cyst, densely adherent, as had been previously diagnosed. So dense were the adhesions that several plates of calcareous matter, one two inches in length by one in breadth, had been formed in the peritoneum. The adhesions were very extensive, affecting the whole of the anterior and lateral walls from two inches below the umbilicus upwards. There were no adhesions in the pelvis, none to the viscera, and only one of recent date and of small extent to the omentum. The hæmorrhage from the adhesions was tolerably profuse, but only one point required to be tied. It seemed to be a suitable case, if any such could be found, for the insertion of a drainage-tube through the retro-uterine cul de sac; and, with the concurrence of his colleagues, Dr. Savage and Mr. Ross Jordan, Mr. Tait passed a double loop of large-sized wire drainage-tube through the roof of the vagina.

A few hours after the operation a faintly-reddish-coloured serum began to pass from the wound about its middle, and continued to do so up to the patient's death; probably several pints in all so passed. Not a drop, however, came by the tube until the body was moved after death. At the post-mortem examination it was evident that the tube was occluded by the pressure of the intestines, for as soon as they were lifted out of the pelvis a large quantity of fluid flowed rapidly through the tube.

The patient died of shock; for there had been no hæmorrhage, nor were there any signs of peritonitis.

Of five other cases of death after ovariectomy in which Mr. Tait has obtained or seen post-mortem examinations, and in which the cause of death was the effusion of purulent or other fluid into the peritoneum, in not one could a drainage-tube have been of the slightest use; and the possibility of benefit arising from the insertion of one seems to be very remote, while the probability of its doing harm is very considerable.

HÔPITAL ST. LOUIS.

CASE OF ANTHRAX OF THE CHIN; PHLEBITIS OF THE FACIAL AND OPHTHALMIC VEINS; RECOVERY AFTER RECURRENCE OF THE DISEASE.
(Under the care of Dr. PÉAN.)

WE are indebted to M. Urdy, Dr. Péan's distinguished house-surgeon, for the following account of this interesting case.

The patient, a cabinet-maker, aged twenty-one, had always enjoyed perfect health till 1869, when he had an attack of small-pox, which left no perceptible traces on the face or the body. There are no appearances of scrofulous or syphilitic disease. He is of a slight make, shows little muscular development, and has a pale complexion. On several previous occasions he has had pimples seated on the upper lip; these all healed readily in a few days, and without causing any swelling of the part. Once, however, the upper lip remained enlarged for about eight days: the swelling disappeared after the application of poultices. This occurred about three weeks before the supervention of the anthrax on the chin.

The patient was admitted on August 10th, 1873. On examining him during the morning visit, there was found on the chin, slightly to the right of the mesial line, a small pimple, having a base about the size of a half-crown, slightly acuminate and very painful. There existed some tumefaction above the hyoid region. The general condition was good. The case was evidently one of anthrax. A large crucial incision, greatly exceeding the limits of the pimple, was made; some healthy pus and fragments of cellular tissue came away. A tonic treatment and applications of poultices were ordered. The urine contained no traces of sugar or albumen.

In a few days the swelling extended to the lower lip. First, the left half, then the right became involved. On the 22nd the state of the patient was as follows:—Lower lip tense, enlarged, and as hard as wood; the mucous surface covered with false membrane, under which could be perceived the excoriated mucous membrane, pitted with very small holes, through which, on exerting pressure, matter and bits of cellular tissue came away. Thus it had the appearance of a membrane bristling with whitish villousities. Large openings were at once made with a knife into the lower lip and the chin, which presented the same alterations. As soon as the bleeding was stopped the incisions were ex-

amined, and the surface of the sections both in the lip and chin offered the same appearances as above described—to wit, everywhere very small isolated foci, but nowhere an accumulation of pus. The general condition was now bad, and fever had set in.

Until the 26th the disease seemed arrested. The tumefaction appeared limited to the lower lip. The chin and tissues of the hyoid region had almost recovered their normal appearance and consistency, and the anthrax itself, the starting point of all these lesions, was in full process of healing. But on the 27th the tumefaction had got beyond the genio-mental groove, and had involved the commissure as well as the neighbouring portions of the upper lip. Notwithstanding free incisions and deep-punctuated cauterisations on the limits of the diseased parts, there was noticed in the upper lip the same development of lesions as had occurred in the lower lip; the tumefaction soon reached its utmost limits, and the elimination of the sloughs began to be effected by isolated foci. The disease, extending progressively, had soon involved the left cheek (the right one remaining unimpaired), and on the evening of the 29th the limits of the disease had reached the upper eyelid upwards and the masseteric region outwards; general condition bad; pulse from 110 to 115, small, and very compressible; insomnia, and slight delirium.

On the morning of the 30th there was slight œdema of the eyelid, and there existed in the neighbourhood of the external corner of the eye an erysipelatous redness with a hardened base. The induration extended in a line parallel with the naso-labial groove, and followed the direction of the facial vein. At 12 o'clock the patient was taken with a fit of shivering, which lasted an hour and a half, and was followed by sweating. He had been coughing for two days, but on auscultation and percussion nothing was discovered except slight dulness on the right side of the chest and slight diminution of the respiratory murmur. Could it be the outset of phlebitis of the ophthalmic vein? This hypothesis was justified by the ulterior course of the disease.

Aug. 31st.—The upper eyelid is getting œdematous; no recurrence of rigor, but the general condition is much worse. Four leeches ordered to be applied around the orbit.

Sept. 1st.—Very bad night; cephalalgia; delirium. The eye is entirely closed by the swollen eyelids; the eyeball bulges forward; the pupil is a little less dilated than that of the other eye, but is still sensitive to the influence of light; slight anæsthesia of the cornea and the beginning of serous chemosis are to be noted. The movements of the eyeball are preserved, though hindered. The patient complains of intense pain in the eye, and great drowsiness. Pulse 110. No sugar or albumen detected in the urine. Poultices to the eye ordered. In the evening there is a slight amendment of the symptoms, and the swelling is a little less. Pulse 110; temperature 39° C. (102.2° F.)

2nd.—The eye is more painful; the chemosis has increased. Ten leeches to be applied, and ice to be kept on constantly. In the evening slight redness of the other eye is observed. Treatment: excision of the chemosis; atropia; the eye to be washed twice daily.

3rd.—Marked amendment; general condition better; the two lips, the chin, and cheek have resumed their normal aspect and consistency. There only exists some slight suppuration in the left commissure, and on the upper lip, in the situation of the incisions which had been made.

The applications of ice were continued until the 10th. The amendment noticed from the beginning of this plan of treatment continued uninterrupted, so that on September 10th the eye had resumed its usual aspect; only slight chemosis subsisted, as also some slight degree of induration along the facial vein. Until the 17th nothing particular was noted. On the 18th slight tumefaction of the upper eyelid was observed. Towards the outer angle of the eye there existed a small pimple. No importance was attached thereto, and simple fomentations were ordered. The next day, however, the tumefaction had increased, and chemosis had again appeared, though less marked. The pain was intense in the external angle of the eye, and the tissues were hardened in this situation. Treatment: fifteen leeches and applications of ice, as previously.

Under this treatment marked amendment was soon observed, and three days after the ice was discontinued. Along the facial vein, however, a small abscess had formed.

It was opened with the knife, and healed rapidly. On the 28th the patient was dismissed quite well. Since then the patient has been seen, and his recovery has been permanent.

Medical Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

TUESDAY, FEB. 10TH, 1874.

DR. A. WHYTE BARCLAY, VICE-PRESIDENT, IN THE CHAIR.

NOTE ON CHOLERA.

BY J. B. N. HENNESSEY, F.R.A.S.,
DEPUTY-SUPERINTENDENT OF THE GREAT TRIGONOMETRICAL SURVEY;
AND

G. G. MACLAREN, M.D.,
CIVIL SURGEON IN MEDICAL CHARGE OF DEHRA DOON,
N.W. PROVINCES, INDIA.

THE authors of the paper first described the geographical position of the town of Dehra between the Sivalik and Himalaya Mountains, the parts of it occupied by the native population (who are under the medical care of Dr. Maclaren), and the civil station where the Europeans reside. The meteorological observatory of Mr. Hennessey lies midway in the district along which the main road from the low country passes to the sanatorium of Mussoorie.

The first case of cholera that occurred in the summer of 1872 was that of a student passing through Dehra on his way to Mussoorie, where he died on July 8th. The first case in a resident of Dehra, who had not been in the way of infection except as residing near the main road along which the student passed, occurred on the 12th of the same month. Three days later other patients presented themselves for treatment, and the disease progressed till September. Its course was indicated in a table of curves, which was shown at the meeting. One special case was related of a poor Eurasian family living near the main road, most of whom died from their obstinacy in returning to the infected house after removal. Though so near to Dehra, and in uninterrupted communication with it, Mussoorie and Landour on the ridge of the hills enjoyed almost complete immunity from the attack.

The diagram referred to above consisted of curves showing the number of attacks each day, the daily deaths and recoveries, and the ultimate number of deaths and recoveries among each day's admissions. On comparing these curves with the Meteorological Register of the Observatory, no corresponding fluctuations were discovered (a complete calm having prevailed), except in the "elastic force of vapour," the curve of which had a singular coincidence with the sudden rises and falls of the other curves, rising with the recoveries as marked in them. The authors referred to their diagram as indicating that the curve of cholera-attacks rapidly rises to a maximum, and then falls as rapidly or descends gradually to zero; and also as accounting for the fact that any so-called specific discovered when the tide is ebbing may prove useless when applied while the curve is rising in a succeeding epidemic.

After alluding to some spectroscopic experiments on cholera evacuations, the authors summarised a few facts connected with the question of infection in favour of the choleraic poison having no vitality, and of an imported cholera patient having no power to infect others except in the presence of the required atmospheric conditions.

ON THE TREATMENT OF RICKETY DEFORMITIES OF THE LEGS BY OPERATION.

BY HOWARD MARSH, F.R.C.S.,
ASSISTANT-SURGEON TO ST. BARTHOLOMEW'S HOSPITAL AND TO THE
HOSPITAL FOR SICK CHILDREN.

The author gave an account of four cases of rickety deformity of the legs which he had treated by operation. In two of them the curvature was outwards, in one outwards and forwards, and in one almost directly forwards.

In the first three cases a tendon knife was passed down to the tibia, where the concavity of the curve was greatest, and the periosteum was divided transversely. A fine saw was next introduced, and the bone partially divided, and then, by a somewhat suddenly-applied force, snapped across; the fibula was either bent or broken, and in one of the operations the tendo Achillis was cut.

In the two cases in which the curvature was outwards the legs are now straight; in the boy whose curvature was outwards and forwards, and in whom the treatment was interrupted by an attack of scarlet fever, the deformity, although much diminished, is not wholly removed. In none of the patients was the operation followed by any serious symptom, and, except in the boy who had scarlet fever, convalescence was complete in about a month. In him it was complete in about six weeks.

In the fourth case, in which the bones of the legs were curved almost directly forwards, and in which the deformity was so extreme that the boy could walk only a few steps at a time, a wedge of bone was taken out of the tibia with a chain saw, the tendo Achillis was cut, and the fibula broken in one leg and cut with bone forceps in the other. These operations, which were performed, the one on April 8th, the other on Oct. 4th, 1871, were not followed by any dangerous symptoms, but small discs of bone became necrosed and were slowly separated from the cut ends of the tibia. Union was firm in one leg in three months, in the other, in which it was much delayed by the tedious separation of the necrosed portions of bone, in six months. The legs are now straight, and the boy walks without impediment.

The paper was illustrated by photographs and casts of the limbs before operation, and the cases were shown.

MR. WILLIAM ADAMS said the cases reported were excellent examples of a surgical operation recently introduced. The result obtained was exceedingly good. The subcutaneous division of the bone appeared to be more applicable to children than the open wound and compound fracture in the fourth case. The former is easily performed, and free from any danger. The operation would be of great use in properly selected cases. He thought there would be but few cases which would require to be treated as the last was. He saw Mr. Little perform the operation six years ago upon a rickety adult aged twenty-three. The operation was severe, the treatment tedious, but the result was very satisfactory. The cutting through the dense ivory tissue was very difficult. Analogous operations on other bones had been followed by good results. He referred to the case of a child with a bent femur, which he had cut through subcutaneously, and straightened. In the four cases reported the rickets was almost limited to the lower extremities. The fact that the femora of the boy (fourth case) had straightened whilst under treatment was interesting. There is a disposition to this spontaneous straightening, and long-continued recumbency is extremely useful, especially in girls, thus avoiding severe pelvic deformity. The child should be kept at rest from one to two years.

DR. HARE asked if, in the cases reported, it was impossible for the legs to be straightened without an operation. He had seen many bad cases get well by recumbency and the use of splints. Would these cases, if so treated, have done as well as by operation? The operation was attended with little risk, and more time was gained.

DR. DRYSDALE asked what was the earliest age at which Mr. Marsh had operated. He thought that more might be done by recumbency and the use of splints before the age of four or five.

MR. McCORMACK asked Mr. Marsh what means he had of judging the best age for operating. The use of the chisel for cutting through the bone was objected to in the paper, as likely to be attended with more danger and difficulty than the saw. He thought the chisel might be used with more freedom and less difficulty than the chain saw. It was much used abroad in such cases.

MR. THOMAS SMITH thought it was important to find out which method was the best, and the age at which the bones set. The method of operation in the first three cases he thought was better than that in the last. He was disappointed at the necrosis of the ends of the bones. He thought it might be better to chisel half through the bone and then break it. By removing a wedge-shaped piece the bone was placed in a good position, but if necrosis always followed, it would not be the best mode of operating.

MR. GAY asked if other treatment had been tried before operating. It was well known that much improvement followed the use of splints, rest, &c. When other treatment had failed, he thought this method good and useful. He was surprised at the little injury to neighbouring parts.

MR. WARRINGTON HAWARD said that if the bones were