Pepper to see her with the view of advising an interscapulo-thoracic amputation. This being agreed upon, and the aspect of affairs being fully explained to the woman and her husband, the operation was performed on Feb. 15th. A stimulating enema having been given and ether having been administered the clavicle was sawn across in its inner half and the vessels were tied with silk. In the shaping out of the flaps all the skin of the acromial and pectoral regions that was unimplicated in the ulceration was saved, and when it had been raised the pectoral muscles, the serratus magnus and latissimus dorsi, the levator anguli scapulae, rhomboids and trapezius, and the cords of the brachial plexus were divided, and the "part" was taken away. Bleeding vessels were secured as they showed themselves, and without any waste of time the flap was adjusted and sutured, bulky dressings were applied with compression, and the patient was taken back to her warmed bed. She was much collapsed in the evening, but at once answered to the injection into the veins of a quart of hot saline solution which was promptly given by Mr. G. D. Maynard, the house surgeon. She made a rapid recovery and when she visited the hospital a month or two later she looked extremely strong and healthy; moreover, she expressed herself as being well satisfied with the result of the treatment which she had undergone.

Remarks by Mr. OWEN.—As a rule the interscapulo-thoracic amputation is performed for malignant disease, and especially in cases of recurrent mammary scirrhus where any less extensive operation cannot be resorted to. Mr. F. Treves has also done it for gunshot wound in South Africa. I am not sure but that this is the first report of the operation being resorted to for the cure of a patient with intractable ulceration after a burn.

The woman had a narrow chest of what Sibson called the "expiratory type," and the experience which I met with during the operation suggested that if I were describing the steps of the operation in a work on operative surgery I should insert a few lines to this effect, that in a thin, narrow-chested subject—and especially when the arm has been long hanging by the side—the subclavian vessels as they rest upon the first rib must be sought for at a very considerable distance above the level of the clavicular incision. Indeed, in my case I found that I could best reach them by making a vertical incision up into the root of the neck.

MONSALL FEVER HOSPITAL.

A CASE OF PNEUMONIA (DOUBLE); EMPYEMA; ABSCESS IN THE ABDOMINAL WALL.

(Under the care of Dr. R. W. MARSDEN.)

At the Carlisle meeting of the British Medical Association the late Mr. William Anderson drew attention to the surgical importance of the sub-peritoneal space. He showed that it was a frequent site for new growths, and that in it formed many abscesses, such as the remarkably extensive one which is described below. In that case the septic infection probably came primarily from the empyema or the pneumonia, and made its way through the diaphragm, perhaps by one of the normal openings in that muscle; it then found itself in the sub-peritoneal space, where it spread easily amongst the soft areolar tissue.

A girl, aged 11 years, was admitted into the Monsall Fever Hospital on June 13th, 1900, with signs of pneumonia at both bases. The history stated that she had been ill for three weeks commencing with headache, and that she had subsequently frequent vomiting and diarrhoea. The temperature was 104.4° F. on admission and during the next three days it fell by lysis to 100°. As the spleen was enlarged to percussion and palpable a diagnosis of enteric fever complicated by double pneumonia was made, but an examination of the blood serum for Widal's reaction gave a negative result. In the meantime the pneumonic signs at both bases had spread over a larger area, and by June 20th, as a marked remission in the temperature had occurred on three consecutive mornings and as the percussion note at the bases gave the impression of increased solidity, a diagnosis of early empyema was made, but since the bronchial breathing at each base was loud and clear, an exploratory puncture was deferred. Between June 20th and 29th the morning temperature averaged 99° and the evening temperature 103°, and the physical signs at the bases seemed to be

quite at a standstill. The patient complained, however, of abdominal pain, which was thought to be of pleuritic origin, since though the abdomen was full and somewhat tense, with a girth at the umbilicus of 20½ inches, there was no tenderness or hardness and percussion revealed no unusual want of resonance. It was, however, noted that respiration was of the costal type.

As the patient seemed to be rather worse an exploratory puncture was now made into the right pleural cavity posteriorly, and a syringe of yellow, creamy, non-odorous, thick pus, of uniform consistence and free from lymph particles, was withdrawn. From the left base also a few drops of purulent material were obtained. Accordingly a piece of rib was removed from the right side, but only two ounces of pus with the characters above mentioned were evacuated. Up to July 3rd the remissions were daily becoming less, and their continued presence was attributed to a small quantity of pus in the left pleura. On the evenings of July 3rd and 4th the temperature was 102.4° and 103° respectively, and on the morning of the 5th the patient was very decidedly worse. During the preceding night she had passed six watery brown stools and had vomited frequently. (It should be mentioned that on two previous occasions—viz., June 20th and 27th—she had vomited, and that throughout the period of observation in the hospital, though the bowels had acted on an average once daily, yet the stools had been very variable in consistence.) She was now lying with her legs flexed upon the abdomen; there was, however, no pain on palpation and no sign of hardness or localised fulness, but a general feeling of tenseness and elasticity. The dulness of the liver and spleen was quite distinct, and percussion of the rest of the abdomen gave a perfectly resonant note. Measurement of the abdomen at the umbilicus showed an increase to 22½ inches, and fluctuation could be obtained from one side of the hypogastrium to the other, but not when pressure was made in the middle line.

Though unable to diagnose the condition of the abdomen, as the patient was so much worse it was decided that exploration was indicated. Accordingly an incision was made in the middle line below the umbilicus. Immediately the sheath at the posterior surface of the rectus abdominis was divided thick yellow pus with the characters already described began to well up into the wound. On inserting the finger it was evident that the pus proceeded from a shallow space between the peritoneum and the transversalis fascia. The outlines of this space could not be determined though a probe was passed almost to the costal margins above and to the extreme flank on each side. No less than 35 ounces of pus were measured, and by inserting a large drainage-tube from the central incision to a counter-opening in each flank, a free exit for the remainder was provided. The patient immediately began to improve and ultimately left the hospital on Sept. 11th, 1900.

Remarks by Dr. MARSDEN.—The uniform distribution of such a large quantity of pus over the front of the abdomen gave so little alteration in the usual physical signs that I have to confess that I did not suspect its presence in that situation, and it is especially on account of the consequent possible difficulty in diagnosis that I have thought the case worthy of record. As regards its origin I am of opinion that it was subsequent to the double pneumonia, both from the course of the disease and the character of the pus, but as I have not previously seen or heard of such a condition, I should be pleased to have information from any readers of THE LANCET who have had a similar case.

BIRMINGHAM GENERAL HOSPITAL.

TWO CASES OF "TRAVELLING" FOREIGN BODY.

(Under the care of Mr. T. F. CHAVASSE.)

In the *Mirror of Hospital Practice* in 1898¹ we published an account of a case in some respects resembling the first of the two cases described below; a piece of steel passed from the stomach into the subcutaneous tissue of the abdomen whence it was removed by Mr. John H. Morgan. In Mr. Chavasse's case the shawl-pin probably perforated the wall of some part of the small intestine. For the notes of the cases we are indebted to Mr. R. E. Sedgwick.

CASE 1.—A girl, aged three years, was admitted to the

¹ THE LANCET, Feb. 5th, 1898, p. 365.