forcible and gave the impression to the hand of the observer on palpation that the heart rotated on its vertical axis. There was a striking disproportionate hypertrophy of the right ventricle. Auscultation revealed the presence of well-marked mitral systolic and double aortic bruits and a well defined musical systolic murmur audible over the pulmonary area, with accentuation of the pulmonary second sound. In the fourth left interspace a very pronounced systolic thrill was detected.²

I gladly acknowledge my indebtedness to Dr. Victor Corbould for the photographs illustrating this case.

The occurrence of congenital heart disease in association with mental deficiency is not uncommon and in the case now recorded it is probable that, in addition to arrested mental and physical defects, there was likewise some congenital cardiac abnormality—that the case was, in fact, one of primary cardiac malformation with the results of super-added rheumatic endocarditis. The patient, after frequent attacks of cardiac distress and anginoid pain, died quite recently, but no opportunity was afforded by the relatives for a post-mortem confirmation of the diagnosis of congenital cardiac trouble, so that the diagnosis of that condition has to rest on a general review of the case.

The family history of rheumatic fever was of interest as regards the possibility of foetal endocarditis.³ Arrested mental and physical development in association with the cardiac physical signs justified the supposition of congenital heart disease, the difficulty of diagnosing the latter condition being increased by the presence of aortic and mitral disease due to acute rheumatism.

The diagnosis of congenital cardiac disease is often a matter of much difficulty and is likewise often unsuspected and masked in patients who first come under observation whilst suffering from some other disease. In this connexion I may briefly cite a case which came under my observation some time ago—that of a young girl suffering from acute phthisis. Six years previously she had a very bad attack of acute rheumatism, and she was then informed by her doctor that “her heart was affected.” On recovering from her rheumatic illness she frequently suffered from attacks of dyspnoea and cyanosis of the lips, face, and fingers. Examination of the heart revealed the presence of mitral systolic and double aortic bruits. This patient succumbed to her pulmonary trouble, and post-mortem examination revealed the existence of a greatly constricted pulmonary orifice and an imperforate septum ventriculorum, the tricuspid, mitral, and aortic valves being fringed with small vegetations. The existence of congenital heart disease was in this case never suspected, the past history of the patient having, unfortunately from a diagnostic point of view, successfully obscured the suspicion of congenital malformation.

Dr. Archibald E. Garrod,⁴ in an article on cardiac malformations in association with other congenital defects, directs attention to the physical auscultatory signs suggestive of pulmonary stenosis which are of considerable diagnostic import. He especially directs attention as to how far reliance may be placed on the presence of associated deformities as indications that the cardiac lesions are due to congenital malformations rather than to foetal or extra-uterine endocarditis. Dr. Garrod's article is worthy of most careful perusal by all who are interested in congenital cardiac disease.

Harley-street, W.

² St. Bartholomew's Hospital Reports, vol. xxx., p. 56; Zeitschrift für Klinische Medizin, vol. xxi., p. 142; Lehrbuch der Auscultation und Percussion, 1883, p. 303.

³ St. Bartholomew's Hospital Reports, vol. xxx., p. 60.

⁴ St. Bartholomew's Hospital Reports, vol. xxx.

TYPHOID FEVER AT CAMBORNE.—At the meeting of the Camborne District Council held on Feb. 11th Mr. J. T. Thomas, L.R.C.P. Lond., M.R.C.S. Eng., the medical officer of health, reported that during January there had been three deaths from typhoid fever. No case of typhoid fever or any other infectious or contagious disease had been notified to him since Jan. 29th.

HEALTH OF FALMOUTH.—Dr. W. King Bullmore, the medical officer of health of Falmouth, in his annual report for 1897 states that the births registered were 255 and the deaths 192, or an annual birth-rate of 20·8 per 1000 and a death-rate of 15·7. There were 26 cases of zymotic disease notified and the death-rate per 1000 from zymotic disease was 2·1.

Clinical Notes: MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTE ON THE TRANSPLANTATION OF SKIN *EN MASSE* WITHOUT PEDICLE FROM ONE PART OF THE BODY TO ANOTHER AND FROM ONE PATIENT TO ANOTHER.

BY CHARLES BELL TAYLOR, M.D., F.R.C.S. EDIN.,
SURGEON TO THE NOTTINGHAM AND MIDLAND EYE INFIRMARY.

SOME years ago I was asked to operate upon a woman for ptosis and in order to remedy the defect I excised a portion of skin from the upper lid. I thought I had removed just enough to effect my object, but found on approximating the edges of the wound that I had done too much and that the patient who formerly could only open her eye ever so little would in consequence of my interference be permanently unable to close it. It was not practicable for reasons into which I need not enter to transplant a piece of skin with pedicle from the immediate neighbourhood of the orbit and I thought I might as well put back the excised lid as seek for fresh material without pedicle elsewhere. I therefore replaced the apparently dead piece of cuticle which took kindly to its old quarters and the shrinkage due to its temporary demise sufficed, as I had hoped it would, to restore the normal position of the lid.¹

I had previously and have since frequently transplanted skin from one part of the body to another, occasionally from one patient to another, and last year I introduced to the notice of the President and members of the Ophthalmological Society of the United Kingdom a patient who had been cured of extensive symblepharon by the transplantation of a large piece of skin on to the surface of the eyeball itself. The illustration here given, which is taken from a photograph of a patient exhibited to the Nottingham Medical Society on Jan. 5th, is an example

New lid transplanted from the forearm immediately after operation.

of restoration of an eyelid by a piece of skin two inches in length (without stretching) and one and a half inches in depth taken from the forearm, the lid and tissues having been so completely destroyed by burn that it was impossible to find healthy tissue anywhere in the neighbourhood of the orbit. The points to be attended to in all such operations are to clear away any subcutaneous tissue, ensure close approximation of the edges, apply pressure, and keep the flap warm. Nottingham.

¹ Transplanted skin shrinks to about one-fifth of its original size.