavourable circumstance the bladder maintained its own fairly well throughout, the urine only becoming slightly turbid toward the last. The patient so far recovered that his attendant was enabled to relieve him by a soft catheter when necessary.

Shaftesbury, Dorset.

A REMARKABLE CASE OF FIBROMA MOLLUSCUM.

By FRANCIS W. CLARK, L.R.C.P., M.R.C.S.

THE following notes of a case of fibroma molluscum will, I think, be of interest from the exceptional rarity of certain of the features presented by it.

The patient, a man aged seventy, is covered from head to foot with a number of subcutaneous tumours of various sizes, some of them being pedunculated, while others are sessile. These tumours are of very soft consistence, and there is an entire absence of that lobulation which is so characteristic of subcutaneous fatty tumours. The largest of these tumours is one which forms a complete anklet around the left ankle. One of the smaller pedunculated growths was removed for further examination, and on section it was found to consist of a gelatinous translucent material, which under the microscope was seen to be composed of a very fine reticulum of fibrous tissue, containing in its meshes a transparent gelatinous material—myxo-fibroma. The patient dates the onset of this condition from a fright he received thirty years ago, when he happened to be a spectator of a severe railway accident. He states that since that time these tumours have gradually appeared, most of them developing during the first twelve months subsequently to the fright. It is a curious feature in the case that the patient's daughter, who was born some twelve months after the appearance of the tumours, is also covered with similar growths, though they are less numerous. The case was shown for me by my friend, Dr. J. Kingston Fowler, at the Clinical Society of London in February last, and was then considered to be unique.

Croydon Infirmary.

DISLOCATION FORWARDS OF THE HAND.

By CHARLES AITKEN, M.B.

THE following report of a dislocation of rare occurrence may be of interest:—

In July last W—, a boy aged sixteen, was brought to my surgery with the history that he was sent up a tree to fasten a rope to one of its branches, so that it could be pulled down in a certain direction. While the boy was among the branches his master cut away at the stem, and the boy fell. He was not sensible for a few minutes after falling, and on becoming conscious thought that his arm was broken. Neither did he remember whether he fell with the palmar or dorsal aspect of his hand facing the ground. On examining him, I found that he had a dislocation forwards of the right hand on the arm and almost compound on the palmar aspect. The ends of the radius and ulna could be felt distinctly on the back, and there was a rounded swelling on the front. On pulling the hand away from the arm the dislocation was reduced with a loud snap. There was some swelling for three months over the carpal bones in front,

but that has entirely disappeared and the boy's arm is now as well as usual. On referring to the surgical dictionary by Heath, and to Holmes' and Hulke's Surgery, I see it is mentioned that the above dislocation is a very rare one indeed.

St. Mawes, Cornwall.

ABSENCE OF THE OCCIPITAL BONE AND SKIN IN A NEWLY-BORN INFANT.

By WILLIAM FRASER, M.B. T.C.D.

I RECENTLY came across a curiosity which will no doubt be of some interest. Among the books at my command (including Dr. Neale's "Digest," Sydenham Society, 1877), I cannot find any mention of a similar case.

About 3 A.M. on Nov. 20th I was asked to go to Mrs. W—, living about eight miles away, who was in labour with her third child. On my arrival there was a mysterious silence and glances which betokened that the baby was stillborn, but the afterbirth was retained. Having seen to the mother, I turned to the child, and the mystery was then explained. I found a female infant of about seven months and a half (though the mother says she did not expect to be confined until the end of December). The body was fairly nourished and well formed, the head flattened in its antero-posterior diameter, the eyes large and protruding; a black mass on the back of the skull proved to be the cerebellum exposed to view, with complete absence of the occipital bone and the skin covering it. On loosening the cerebellum and lifting it up I could see the base of the skull, and was able to push a piece of wood down the spinal canal. No cause could be assigned by way of fright or anything else.

Ashburton, Devon.

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. Prooemium.

MIDDLESEX HOSPITAL.

CASES OF SARCOMA IN CONNEXION WITH KNEE, FOOT, AND EAR; RESULT.

(Under the care of Mr. HULKE.)

THE cases of sarcoma reported in our impression of May 28th (p. 1086) illustrated the occurrence of this form of new growth in young adult life, evincing in its progress clinical features as malignant as those exhibited by any carcinoma. The first case of the present series exemplifies the same facts; it illustrates local recurrence after excision, and infection of remotely situated viscera manifesting itself at a date long after amputation of the limb. But this case has an additional interest in the illusory resemblance presented by the primary tumour in its clinical characters, in its apparent seat and connexions, and in its naked-eye appearances after removal to a multilocular ganglion. The deception was occasioned by the presence of the myxomatous elements, which simulated the structureless colloid contents of a common ganglion. The second case illustrates the occurrence of melanotic sarcoma in middle life in a form which, as regards the primary tumour, deceptively resembled epithelioma, and which led to its being mistaken for this—a mistake not unlikely to occur where the melanotic constituent exists in a minimum quantity in the original tumour, and only attains considerable development in the larger secondary masses, a by no means uncommon circumstance. The frequent development of melanosis in moles is too well known to need more than passing mention. The sole and the clefts between the toes would seem to be the favourite situations for this form of sarcoma, possibly because in these situations any little, apparently trivial, tegumental disorder is more exposed to pressures and to other kinds of local irritation. The third case is an instance of melanotic sarcoma occurring at an unusually early age, and in a very