eating with the boy's parents. As an operation for pulmonary abscess it proved successful, but from the long previous duration of the case pyæmic infection had occurred.—Mr. C. MANSELL MOULLIN gave details of a case of hydatid cysts of the liver, which ruptured into the peritoneal cavity, and in which abdominal section was performed. The patient was a thin anæmic youth, aged nineteen. The tumour was first perceived eight years ago. In September, 1889, something gave way in the abdomen; the swelling disappeared, and an eruption of urticaria, with slight shock, followed. Ascites set in afterwards, and the patient was admitted into the London Hospital under Dr. Stephen Mackenzie. The abdomen was aspirated on three occasions, fifteen to twenty pints of dark greenish-brown fluid being evacuated each time. Hooklets were found in the last. Abdominal section was performed on Dec. 28th, an immense quantity of fluid draining away. Recovery was very much delayed by the slowness with which the cyst wall separated and the difficulty of extracting the sodden fragments. In about three weeks bile ceased to make its appearance, but the patient did not rally. A few days later a second much larger cyst with thicker walls burst into the suppurating cavity, the shock on this occasion nearly proving fatal. Then the cavity slowly contracted, and the patient was discharged with the wound healed in April. Attention was directed to the very different estimates of the mortality attendant on rupture of the hydatid cysts into the peritoneal cavity and the great difference to the severity of the symptoms, especially the degree of shock. It was pointed out that the symptoms of poisoning that usually followed could only result from some constituent of the fluid itself, possibly a ptomaine, the presence of which in living active cysts had been shown by Langenbuch and confirmed by Brieger and others. This would also serve to explain the results obtained experimentally by Roy and Humphry. On this supposition the subsequent onset of peritonitis and its severity must be regarded as dependent chiefly upon the nature of the debris that entered the peritoneal cavity at the same time.—The PRESIDENT asked the experience of surgeons as to whether these cavities should be washed out. His own feeling was that they should not be so treated.—Mr. HOWARD MARSH said that the difficulties were very great when one attempted to do anything active surgically to the lung itself. The hæmorrhage on incision into its substance was profuse, and there was great difficulty in getting sufficient room, even if ribs were freely removed. It was a difficulty, again, to leave the wound in an aseptic condition because of the usual free communication with bronchi. He referred to a case in which a patient had apparently a simple empyema, but the sinus would not close. Portions of ribs were removed, and there was extremely severe hæmorrhage. The sinus still remained open, and a quantity of blood had since escaped both from the sinus and by way of the bronchi, though he had no clue as to its cause. He thought that hydatid cavities should not be washed out. A little time ago he saw a lady, in consultation with Dr. Douglas Powell, with a chest complaint. It was thought to be empyema and a portion of rib was resected, when there gushed out a large quantity of hydatid material. It must have been hepatic in origin, for afterwards there was a free discharge of bile; the patient ultimately did well. He once nearly destroyed a patient by washing out with weak iodine a chest cavity which communicated with a bronchus.—Mr. ROBINSON, while agreeing that as a rule chest cavities should not be washed out, pointed out that in the case under discussion the cavity was large, the pus was malodorous, and the patient was suffering from septic poisoning. The injection of a small quantity of weak Condy's fluid had no bad effect whatever.—Dr. ORD, in reply, while agreeing that a cavity containing living hydatids might be opened and left, yet when they were suppurating he saw nothing to distinguish them from any other abscess, and held that it was proper treatment to wash them out.

MIDLAND MEDICAL SOCIETY.

WEDNESDAY, DEC. 9TH, 1891.

Mr. BENNETT MAY, F.R.C.S., President, in the chair.

Bulbar Paralysis, with Bilateral Paralysis of the Abductors of the Vocal Cords; Death after Tracheotomy—Dr. SUCKLING read notes of the case of a man aged forty-

three, a commercial agent, who was admitted into the Queen's Hospital under his care on account of attacks of urgent dyspnoea. He had been ailing for three or four years, and had gradually become worse. His speech was slurred and thick. The lower lip hung down flabbily, and he had to press it against his gums when eating. There was distinct paresis in the lower part of the face on the left side. He suffered also from dysphagia, especially for liquids. The soft palate and uvula were relaxed, but not quite paralysed. He could protrude the tongue, but its movements were feeble. Phonation was feeble. He had no power of expectorating, and this gave him much discomfort. There was paresis and wasting of the left deltoid, and wasting of the left supra- and infra-spinati. The thenar eminence on both sides was flattened. The vocal cords were adducted on inspiration, and were drawn closely together, occasioning stridor; on expiration they were slightly separated, the edges vibrating. Dr. Suckling did not consider it safe for the patient to leave the hospital until tracheotomy had been performed, and the patient himself was very anxious to have the operation done. He was in a very feeble state, being obliged to sit up in bed to breathe, and his breath sounds over both lungs were very feeble. A few hours after the operation was performed, no anæsthetic being used, the patient became suddenly worse and was cyanosed. The breathing became very slow and shallow, and soon ceased. There were no history of syphilis, the knee jerks were normal, and there were no signs of locomotor ataxia. A microscopic examination of the medulla had not yet been made. The occurrence of paralysis of the abductors of the glottis in bulbar paralysis was rare. The man had been a drinker, but had never worked in lead.

Sarcoma of Radius.—Mr. HEATON showed this specimen. The clinical history was very meagre. Had noticed swelling of forearm for three months. Swelling was painless, but slightly tender on pressure, and had lately become more tender. Three days before admission it suddenly increased in size. Typhoid fever six months before; no history of tumour. He had fairly well-defined swelling in upper two-thirds of right forearm, chiefly over dorsal aspect of radius. Swelling firm and elastic, softer in places, tender, attached to radius; no pain in swelling at night, nor rise of temperature. Diagnosis lay between chronic osteitis, periostitis, or some form of new growth. The attacks of pain, rapid history, also of raised lump and history of sudden increase in size without any evidence of inflammation, all pointed to new growth. Grooved needle drew off a little blood. An incision made into tumour showed bone enlarged, and encountered a soft, vascular, marrow like tissue. Amputation refused, but consent afterwards given; performed. Boy made good recovery; seen a few weeks ago in good health. The specimen was a well-defined and encapsuled sarcoma of shaft of radius. Bone thickened by deposit of new bone from periosteum. Growth seemed to have started in the medulla, but, instead of expanding the bone, to have perforated it and enveloped it as a periosteal sarcoma would. Tumour, very vascular when fresh, had shrunk and become pale in alcohol. Microscopically, a myeloid sarcoma, with numerous well-defined multi-nucleated giant cells. The case is interesting on account of the extreme rarity in which a myeloid sarcoma grows from the shaft; nearly always at one articular end, and then expands the bone around it.

Disease of Testicles—Mr. BARLING showed a patient, aged thirty-one, with acute tubercular disease of both testicles. The disease was attributed by the patient to an injury three months ago, but the history of this is uncertain. When first seen each epididymis was a good deal enlarged, irregular, and very tender; a little fluid existed in each tunica vaginalis, and the cord was rather thickened and the skin of the scrotum red. There was no appearance or history of urethritis; no evidence or history of syphilis. The temperature at night varied from 101° to 103°, and in the morning was about 99°. No definite evidence of any other tubercular lesion could be discovered in the body. At the present time the disease had extended to the body of the testicles on each side, and the enlargement was steadily increasing. The left testicle was the size of a small fist, and both were very tender. The patient was advised to have double castration performed (after exploratory incision) for two reasons—viz., the disorganised condition of the testicles rendering them functionless, and the danger of general infection and of extension to the base of the bladder. Operation was declined.

Retroversion of the Gravid Uterus.—Dr. PURSLOW read notes of a case of retroversion of the gravid uterus. The patient, who had had four children and no miscarriages, was admitted at 6 P.M. on Nov. 14th, complaining that she had been unable to pass urine from noon on the previous day; no other symptoms. Last menstruated on Aug. 1st. On examination the bladder was distended, reaching to umbilicus, and there was a well-marked retroversion of uterus, the os being high up behind the pubes, and the fundus forming a large doughy swelling in posterior part of the pelvis. After withdrawing urine an attempt was made to replace fundus by pressure of fingers in vagina and then in rectum, but this did not succeed. The patient was then placed in genu-pectoral position, and the uterus righted itself, and there was no further trouble. Dr. Purslow urged the importance of trying replacement in genu-pectoral position before proceeding to give an anæsthetic.

Biliary Calculus.—Mr. CHRISTOPHER MARTIN showed a biliary calculus removed ten days previously by Mr. Lawson Tait by the operation of cholecystotomy. The patient was a middle-aged woman who had suffered from repeated attacks of biliary colic during the preceding three months. Each attack was followed by violent bilious vomiting, but never by jaundice. She had never found gall-stones in the fæces, nor had the stools been pale in colour. On examination the gall-bladder was found to be greatly enlarged, reaching to two inches below the umbilicus. It formed a smooth fluctuating mobile swelling the shape of a soda-water bottle. At the operation it was found to be distended with a clear, colourless mucous fluid, in which not a trace of bile could be discovered. There was but one stone, and this was impacted in the neck of the gall-bladder. It was about the size and shape of a nutmeg, and remarkably tuberculated on the surface. The patient was making an excellent recovery.

Mr. ROSS JORDAN read a paper on the Lunacy Act of 1890, and the certification of lunatics.

NOTTINGHAM MEDICO-CHIRURGICAL SOCIETY.

Mr. A. R. ANDERSON, F.R.C.S., President, in the chair.

THE meeting on Jan. 6th was a Clinical and Pathological evening.

Mr. TRESIDDER showed a boy on whom he had removed a piece of the cartilage of the ear for the remedy of out-standing ears.

Mr. GERATY described the case of a man aged sixty who suffered from Multiple Sarcomatous Tumours. When first seen there was only one nodule on the forearm. This was excised, and soon afterwards superficial nodules appeared on the trunk and face. Many of these had a purpuric zone round them. Some small nodules were observed to diminish in size and ultimately disappeared, while fresh ones continued to appear. The patient suffered no pain, but became weak and anæmic-looking. He died a year after the removal of the original tumour.—Dr. W. H. RANSOM followed with remarks on the spontaneous recession of Sarcomata. He remarked on the rarity of this occurrence, and mentioned instances of it in medical literature and coming within his own knowledge. He also alluded to cures of sarcoma which have been reported under the use of arsenic, the iodides, and mercury. There were three varieties of nodule in Mr. Geraty's case: (1) A patch of discolouration not raised above the surface in which blood-corpuscles were found, but no sarcoma cells, although they were probably present; (2) extravasation of blood into a sarcoma nodule provided with limiting capsule; (3) infiltrating growths without capsule. He considered the essential cause of recession of the growths was hæmorrhage, the effect of which was to destroy the vitality of the cells and render the mass capable of absorption.—Dr. HANDFORD found arsenic useless in lympho-sarcoma infiltrating the neck.—The President and Dr. Boobyer also spoke.

The PRESIDENT reported two cases in which he had successfully removed large Tumours from the gluteal region. Both occurred in women. In one the growth proved microscopically to be a myxo-fibroma; it was about the size and shape of a Rugby football. In the second case, a small lump which had existed for many years began suddenly to

enlarge, and at the time of operation had attained the size of a child's head, on weighing removal 5 lb. A microscopic section, prepared by Dr. W. H. Ransom, showed the tumour to be an atheromatous cyst undergoing sarcomatous degeneration. Islets of sebaceous cells were to be seen amongst the sarcomatous tissue. He also referred to (1) a case of pure adenoma of the breast, a microscopic section of which was shown, and commented on the rarity of this growth; (2) a case of carcinoma uteri which he had successfully removed by vaginal hysterectomy; and (3) a case of melano-sarcoma of the ciliary region with cataract.

Mr. TRESIDDER related the case of a man, aged seventy-one, who had been ill eleven days, and was admitted into the hospital with symptoms of obstruction.* Laparotomy was done, and the man died. A specimen was shown of the cæcum surrounded by an abscess cavity in which lying free were the appendix and a foreign body.

Mr. TRESIDDER also showed specimens of Gastro-enterostomy. The operation was unsuccessful, and was performed on a patient already much weakened by cancer of the pylorus of seven months' duration. Duodenal ulcer had been diagnosed during life, and Mr. Tresidder discussed the difference between gastric and duodenal ulcer. Death occurred from hæmorrhage. The size of the ulcer was an inch and a half by half an inch.

Specimens.—Mr. ANDERSON: Tumour of Buttock; Uterus removed for Carcinoma; Sarcoma of Ciliary Region; Adenoma of Breast.—Dr. W. H. RANSOM: Sarcomatous Testicle; Microscopical Sections of Sarcoma, Myxo-fibroma, Spindle-celled Sarcoma, and Adenoma of Breast.—Mr. CLEMONS (for Mr. Anderson): Sarcoma of Ciliary Region.—Dr. CATTLE: "Fuchsine Bodies" in Carcinoma, which were considered due to the deep staining of globules of degenerated protoplasm; Sections showing development of Mammary Carcinoma from the Epithelium lining the Alveoli.

Reviews and Notices of Books.

An Introduction to Human Physiology. By AUGUSTUS D. WALLER, M.D., Lecturer on Physiology at St. Mary's Hospital Medical School. London: Longmans, Green, and Co. 1891.

IN this work, which we gladly welcome from so excellent a teacher, Dr. Waller presents what in his judgment are the chief points in physiology that should be understood by the medical student. The arrangement adopted by Dr. Waller is to consider in the first place the phenomena of nutrition, including the blood circulation, respiration, digestion, secretion, the balance of the economy and animal heat; and in the second part the phenomena of excitation, including the nervo-muscular apparatus and senses. Each chapter is preceded by a syllabus of the subject, which may be of use not only to the student but to the teacher, by showing the order in which the subjects treated of are discussed. The first one, under the head of Circulation, is particularly full, and gives the page on which each point is treated. In this chapter we notice an instructive woodcut giving the duration of systole and diastole, with different pulse frequencies, showing that the systole shortens by about two one-hundredths of a second for each increase of ten beats per minute, and that the diastole shortens by about ten one-hundredths of a second. The nature, mode of determining and variations of blood-pressure are well and clearly given, but call for no special notice. The author estimates the quantity of blood discharged from the heart into the arteries at each systole at four ounces.

The chapter on Respiration contains a drawing of an ingenious and handy little apparatus for determining the quantity of oxygen and of carbonic acid gas in expired air. In regard to ventilation, he observes, the air of a room in which respiratory CO₂ does not exceed 2 per 10,000 is fresh, when the respiratory CO₂ is between 2 and 4 per 10,000 the room begins to feel close, between 4 and 6 per 10,000 it is