which is still imperfectly understood, perhaps because of its previous rarity before the advent of its probable parent influenza.¹ The indications of frontal and antral empyema are often clearly shown. Unfortunately the same cannot be said of the sphenoidal and ethmoidal, but the two latter are rarely involved except in common with the others. In view of the recent and increasing interest which has arisen on this subject I venture to record three cases which for comparison I quote together.

In these cases the appearance of the patients was anæmic and the teeth were much decayed, and there was a history of influenza. The nasal discharge was unilateral; it was first mucoid and then intermittently purulent. In one case the pain followed the course of the supra-trochlear nerve and in the other cases it followed the course of the supra-orbital nerve. In two cases the pain was not apparently dependent upon retention, and in the third it was less or disappeared with a free flow of pus. Its duration was never more than for four of the 24 hours, and it was most intense about midday. Slight pain was also present in all of the patients in the malar and superior maxillary bones on one side. In two cases the tenderness was not severe and followed on slight pressure on the nasal side of the orbital roof. In the third patient there was no tenderness. Sneezing was a constant annoyance and heralded the nasal discharge. All three patients suffered from a spasmodic cough which was worse after sleep. In one patient the maxillary antrum on the same side was distended with pus. This some years before had been drained through the alveolar process. In the other two patients implication of the antral and the other sinuses was not marked. In all congestion of the conjunctivæ, especially on the affected side, transitory giddiness, tinnitus aurium, indefinite pains in the head, and slight epiphora were present and often there was a raised temperature. The inflammation was at times quiescent, only to be again and again excited by "catching cold" which was of frequent occurrence. A polypoid state of the mucous membrane of the middle and inferior turbinated bones on one side, and in two of the patients mature polypi also, were associated conditions.

The treatment consisted in the removal of the polypi and cauterisation of the diseased mucous membrane. Nasal douching was then tried, but all the patients complained of deafness and increasing tinnitus, so a coarse spray was substituted with a warm alkaline antiseptic and occasionally a menthol or alcohol fine spray. None of the patients would entertain any operation beyond those for the removal of the polypoid growths.

Though there has been much improvement in respect of pain and discharge, yet it must be confessed that there has been no absolute cure. One patient since the removal of the polypoid growths has had an intermittent semi-purulent expectoration. The presence of pus in the sputa corresponds accurately with the intermittent character of the purulent nasal discharge. I would suggest the following queries: 1. As to the origin of the disease, is it not probable that nasal polypi were present at the time of the so-called "influenzal" illnesses? 2. Were not the decayed teeth the starting point of the "coagulation-necrosis" of the nasal mucous membrane? The intimate relation between the teeth and the nasal cavities has been already shown.² The case referred to was cured by the extraction of a tooth. 3. Is it not likely that the "attacks of influenza" were really acute suppuration of the sinuses and that the symptoms were those which would occur as part of an infective process were the duct or ducts temporarily blocked? 4. As regards the advisability of operation on the frontal sinuses, one would feel inclined to hope that the partial shrinking of the sinuses which occurs with advancing age would tend to ameliorate the distressing symptoms and, with a better general state of health, to bring about a natural cure. This would be assisted by appropriate palliative treatment; though before this perhaps ideal state is attained the patient must run a grave risk of local and general infection. The direct operations for permanent cure are numerous and they aim at the obliteration of the diseased cavities. This filling up of air reservoirs must be, at least physiologically, detrimental. The good results of surgical treatment for empyema of the maxillary antrum are beyond dispute, but operations on the

(surgically) more remote sinuses at present seem much less hopeful and by no means free from danger. Lastly (5) I would point out that Mr. Walsham's warning against the nasal douche was exemplified by the foregoing cases.

Chiswick, W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF STRANGULATED RIGHT INGUINAL AND SCROTAL HERNIA; LAPAROTOMY; RECOVERY.

BY HENRY SMITH, M.R.C.S. ENG., L.R.C.P. LOND.

IN the first number of THE LANCET of this year was published an interesting paper by Dr. E. Matthews Owens entitled "Herniotomy plus Laparotomy Successfully Performed under very Unusual and Difficult Circumstances." Its perusal was of great interest to me at the time and has since been the means of saving life in a case which, with your permission, I will briefly record.

A fellah, aged about 20 years, who was employed on the Nile reservoir works, was brought to me there at 10 A.M. on May 30th, 1899. While lifting a large stone a few minutes before he had been seized with sudden pain in the groin and a cursory examination quickly revealed the fact that the patient was suffering from a tightly strangulated right inguinal and scrotal hernia. Gentle taxis was tried, but recognising the probable necessity for operation he was removed without delay to the American Mission Hospital and there was seen by Dr. H. T. McLaughlin. Taxis was again attempted under an anæsthetic but without result. An incision three inches long was at once made by Dr. McLaughlin over the external ring and the structures were divided until the bowel appeared, much congested, but not having lost its polish. Seven or eight inches of the bowel were found external to the ring and every effort was made to return it. The incision was cautiously enlarged to the utmost limit of safety. Native assistants raised the lower limbs till the position of the body was entirely reversed. The most painstaking manipulation was persevered with but to no purpose. In this dilemma I thought of the paper in THE LANCET and Dr. McLaughlin gladly followed the plan carried out by Dr. Owens. A median incision four inches in length was made. One hand was introduced into the abdominal cavity, some flatus passed along, and working with both hands the bowel was with very little difficulty partly drawn and partly pushed back into the abdomen. Both wounds were now stitched up and the right testicle, which had presented at the lower end of the inguinal incision, was restored to its place. The whole operation took nearly three hours. The after-treatment was simple. The patient did not display a single bad symptom. The stitches were removed on the fourteenth day and the patient was discharged on the thirtieth day radically cured, and he now has the additional satisfaction of exchanging his duties as a labourer for the lighter work of a watchman in consideration of his experiences.

I do not for a moment mean to compare the difficulties of the operation with those of Dr. Owens. Our operating-room is small, but vastly better than a ship's cabin, and our antiseptics are more up-to-date. I wish rather to thank him and you for the publication of such a case the recollection of which at the right moment proved so useful to our patient.

Assiout, Upper Egypt.

SUPRAPUBIC DRAINAGE IN PERINEAL FISTULA.

BY J. CROPPER, M.B., B.C. CANTAB.

IN the autumn of 1896 a boy, aged 11 years, from the neighbouring village of El Zib on the coast, came here with a perineal fistula the result of a native quack operation for stone. This operation is generally performed by pressing on the bladder above the pubes and cutting down on to the

¹ THE LANCET, Feb. 19th, 1898, p. 486.

² A Case of Coryza Apparently of Dental Origin, THE LANCET, Jan. 1st, 1898, p. 49.

stone in the perineum, the half of a freshly killed chicken being the only dressing applied. At the time I attempted to close the opening by a plastic flap operation but without success. The patient was then treated with temporary benefit by an Arabian doctor who applied a hot iron wire to the fistula. Despairing of any good result the boy then went home. In the summer of 1897, however, he turned up again, having become a great nuisance to his friends by his foul condition. Having passed a catheter I fully excised the fistula (the patient being under chloroform) in its whole depth and freely opened the ureter, bringing the edges together deeply with silkworm-gut sutures. No catheter was tied in and healing by first intention took place, and in a few days the patient left us, apparently soundly healed. After the lapse of a year, however, the fistula opened up again, owing, as was afterwards discovered, to a small urethral calculus of the size of a grain of wheat which had lodged in the internal opening of the fistula and to pressure on the perineum from riding a donkey. I again cut down as before, finding the calculus in the fistula, and closed the wound with deep sutures. Unfortunately, however, healing did not take place. Later I opened the bladder suprapubically and attempted to drain it with a curved silver tube. This, however, caused so much irritation (not draining well) that it had to be removed. Owing to a severe attack of malaria nothing further was done. On May 18th, 1899, finding that no stricture existed I again opened the bladder, cutting down on a catheter introduced into the bladder and drained it by a straight rubber tube (No. 12) perforated at the sides, packing the wound with iodoform gauze, and at the same time freshening the fistula. The boy was kept lying half over on his face and the bladder drained very well. There was at no time any rise of temperature and on June 14th the fistula was soundly healed and all the urine was passed normally.

Acre, Palestine.

A CASE OF COMPLETE ANTERO-POSTERIOR DISLOCATION OF BOTH KNEES.

BY H. E. HAYCOCK, M.R.C.S. ENG., L.R.C.P. EDIN.

I VENTURE to send a short account of the above as I think few can have seen the injury which must be extremely rare.

On March 4th, 1899, a strong and muscular man, aged 31 years, employed to drive the engine connected with some brickworks near here, was oiling some bearings when his arm for some unexplained reason became entangled in the band which passes from the axle of the flywheel to the governors. His account shows that he was dragged to the axle and there performed many revolutions in a space about two feet from the ground. The noise occasioned by his feet striking the wooden floor attracted a fellow-workman who promptly stopped the engine. The band was found tightly bound around the patient's arm and had to be divided to release him. His boots were much shattered and one had lost its sole. On examination he complained of pain in both legs, more especially beneath the knees, and the condition of both was much the same and as follows. Anteriorly the tibiae were prominent with a large depression above. There was not much effusion. The patellae were freely moveable. Posteriorly the condyles of the femur were prominent and already (within an hour of the accident) there was considerable bruising. Both joints could be readily flexed. Both legs were congested and swollen. Reduction required a fair amount of force but was readily effected, and both joints resumed their natural shape. The after-treatment consisted of the application of back splints with icebags to the knees. The patient now has (four months after the injury) complete power of flexion and no pain in the joints, though he still suffers from a wound in one foot. He wears knee-caps and uses crutches.

Alfreton.

DEVON AND EXETER HOSPITAL.—At the quarterly meeting of the governors and friends of the Devon and Exeter Hospital held on July 25th it was decided on the motion of Mr. Bell that no patient or his friends should pay the whole or any part of the cost of a recommendation for admittance to the institution and in the case of any such payment the recommendation would be forfeited.

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.

ST. MARY'S HOSPITAL.

A CASE OF SARCOMA OF THE CAROTID SHEATH; REMOVAL OF THE GROWTH TOGETHER WITH PORTIONS OF THE CAROTID ARTERIES, INTERNAL JUGULAR VEIN, AND PNEUMOGASTRIC NERVE; RECOVERY.

(Under the care of Dr. SCANES SPICER and Mr. H. STANSFIELD COLLIER.)

FOR the notes of the case we are indebted to Mr. R. E. Hodgson.

A man, aged 59 years, was admitted into St. Mary's Hospital on Jan. 13th, 1898. He complained of "loss of voice" and of a swelling in the neck. The patient had never suffered from venereal disease. He had enjoyed good health until 19 weeks before admission, when he suffered from a severe cold and cough and his voice became hoarse. The hoarseness gradually became worse and he suffered from attacks of difficulty of breathing which came on nearly every night and lasted for some hours. The attacks were attended by noisy stridor and some of them were severe and accompanied by epigastric recession. The patient was under the care of Mr. Clarke of Horley who discovered a swelling in the left side of the neck and attributed the attacks of dyspnoea to irritation of the recurrent fibres of the vagus nerve. Iodide of potassium was given and the patient was sent to London to be seen by Dr. Spicer. The patient was shown at the meeting of the Laryngological Society on Dec. 8th, 1897, when the lump in the neck resembled a mass of enlarged matted glands. For a few days before admission the patient had been free from attacks of dyspnoea, but he said that the cough was as bad as ever. While the patient had been under observation the swelling had markedly increased in size.

Upon admission the patient was very thin. He had a sallow complexion and well-marked arcus corneae. There was a hard mass of about the size of a hen's egg situated beneath the left sterno-mastoid muscle. It was ovoid in shape. Its long axis was in the line of the common carotid; its lower limit was at the level of the lower border of the cricoid and its upper limit corresponded with the upper border of the thyroid cartilage. The mass was not lifted up with the larynx in the act of swallowing; the sterno-mastoid muscle could be moved over it and it appeared to be quite separable from the transverse processes of the vertebrae. The carotid pulse could be felt upon palpation of the fore part of the lump, but there was no expansile pulsation of the mass. Manipulation caused instant cough. The patient preferred to speak in a whisper, but upon request he phonated in a very husky manner. Laryngoscopic examination showed that the left cord lay motionless in the cadaveric position. The right cord was natural. No anaesthesia of the larynx was observed. The left pupil was smaller than the right one. It re-acted to accommodation and to light. The left palpebral fissure was smaller than its fellow and there was marked drooping of the left upper eyelid, though upon effort the patient could raise the lid well. No other evidences of disease were found and repeated observations failed to discover any changes in the cardiac and respiratory rhythm.

An operation was performed on Jan. 21st, 1899. Mr. Henry Davis administered ether, followed by chloroform. Mr. Collier exposed the tumour by an incision along the posterior border of the sterno-mastoid and by transverse division of its fibres. The tumour appeared to be limited by the carotid sheath and it surrounded the contained structures. Ligatures were placed upon the internal jugular vein and the common carotid close to the clavicle, and the vessels together with the vagus nerve were divided on the thoracic side of the tumour. The growth was readily separated from