

ten days, leaving her fairly convalescent at the end of two weeks. As she was feeling stronger, she walked for some little distance, but on her return home was again seized with the acute pain over the right ovary, became perfectly blanched, staggered to a sofa, and was profoundly collapsed for about twelve hours; from this condition she very slowly recovered, and still referred all her pain to the right side of the lower abdomen. On vaginal examination I found the os and cervix uteri oedematous and very tender, but unlike what is usually found in commencing pregnancy, the uterus was fixed and deflected to the right; posteriorly there was a tender semi-solid mass; abdominal percussion—as far as could be ascertained on account of the tenderness—gave a duller note than normal from the groin to the umbilicus on both sides. Her condition during the next twelve days was very unsatisfactory. She had a recurrence of peritonitis, and suffered most distressing pain. Her pulse was never under 140, and her temperature averaged 103° F. Neither herself nor relatives would consent to any operative interference. On the fourteenth day her symptoms became aggravated, and as she would evidently sink before many hours elapsed, permission was given for abdominal section.

On opening the abdomen in the mesial line about a pint and a half of very dark-coloured serous fluid gushed out. On the right side the uterus was bound down by adhesions and coagula to the brim of the pelvis. The right broad ligament was a mass of coagula, the Fallopian tube being much thickened and enlarged; the left broad ligament was encased in coagula, but it was impossible to recognise the Fallopian tube; the intestines at the lower part of the abdomen were matted together by inflammatory adhesions. To appearance and touch much of the coagula resembled placental tissue, but nowhere could I find a trace of an embryo. I removed as much of the coagula as possible without injuring the intestines, thoroughly washed out the cavity with warm water, and inserted a glass drainage-tube into the pelvis. She rallied well from the operation and suffered little pain. On the eighth day, however, she died, obstinate constipation and vomiting being the predominant symptoms.

In my opinion the patient had a right tubal pregnancy; the first attack of peritonitis killed the ovum, which burst after the exertion of walking, and so caused the hæmatocele. If at this time consent had been obtained for the operation her chances of recovery would have been more promising; but on the fourteenth day fresh bleeding took place and handicapped the operation, from which she had not sufficient strength to rally. Under similar circumstances I should not hesitate to advise an early operation, as I think I might promise a fair relief from pain and a probably favourable result.

CASE 2. Cystic Degeneration of both Ovaries with an old Hæmatocele.—M. C—, aged forty-two, married, with six children, nine months ago was attended by a midwife, who delivered her after a very severe labour. Some weeks afterwards, not feeling strong and suffering great bearing-down pains and pain in defecation, she consulted a medical man, and was treated by rest in the recumbent position and tonic medicine, but not feeling much better she was admitted under my care into the Guest Hospital. I found the uterus retroflexed, but fairly movable on the sound. Posteriorly, in Douglas's pouch, there was a tense swelling, somewhat caudate in shape and very painful on pressure. Per rectum it was more defined; over both ovarian regions there was considerable tenderness, so much so that it was impossible to ascertain their condition. She could not walk or stand without much bearing-down pain, and she had occasional attacks of obstinate vomiting; the temperature was normal. Permission to explore the abdominal cavity could not be obtained; I therefore treated her with morphia suppositories and mild aperients, keeping her entirely in bed, considering that hers was a case of pyosalpinx—very full—coming on after delivery. As she did not obtain the relief she anticipated, she left the hospital at the expiration of three weeks, but returned after two months, during which time she had had no cessation from pain, and had lost 12 lb. in weight.

As the patient was now quite unable to do anything, and was evidently becoming worse, after consultation I performed abdominal section, and found the right ovary considerably enlarged and full of cysts; the left ovary was also in a state of cystic degeneration, and bound down firmly in the recto-vaginal cul-de-sac. On removing it, a small cyst which was adherent burst, its contents being lost in the

pelvic cavity. On rectal examination, directly after its removal, the caudate swelling could still be felt, tense and firmly adherent, evidently an old hæmatocele, which had become partially absorbed, and was now organised. In both instances the Fallopian tubes were intact. I thoroughly washed out the pelvic cavity with warm water; and as hæmorrhage was very slight, I did not resort to drainage. She passed a fair night, but never completely rallied from the shock, and died twenty-eight hours after the operation.

No post-mortem examination was allowed, but I examined the wound, and found that there had been no bleeding; the stumps of the appendices were healthy-looking, and, as far as I could ascertain, there was no appreciable cause for her death except exhaustion. Had she consented to the operation when it was first proposed, I feel assured that her life would have been saved. I have twice operated on more seemingly unpromising cases with favourable results, but this patient was of a depressed, nervous temperament, and greatly dreaded the operation, making her on this account a very unfavourable subject. The case was of interest on account of its diagnostic difficulties, as the swelling was in shape, position, and history typical of what is usually found with pyosalpinx.

Tipton, Staffs.

A CASE OF RAPID PLEURAL EFFUSION TREATED BY ANTISEPTIC INCISION.

By ALBERT WILSON, M.D.

THE following case is of interest, as it shows the advantage of an incision made during the early stage of pleural effusion before it had become a case of empyema. In fact, the effusion was so large and so rapid, and the dyspnoea and cardiac depression were so great, that the case would never have reached the stage of empyema if prompt operative treatment had been delayed.

The patient, Mrs. B—, aged thirty-five, was first seen by me on March 3rd, 1886. She complained of breathlessness and increased cough, and she had been ill nearly a week. There had been no rigors; the pulse was 140, small and weak; the expectoration was mucous, slightly rusty; respiration 40; temperature under the tongue 102°. On examining the chest, the left base was dull on percussion. The front of the chest was normal in all respects. Auscultation: At the right base there were moist râles and crepitations; at the left base there were no respiratory sounds audible; vocal resonance was increased over the right base, whilst it was oegophonic over the left base; vocal fremitus was increased over the right base, but absent over the left. The absence of vocal fremitus decided the diagnosis as pleurisy and pneumonia.

March 4th.—The dullness is higher posteriorly, and in the axillary line there is also dullness in front from the left side when she sits up. The first sound, which is weak, is loudest behind the sternum. Temperature 101°; pulse 140; respiration 46.

5th.—General condition worse and increased effusion. Absolute dullness at and below the third rib in front, and from a line parallel with the fourth dorsal vertebra behind. The right chest is normal, except for cardiac dullness over the fourth right costal cartilage. The apex of the heart is now almost under the right mamma. There is a total absence of respiratory sounds all over the left chest, both back and front, except above and just below the clavicle. Oegophony is well marked at the angle of the left scapula, the vocal resonance is altered in front, vocal fremitus is absent on the left side, and there are moist sounds over the right base. Temperature 101°; respiration 48; pulse 140. The pulse tracing shows a very small wave, due to the feeble cardiac impulse and the contracted arteries. Operative treatment was now imperative. Being a disciple of Lister, I did not feel justified in opening this large cavity without the spray, as it was a small foul room, and the impure air entering the pleural cavity would be very dangerous and certain to cause suppuration. Further, to wash out the cavity, which I had allowed to become septic, would be an unnecessary labour for me, and a needless and rather dangerous entertainment for the patient. I preferred prevention to cure. I made an incision between the seventh and eighth ribs posteriorly to the axillary line. Clear serum poured forth in abundance; more than five pints were

collected and about a pint was wasted. Air entered the chest freely. When I introduced my finger through the ribs, I could not reach the lung for at least half an hour after the incision was made. When the lung did expand the surface of the pleura was found to be quite rough. A tube four inches long was inserted downward and backwards, and I applied a small dressing of boracic lint soaked in mercurial solution. Within an hour the heart sounds were to be heard under the left breast. Friction was heard posteriorly as soon as the pleural surfaces were apposed. The friction gradually appeared from above downwards, as the expansion of the lung was very gradual, and when I left it had not fully expanded at the base, which I proved with my finger. The pulse tracings, taken every few minutes, were very interesting. Before the operation it was a slight deviation from a straight line, being so feeble. Soon after the operation the pulse wave expanded, getting larger and fuller until there was a full, sharp, apex systolic wave with a marked diastolic wave, showing low arterial tension, due to the relaxation of the arteries and the removal of the pressure on the heart and main vessels.

6th.—Temperature 101°; pulse 120; respiration 32. The wound was dressed under the spray. There was a free serous discharge through the tube, and air enters with inspiration. The physical signs of pleurisy are well marked.

7th.—Temperature 101°; pulse 120; respiration 26. Wound dressed and tube removed. I inserted my finger to feel the pleura. It felt rough and spongy, like the placenta. I passed my finger round, separating the adhesions of the two surfaces, and it reminded me of a case of placenta prævia. It was the adhesion of the surface that determined me to remove the tube.

8th.—Temperature 101°; pulse 108; respiration 26.

10th.—Temperature 100°; pulse 98; respiration 24. Wound dressed. Very little thin serous discharges. Physical signs normal over both lungs. I could not trace the cause of the slow fall in temperature. The patient, though very weak, is doing well, considering that she was at death's door before I operated.

15th.—Temperature 99°; pulse 90; respiration 20. Wound dressed, and healing satisfactorily. Before the operation I measured each side of the chest from the anterior to the posterior mesial line just below the mammæ. The right half was 16 in., the left 17½ in. To-day, five days after the operation, each side measures 16 in. alike. The spine is perfectly straight, and the left chest is not shrunk. These results could not be attained by aspiration, however skilfully done. The patient was soon restored to perfect health.

Leytonstone.

A CASE OF SUPPOSED FRACTURE OF NECK OF SCAPULA.

By G. Y. EALES, M.R.C.S. ENG., L.R.C.P. ED.,

HOUSE-SURGEON, TORBAY HOSPITAL; LATE ASSISTANT DEMONSTRATOR OF ANATOMY AT ST. GEORGE'S HOSPITAL; AND SENIOR ASSISTANT-SURGEON, SIRHOWY IRONWORKS.

LAST September R. B—, aged fifteen, a spare, delicate-looking lad, came to me with an injury to the left shoulder. He was playing with several boys, butting at each other with folded arms, when he was knocked over and fell on his left shoulder. On examination I found the following points of observation:—1. Considerable bruising of the deltoid. 2. The acromion process prominent, with depression underneath, and outer third of the deltoid flattened. 3. Arm lengthened about an inch and a half, and drawn away slightly from the side. 4. A rough object high up in the axilla in the neighbourhood of the neck of the scapula. 5. Humerus rotated freely and smoothly, and with but little pain. 6. A round projection in front and below the shoulder, which proved to be the head of the humerus on rotating that bone. 7. On raising this projection upwards, outwards, and backwards, crepitus was produced; the contour of the shoulder was restored, with disappearance of the deformity. 8. Slight increase of vertical measurement around the joint. 9. Great freedom of passive motion, with but little pain.

Owing to the bruising I was unable to manipulate the coracoid process; I therefore put the arm up with a pad in the axilla, with the elbow raised and bandaged to the chest. Five days afterwards, the bruising and swelling

having partially subsided, I took off the bandages and found the same condition of things as when I first saw him, but much more plainly. On raising the head of the humerus all the symptoms disappeared, accompanied by loud bony crepitus audible to the bystander; and on removing the reduction force all the above-named symptoms again appeared. I was struck with the ease and comparative absence of pain with which the fracture could be reduced, also the readiness with which it became displaced on removing the reduction force. The rough object in the axilla was now more distinct, and disappeared on reducing the fracture, and was apparently the scapular neck. I now noticed also that the coracoid process did not appear to move on reducing the fracture.

Remarks.—The noteworthy features of the case were (1) the ease with which the fracture could be reduced, together with the ensuing deformity on removing the reduction force; (2) the great freedom of passive motion; and (3) the striking resemblance to dislocation into the axilla. With regard to this latter, the lengthening of the arm, the freedom of passive motion, and the easy reduction of the deformity in the way I have mentioned were sufficient to exclude simple dislocation into the axilla. The other lesions which this injury simulates appear to be (1) dislocation of the humerus into the axilla, with fracture of its neck; (2) separation of the epiphysis of the humerus; and (3) dislocation of the humerus into the axilla, with fracture of a portion of the glenoid cavity of the scapula. The lengthening of the arm and the movement of the head of the humerus on rotation are against the first two. Holmes, in his *System of Surgery*, states that it is the opinion of most modern writers on surgery that a simple fracture of the anatomical neck of the scapula never occurs, and that Malgaigne has shown that the symptoms of the supposed lesion are identical with those of dislocation of the humerus into the axilla, with fracture of a portion of the glenoid cavity of the scapula. In another place Holmes admits that the two lesions are indistinguishable during life. I hardly dare to express an opinion in the face of such high authority; but why should not a simple fracture of the anatomical neck of the scapula occur as readily as the more complicated injury? because the force to produce either must be of the same nature and very considerable. It appears to me that the symptoms of this case are so analogous to those quoted by Dr. Lotzbeck of Munich¹ and that recorded by Spence,² and bearing in mind the fact of the coracoid process being apparently stationary, that I feel justified in saying that in all probability this was a case of fracture through the anatomical neck of the scapula.

The lad having passed from my care and observation for treatment by another surgeon, I am unable to give any details of the progress of the case, but I afterwards ascertained that he eventually gained very good use of the arm. Torquay.

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.

WEST LONDON HOSPITAL.

ABSCESSSES OF THE NECK AND BEHIND THE PHARYNX,
ALMOST CAUSING DEATH FROM SUFFOCATION.

(Under the care of Mr. WAINWRIGHT.)

ABSCESS at the back of the pharynx is a very formidable disease, as is illustrated by this case, and requires the most prompt surgical treatment. The chief danger is that of suffocation, either from œdema of the glottis or the mechanical effect of the swelling. In this case the relief afforded by incision of the external abscess made it probable that the post-pharyngeal abscess communicated with it, but the subsequent progress of the case negated this view.

¹ See New Sydenham Society's Biennial Retrospect for 1867-8, p. 240.

² Edinburgh Medical Journal, 1863.