

spine; there was also some extravasation extending upwards into the abdominal muscles from this; all over this region there was great tenderness. The left side of the pelvis appeared loose; there was no crepitus, and the impression given was that of a fracture in the pubic portion of the left os innominatum. The patient vomited soon after admission; there was no blood in the vomit. The urine was drawn off; there was no blood in it; sp. gr. 1020, acid, and apparently normal. An injection of a quarter of a grain of morphia was given at night, and a one-grain opium pill ordered every six hours. Ice was applied to the groin, and the patient kept strictly in the recumbent position. Evening temperature 99°.

March 25th.—The patient appears better, having recovered to a considerable extent from the shock. The pulse is fuller and less rapid. There had been no further vomiting, and he had slept well after an injection of morphia. Temperature, morning, 99·2°; evening, 99·2°; last night, 101°.

27th.—There is some redness about the extravasated blood in the left groin. Temperature 100·4°.

April 1st.—He still complains of great pain across the lumbar region, and after the action of the bowels, produced by an enema, this was worse. The urine, which has had to be drawn off regularly, is to-day offensive, and there is evidence of cystitis. A bed sore has formed over the right buttock. The temperature has continued high since March 27th, averaging about 100·2°, but to-day rising at 4 P.M. to 103°.

10th.—Feeling better and in less pain. The bed sore is healing, and the bowels act well. The bladder has been washed out daily since the 1st with dilute solution of Condy's fluid, and the urine is less offensive (sp. gr. 1025). The temperature, which has been higher during the last few days, rose to 104° in the evening.

The patient died on the 28th. He had been getting weaker for some days. Lately there had been subsultus tendinum, and much sweating. The cystitis had improved, but the left leg had been swollen and painful for a fortnight, and latterly extremely swollen and oedematous, with a good deal of pain. There had been swelling of the right leg for about a week. One spot on the sacrum, above a deep bed sore which had formed, was very tender to the touch. He had no rigor until the day of death, when at 8 P.M. there was one lasting several minutes, after which he passed into a drowsy condition. Later there was a slight attack of shivering, during which the temperature rose to 103·4°. During the last few days of life the temperature was generally high, especially in the evening, when it usually exceeded the morning by two degrees; but on the 16th it had fallen to 95°, and was less regular for a day or two. He had emaciated greatly.

At the post-mortem examination, which was made by Dr. Sharkey on the following day, the body was that of a very fat man. Considerable decomposition had set in. The left leg was swollen and oedematous, the right leg only slightly so. The layers of the right pleura were firmly adherent; both lungs were congested and oedematous. Heart very soft and pale; microscopical examination of the fibres showed considerable brown atrophy. The liver was markedly fatty. Spleen large and soft. Brain, kidneys, and intestines all healthy. The bladder contained purulent urine, and the walls were congested and inflamed. Both femoral veins contained ante-mortem partially decolourised clots, which were only very loosely adherent to the walls of the vessels. The tissues of the abdominal wall, especially the subperitoneal connective tissue, of the pelvis was pigmented deeply black by former hæmorrhages, but no inflammation was present, except just about the site of fracture, which appeared to involve the third sacral vertebra, which was comminuted. Very slight traces of inflammation were found in the neighbourhood.

*Remarks.*—Fracture of the sacrum, requiring great force to produce it, is usually accompanied by fracture of the other bones entering into the formation of the pelvis, or by injury of the contained viscera; and proves almost invariably fatal. It follows from this mode of causation that fractures of this bone are usually compound; and there is no more common cause than gunshot. The result of gunshot fractures is well shown by the statistics published after the American war of the Rebellion. Of 145 fractures of this bone alone, the result was undetermined in 3; of the remainder, including all degrees of severity, 43·7 per cent. died. Among the recoveries were 8 out of 9 cases in which the rectum had been wounded, and 4 in which the bladder had been injured. In

some the injury has been accompanied by considerable pain during defecation, and it has been difficult to keep the fragments in position. No such difficulty was experienced in the present instance, and the amount of pain suffered by the patient was comparatively slight. We do not think that thrombosis of the femoral veins has been previously noticed in such cases, but the affection being on both sides would suggest some possible extension of inflammation from the immediate neighbourhood of the fracture, though few traces of inflammation were found post mortem. Against this view, however, is the fact that the left leg had been swollen for a week before any swelling appeared in the right; and a more probable explanation would be that this was an accidental complication following the contusion to the left groin, marks of which were evident for some time after admission.

#### CUMBERLAND INFIRMARY.

PELVIC ABSCESS, WITH GENERAL PERITONITIS, CAUSING  
INTESTINAL OBSTRUCTION; ENTEROTOMY; DEATH  
SEVEN MONTHS AFTER THE OPERATION;  
NECROPSY.

(Under the care of Dr. BARNES and Dr. MACLAREN.)

FOR the following notes we are indebted to Mr. Charles A. Morton, late house-surgeon.

H. T—, aged twenty-one, was admitted on June 19th, 1885. The illness began on Jan. 6th with burning pain in the epigastrium and vomiting. The vomiting has continued until to-day and has been very frequent. Now the pain is not limited to the epigastrium, but is felt over the whole abdomen. There was no severe pain in the cæcal region at the beginning of her illness. During the first week the bowels were open regularly, but there was no action from Jan. 12th to Jan. 18th, when they were opened after an enema, and on the 19th they were opened twice without an injection. Between the 6th and 12th enemata were used without success. Three weeks ago she vomited frequently for some hours, but did not suffer from abdominal pain.

On admission the abdomen was somewhat distended; tympanitic, except in the region of the cæcum and ascending colon, where there was dulness; no tenderness; no swelling discovered; nothing felt per rectum; rectum empty; a few petechial spots on the abdomen; pulse feeble; anxious expression of the face. The bowels were open in the evening; motion liquid.

Jan. 20th.—Abdomen more distended, with less dulness in cæcal region; there has not been any vomiting. The bowels have not been again opened, though she has had several injections. One grain of opium ordered every four hours.

21st.—Abdomen more distended, with increased dulness in the region of the cæcum and ascending colon. No vomiting, and no action of the bowels. Pulse rapid and weak.

22nd.—No marked change, but slight abdominal tenderness was present.

23rd.—Abdomen greatly distended; great prostration. Per rectum, a large, hard, tender mass is felt on the right side of the bowels some little distance from the anus. Under ether an aspirator needle was inserted into the cæcal region line. No fæcal matter was withdrawn. On attempting to puncture the rectal swelling from the rectum, it burst, and nearly an ounce of pus came away.

24th.—The patient not relieved; fæcal vomiting and great prostration. Under ether an incision was made in the cæcal region into the peritoneum. The bowel which presented (small intestine) was much inflamed, and pus and lymph came out of the cavity of the peritoneum. The bowel (which contained valvulæ conniventes) was stitched to the wound and then freely opened. A very large quantity of liquid fæcal matter escaped. An incision was made from the vagina into the peritoneal cavity for drainage here. The bleeding necessitated plugging the vagina.

25th.—She is a little stronger; pulse still very rapid (140) and weak. Free discharge from the wound. No vomiting, but no action of bowels. Abdomen a little distended again since the operation, and very tender.

28th.—There has been no vomiting since the operation, and the bowels have acted freely through the wound. She is decidedly stronger, and has not any abdominal pain. Still takes one grain of opium every three hours. On the previous day (Jan. 27th) a large tube was introduced into the abscess cavity through the rectum. A little fæcal matter now comes from the rectum.

Feb. 4th.—The tube came out of the rectal opening. Some

*Post-mortem examination.*—The artificial anus was about from the ileo-cæcal valve; the intestine below relatively empty and much contracted. Beneath it, in the right side of the pelvis, was an abscess about the size of a duck's egg. It was situated to the right side of the uterus. The right ovary in the thickened tissue which formed the abscess; the cæcum was adherent to it above, and the rectum and uterus were adherent to the uterus. The left ovary was adherent to the surrounding parts that it could not be recognised as an ovary. The vermiform appendix was not in the abscess wall beneath the cæcum; here the abscess had been perforated. The uterus was normal.

THEOLOGICAL SOCIETY OF LONDON.

LAND SUTTON read a paper on Ovarian and other The main object of this communication was to show ovarian cysts—that is, those cysts which arise in the yma of the ovary—originate in the corpora lutea. Material especially used consisted of the uterus and its appendages furnished by seventy cows, of all ages and conditions; fifty pigs; twenty mares, in addition to the fifty cows; and the varied material obtained at the Royal Gardens. The specimens of ovaries exhibited were selected so as to show all the stages in the formation of cysts, from the ordinary corpus luteum to cysts as

Dr. HALE WHITE showed a specimen of the liver, divided into two parts by a constricting band, the one normal and the other cirrhotic. The liver was removed from a patient who died with large white kidneys. Stretching the surface of the liver was a deep fissure, which was situated at the attachment of the posterior part of the falciform ligament, and ran along the upper surface at the

extravasation extending upwards from this. Over this region the left side of the pelvis was not depressed, and the impression of the pubic portion of the left ilium was not felt even after admission into the venous. The urine was not passed in it, except 10.30, and 11.30. As a sign of a fracture of a bone at night, and a one grain opium was applied to the groin, and the patient was placed in the recumbent position.

The patient, however, having recovered from the shock. The pulse is fuller and he has no further vomiting, and he is given of morphia. Temperature, 101° last night, 101°.

The state of the extravasated blood was not ascertained. The patient was in great pain across the lower part of the bowels, produced by the rupture, which had to be relieved by the use of a right rectal tube. The patient was since then in a more comfortable position, and the pain was relieved.

After a few days the patient was well, and the pain was relieved. The patient was in a more comfortable position, and the pain was relieved. The patient was in a more comfortable position, and the pain was relieved.

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On admission the abdomen was somewhat distended tympanitic, except in the region of the caecum and ascending colon, where there was dullness; no tenderness; swelling discovered; nothing felt per rectum; rectum empty; a few petechial spots on the abdomen; pulse feeble; anxious expression of the face. The bowels were open in the evening; motion liquid.

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24th. The patient not relieved; faecal vomiting and great prostration. Under ether an incision was made in the caecal region into the peritoneum. The bowel which was sent (small intestine) was much inflamed, and pus and lymph came out of the cavity of the peritoneum. The bowel (which contained valvula conniventes) was still to the wound and then freely opened. A very large quantity of liquid faecal matter escaped. An incision was made in the vagina into the peritoneal cavity for drainage here. The bleeding necessitated plugging the vagina.

25th. She is a little stronger; pulse still very rapid and weak. Free discharge from the wound. No vomiting but no action of bowels. Abdomen a little distended since the operation, and very tender.

26th. There has been no vomiting since the operation, and the bowels have acted freely through the wound. She is decidedly stronger, and has not any abdominal pain. She takes one grain of opium every three hours. On the previous day (Jan. 27th) a large tube was introduced into the abdominal cavity through the rectum. A little faecal matter now came from the rectum.

Feb. 4th. The tube came out of the rectal opening. She

swelling still felt from the rectum. Has greatly improved in the last few days. Wound discharges faecal matter freely. She is quite free from pain and abdominal tenderness.

5th.—Bowels acted once or twice per rectum; watery motions, with a little solid matter in them. The rectal swelling slowly subsided, and feces were discharged from the artificial anus and from the rectum.

The patient's strength gradually returned, and towards the end of March she was able to sit up. But on the 29th she had a rigor with high temperature, and again on the 30th, and vomiting with slight abdominal pain again set in. These symptoms did not continue, but were followed by a recurrence of rectal swelling, close to the place where the former abscess burst. This swelling increased slowly; emaciation became very great; she would hardly take any food; her strength gradually failed, and she died on Aug. 18th. After March she had no recurrence of the abdominal symptoms.

*Post-mortem examination.*—The artificial anus was about two feet from the ileo-caecal valve; the intestine below was comparatively empty and much contracted. Beneath the caecum, in the right side of the pelvis, was an abscess cavity of about the size of a duck's egg. It was situated behind and to the right side of the uterus. The right ovary was lost in the thickened tissue which formed the abscess wall. The caecum was adherent to it above, and the rectum and omentum were adherent to the uterus. The left ovary was so firmly adherent to the surrounding parts that it could not be recognised as an ovary. The vermiform appendix was adherent to the abscess wall beneath the caecum; here the end had not been perforated. The uterus was normal.

## Medical Societies.

### PATHOLOGICAL SOCIETY OF LONDON.

*Remarkable Parietal Coagulum in Heart.*—*Recent Haemorrhage into Spinal Cord.*—*Cysts in Reproductive Organs of Animals.*—*Fatty and Cirrhotic Liver.*—*Contracted Fingers.*—*Gummata of Liver in Child.*—*Iridescent Calculi.*

AN ordinary meeting of this Society was held on Tuesday last, Dr. J. S. Bristowe, F.R.S., President, in the chair.

Dr. BRISTOWE showed a Heart whose ventricles were lined by laminated clot. The specimen was taken from a man aged forty-four, who had suffered for two months from severe pain about the trunk. At the necropsy cancer of the stomach was found, though unsuspected during life. The ventricles of the heart were lined with an old coagulum entangled amongst the meshes of the columnæ carneæ; the free surface was only slightly rough and looked smooth; the columnæ and papillares were thoroughly concealed.

Dr. W. C. CHAFFEY showed microscopic specimens of Haemorrhage into the Grey Matter of the Spinal Cord. The patient was a female child, aged four years, whose illness began with vomiting one day after a fall. Paraplegia, disturbance of micturition, gurgling in the throat, some weakness of the intercostals and left arm, retraction of head, difficulty in sitting up, ineffectual cough, no loss of sensory functions, and loss of reflex phenomena in the legs, without convulsions were the main symptoms. The patient died nine days after the fall, and eight after the commencement of the symptoms. The spinal cord was swollen in the lumbar enlargement. Extensive hæmorrhages were found in the lumbar and cervical swellings of the cord, occupying accurately the grey matter of the anterior cornua. The nuclei of origin of the nerves in the medulla oblongata were affected.

Mr. BLAND SUTTON read a paper on Ovarian and other Cysts. The main object of this communication was to show that ovarian cysts—that is, those cysts which arise in the parenchyma of the ovary—originate in the corpora lutea. The material especially used consisted of the uterus and its appendages furnished by seventy cows, of all ages and conditions; fifty pigs; twenty mares, in addition to the fifty reported upon; and the varied material obtained at the Zoological Gardens. The specimens of ovaries exhibited were selected so as to show all the stages in the formation of the cysts, from the ordinary corpus luteum to cysts as

large as Tangerine oranges. The mode of formation of the cysts in these cases admits of no doubt, for the only instrument needed in the investigation was a sharp knife. The peculiar yellow colour of the material composing these curious bodies renders the identification indisputable. The various conditions are best traced in cows, in which ovarian cysts occur with tolerable frequency. Multilocular cysts are the result of the concomitant growth of two or more cysts in the same ovary. This was by no means a rare event. The same process could be traced in the ovary of the sow, in asses, in mares, in a tiger, and in monkeys. Specimens of cysts arising in this way may also be seen in the ovary of the human female. The question next arose, If these cysts begin in the corpora lutea of pregnancy and of menstruation, how are they to be accounted for in the ovaries of the child and even the foetus? Waldeyer and Biegel have both insisted that the ovaries do not remain idle in early life, but that many of the follicles ripen, atrophy, and form a sort of corpus luteum even in the foetus. This is no abstract statement. Doran's "find" of an incipient papillary cyst in the tissue of the hilum stimulated Mr. Bland Sutton to examine foetal ovaries. To his astonishment, he found ovarian cysts very frequently in the human foetus, and three typical specimens were shown. In one specimen in particular ova could be seen in the follicles exactly as in an ovary after puberty, but of course much smaller. These observations went to show that in the foetus, child, or mature female, cysts might arise in the corpora lutea. Whilst working at the foetal human ovaries Mr. Sutton had good reason to endorse the view that the cysts arising in the "hilum of the ovary" take origin in the remains of the Wolffian body; on one occasion he was able to make out an almost complete longitudinal section of a Wolffian tubule, and in one specimen the true tissue of the ovary was scarcely represented, but it seemed to be made up almost entirely of Wolffian remains. The remaining specimens were exhibited to demonstrate the following points:—(1) A cow's uterus and vagina showing large cysts in the vaginal wall developed in the lower (posterior) end of Gartner's duct. The ducts of Gartner and Skene's tubes are one and the same structure; the glands described by some as independent structures are only diverticula from the ducts, and are homologous with the vesiculæ seminales of the male. Broad ligament cysts unconnected with the parovarium in mares, cows, pigs, and kangaroos were shown, and also examples of hydrosalpinx in pigs and in the cow. This condition seems not to be infrequent, and is a cause of sterility in these animals.—Mr. ALBAN DORAN was glad to find that Mr. Sutton confirmed him in maintaining that ovarian cysts might arise from the parenchyma, for he was not prepared to admit that it was proper to speak of corpora lutea; he preferred to call them follicles that had undergone involution, without any necessary connexion with impregnation, menstruation, or rut. It was necessary to distinguish, as Dr. Klein had done in his Handbook, between the tissue of the hilum and the parenchyma of the ovary. The former is the blastema which has been found to develop in the embryo around the upper part of the Wolffian body. The dilated lymphatics observed by Mr. Sutton corresponded to the "kystes lacuneux" of Verneuil, which formed conspicuous but ill-defined cysts in the broad ligament in cases of myoma of the uterus. To decide the true position of the orifice of Gartner's duct it was necessary to make sure where the vagina ended and the vestibule began in different species of animals. Owing to differences in the development of the lower part of the united Müller's ducts, the true vagina was sometimes very long, in others was almost replaced by the vestibule.—Dr. KINGSTON FOWLER said that he had seen in a human ovary a cyst originating in a corpus luteum.—Dr. W. B. HADDEN said that he had seen many pediculated cysts attached to the broad ligament. Were they foetal remnants or parovarian?—Mr. BLAND SUTTON said that Dr. Hadden's specimens were examples of dilated tubules of the parovarium that had become free. A pair of unaided eyes and a sharp knife were all that was necessary to recognise the facts which he had recorded.

Dr. HALE WHITE showed a specimen of a Liver divided into two parts by a constricting band, one part being fatty the other cirrhotic. The liver was removed from a man who died with large white kidneys. Stretching across the upper surface of the liver was a deep fissure, which began behind at the attachment of the posterior part of the suspensory ligament, and ran along the upper surface at the attachment