associate this with the pain, so that there was no definite history of an exciting cause of over-exertion, as in the former aneurysm. He resumed work, however, attributing the pain, as before, to rheumatism, and took no further notice of the discomfort until three nights before admission, when he put his hand by accident upon a pulsating swelling under the right clavicle.

On examination after admission, the hollow below the outer third of the right clavicle internal to the deltoid was found filled up, but not replaced by any marked prominence. Over a corresponding area, extending two inches and three quarters down from the clavicle and two inches inwards from the coracoid process, pulsation could be both seen and felt, distinctly expansile, but unaccompanied by thrill. A single systolic bruit was heard, most loudly just below the clavicle, of a soft, scraping character. The outlines of the tumour were not clearly defined, but corresponded with the visible pulsation. Above the clavicle there was some increase of pulsation, but no tumour to be made out. The axilla was, if anything, deeper than on the left side. Pulsation could be completely arrested by pressure on the subclavian above the clavicle. The right radial pulse at the wrist was markedly weaker than on the other side. The heart's apex beat was an inch and a half below the nipple and just external to it, but without abnormality in the sounds. The arteries were not anywhere obviously thickened. The liver appeared to be diminished in size, but the other organs were healthy. There was nothing to be felt of the old left popliteal aneurysm, but the foot on that side was colder, and there was much less pulsation in the posterior tibial and dorsalis pedis on that side. The right popliteal could be felt beating. The femorals pulsated normally and apparently equally on both sides. The patient was ordered to keep his bed, and was put on milk diet. The pain continued to increase, even with the arm elevated by a sling, and he slept badly.

On June 17th Mr. Sydney Jones, after consultation with his surgical colleagues, decided to tie the subclavian at once, judging the patient unlikely to tolerate digital compression well, and taking into account the increased difficulty of the operation after an unsuccessful attempt. The patient was accordingly put under ether, which he took badly and in large quantity. The shoulder was washed with carbolic acid (1 in 20), and the usual incision was then made for tying the subclavian in its third part. The artery was exposed without any particular difficulty, lying rather deeply; it appeared so distinctly dilated at the distal end that Mr. Sydney Jones prolonged the incision into the sternomastoid far enough to expose the scalenus, and then tied the vessel with thick catgut at the highest attainable point. The spray was not used. A small drainage-tube was inserted, the wound powdered with iodoform, and four or five sutures introduced. Iodoform gauze, salicylic wool, and carbolic gauze bandages were used for the dressing, with sandbags for the fixation of the head, and a flannel bandage to secure the arm.

June 18th.—10 A.M.: Temperature normal. The patient said that the old pain in the shoulder-blade was quite gone, and that he passed a better night than he had done lately. The temperature rose to 99.4°. Milk and ice only allowed.

19th.—Temperature in the evening 99.2°. Slight aching pain in the arm and hand is complained of. The patient is not disposed to be restless.

20th.—The temperature never subsequently rose above 98.8°. The wound was dressed in the evening for the first time, and found united by first intention all along. The stitches were all removed, except one beyond the tube, and this latter was shortened.

23rd.—Beef-tea and Brand's essence were added to the milk for diet. The wound was dressed again, and the drainage-tube removed.

26th.—The wound has quite healed, except just at the site of the drainage-tube. No pulsation has yet been felt in the sac of the aneurysm or in the radial at the wrist. The whole right arm is warmer, moister, and redder than the left; the nails have distinctly grown less rapidly; on pressure being applied sufficient to blanch one of the finger-nails, the blood returns more rapidly than on the left side. No pain is complained of. The patient sleeps well, and says he feels quite well.

28th.—The wound is now completely healed throughout.

July 1st.—Pulsation could be felt to-day in the radial of the right side. Fish and eggs were added to the diet. The patient had, in short, no bad symptom, and some days later was allowed to get up, keeping the arm still bound to the

side. Pulsation was just perceptible on several days subsequently, but did not persist.

He was discharged on July 18th. When seen three months later, there was no return of pulsation, either at the site of the aneurysm, which was contracting, or in the radial.

CASE 2.—The patient, a stoutish, thick-necked, well-nourished, healthy-looking man, aged sixty-four, consulted Mr. Sydney Jones on Aug. 8th, 1885. He had suffered from pain about his shoulder for from eight to ten years, and a swelling had appeared about two months previously below his left collar-bone. On examination this was found to be a rounded pulsating swelling below the outer third of the clavicle, pushing it upwards and partly overlapping its lower border; it was almost the size of half an orange, was firm and elastic, not tender, but somewhat painful. The pulsation in it was easily controlled by pressure applied to the subclavian artery, this also arrested the pulse at the wrist. There was a distinct bruit to be detected in the swelling. There did not seem to be any difference in the two pulses. There was no evidence of cardiac disease.

On August 15th Mr. Sydney Jones ligatured the subclavian in its third part; this operation was somewhat difficult on account of the shortness of the neck and the extent to which the clavicle was pushed upwards. Ether was given, and the usual incision for ligature of the artery made. There was much venous distension, and the external jugular, being in the way, was ligatured in two places and divided between. The subclavian was deeply placed, but, after a careful dissection, it was exposed and the aneurysm needle passed from below upwards. The artery, which was thinned, tore at this stage a short distance above the aneurysm, and there was a sharp gush of blood. Artery clamp forceps were quickly applied, and the vessel secured above and below the opening; this opening was seen in front of the vessel, and was about three lines in extent. Chromic acid ligatures were then passed carefully round and tied on each side of the tear in the artery. The pulsation quite ceased in the aneurysm. The operation was performed under the spray, and antiseptic dressings were applied after the insertion of a drainage-tube and the closure of the wound.

The subsequent progress of the case was most satisfactory. The dressings were changed on Aug. 20th, when the wound had healed, excepting at the ends of the incision through which the drainage-tube passed. There was hardly any discharge. It was dressed again without the spray on the 24th, 27th, and 31st, and on Sept. 2nd and 5th. The left radial pulse could be felt on Aug. 26th. The patient complained of no pain. During the first night he was rather restless and suffered from dryness of the mouth and thirst, but beyond this had nothing to complain of excepting constipation later on, for which he required frequent aperients. The highest temperature after the operation was 98.8°, and the lowest 96.2°; the average would be 97.5°.

He was last seen on Oct. 9th. He had lost all trace of the pain which he had suffered from previous to the application of the ligature. The aneurysmal swelling was rapidly contracting and firm, though still connected with the lower margin of the clavicle; of course all pulsation had ceased.

LIVERPOOL EYE AND EAR INFIRMARY.

GUMMA OF THE OCULAR CONJUNCTIVA; CURE; REMARKS.

(Under the care of Mr. CHARLES G. LEE.)

A. W—, aged forty-four, single, by occupation a labourer, applied for advice at the out-patient department on July 18th, 1885, and gave the following history:—Fourteen days ago he got very wet while working in the sewers, and in a day or two subsequently noticed that his right eye became inflamed, especially at the inner corner, but, supposing it to be a simple cold, paid no attention to it until three days before coming to the infirmary, when a little discharge came away. He has not, however, had any treatment up to the present time. He has always had good health with the exception of an attack of venereal disease contracted twenty years ago, which consisted of a chancre, followed by a rash on the skin; about this time also his hair came off in large quantities. He was treated by a herbalist, and persistently denies any venereal complaint since this. Last Christmas he commenced to suffer with a sore-throat, and this continues to the present.

Present condition.—The patient is a tall spare man of only poor muscular development considering his occupation;

speaks with marked nasal intonation. Cuticular surface normal, except for three small circular depressed cicatrices, two of which are situated over the right tibia, and the third and largest in the interclavicular notch. On examining the eyes the right lower lid is seen to be slightly swollen and congested, resembling the primary stage of a sty; its conjunctival surface is slightly more vascular than normal. When the lid is everted a somewhat extensive ulcer is exposed, with thickened edges; surface covered with a scanty greyish yellow pus, which hides a few flabby granulations. Taking the caruncle as a centre, half of which structure has been destroyed, it has spread laterally in an upward direction for about two millimetres, and in a downward one for some five millimetres, as though its extension had been determined by the plica semilunaris; it does not convey any marked hardness or cartilaginous sensation to the touch. The ulceration is entirely confined to the ocular conjunctiva; the lid has quite escaped implication, and the lacrymal conduits are also free. Eyeball quite normal. Pre-auricular gland not enlarged. Throat: right half of uvula has entirely disappeared, also greater part of right side of the soft palate; the remainder is red and inflamed, with thick, irregular edges, having some resemblance to the ocular ulceration. The posterior pharyngeal wall is covered with a thick, tenacious, and offensive discharge. No ulcers or swelling of tongue. Nitric acid was applied to the conjunctival ulcer; an ointment of equal parts of iodoform and glycerine was ordered to be kept constantly applied; and chlorate of potash gargle for the throat.

July 22nd.—A mixture containing a sixteenth of a grain of perchloride of mercury, five grains of iodide of potassium, and fifteen grains of powdered cinchona, in an ounce of water, was given three times a day.

24th.—About the same. To-day Dr. A. Bernard saw the patient, and at his suggestion it was decided to continue the iodide, but as the patient refused to come into the infirmary only five grains were added.

29th.—He was admitted as an in-patient. The ulceration already diminishing. He is now taking fifteen grains of iodide. Iodoform and starch, in equal parts, were prescribed for the throat, to be blown on the parts.

Aug. 8th.—The patient was discharged at his own request, as he was anxious to resume work. He has had the iodide increased to twenty grains for the last three days.

15th.—The gummæ have disappeared, and the throat is much better.

29th.—Ulceration entirely healed, but still a little thickening of the conjunctiva over the site lately occupied by the ulcer. The throat is also healed, but with considerable loss of substance and numerous cicatricial bands, one of which almost entirely occludes communication between the pharynx and the nasal cavities. The patient was recommended to a general hospital in order to see if these bands could be divided, as he suffered with obstruction to breathing from their presence. He was still taking iodide of potassium, fifteen grains for a dose.

Sept. 12th.—The patient presented himself to-day, and only a very slight cicatrix, and that not easily distinguishable, marks the site of the conjunctival ulceration. The throat has firmly cicatrised. Since his last visit the patient has been under the care of Mr. R. Jones, of Stanley Hospital, who has divided some of the bands in the pharynx, which has afforded great relief to the patient's breathing. He still takes iodide in five-grain doses.

Remarks by Mr. LEE.—From the first little doubt was entertained of the venereal origin of the affection; but owing to the extreme rarity of tertiary lesions in this situation, it was thought that, notwithstanding the patient's assertions to the contrary, we might be dealing with a chancroid of the conjunctiva, and accordingly local treatment was employed. That the ulceration could not be accepted as evidence of an early syphilitic stage was apparent both from the condition of the palate and from the absence of any symptoms that are usually exhibited in such particular pathological eras. On the occasion of the patient's second visit, observing no change, iodide of potassium was prescribed, and on July 24th, the patient's third visit, Dr. Bernard, struck with the close similarity of the palatal and conjunctival ulcerations, confirmed our growing suspicions by pronouncing both to be of undoubtedly tertiary order. The rapid cure under the employment of the potassium salt entirely verifies these views of the etiology and sequence of the affection. In Berkeley Hill's treatise on Syphilis reference is made to two cases of

gumma of the caruncle, reported by Taylor (*American Journal of Medical Science*, 1875); and on reading that able monograph, I find both patients to have been men, and to have suffered from syphilitic lesions; in each case the affection was double, and in neither case were the eye structures or Schneiderian membrane implicated. In only one patient was the result of medicine proved, as the case first reported fell into the hands of a surgeon who, failing to suspect the true nature of the affection, extirpated the neoplasms with the surrounding skin. The second case—more fortunate—remained under Dr. Taylor's care, and with the employment of iodide, the enlargements disappeared. Commenting on these cases, the author points out that the structure of the caruncles is such as to render them liable to syphilitic inflammation. I have referred at some length to Taylor's cases, as they are the only ones at all parallel to the one I report, or that I have been able to discover, even with the aid of the extensive library of the Liverpool Medical Society.

STATION HOSPITAL, PIETERMARITZBURG.

ENORMOUS LYMPHATIC GROWTH IN THE ABDOMEN; DEATH; NECROPSY.

(Under the care of Surgeon C. R. Woods, B.A., M.D., Medical Staff.)

THE following case read in connexion with one under the care of Dr. Philipson, of Newcastle-on-Tyne, and reported by him in THE LANCET of May 22nd, 1885, is of interest, inasmuch as this was also a primary growth in the abdominal glands, and caused much difficulty in diagnosis.

Private Tucker, Welsh regiment, aged twenty-five, with four years and a half's service, was admitted into the Station Hospital, Pietermaritzburg, Natal, on May 5th, 1884, complaining of pain in the lumbar region of about two months' duration, and evincing some tenderness on pressure over the abdomen, but more especially marked in the epigastric region. There was no family history of scrofula or cancer, and the patient, who denied having had syphilis, was able to perform his duties as a soldier up to the time of his admission. He stated that he had become thin and weak lately, but did not complain until the occasional severity of the pain compelled him to report himself sick. The temperature of the patient was normal, appetite good, and tongue clean; but he was subject to pain at times after eating. There was no vomiting, but diarrhoea was often present, which was kept in check by astringents and sedatives. No hæmorrhage had taken place from the bowels. The urine was high-coloured, but there was no albumen or sugar present. Physical examination of the chest revealed no abnormal signs. On examination of the abdomen, the edge of the liver could be just felt below the ribs, and on deep palpation a badly-defined hard substance could be felt, which did not move with respiration or seemingly receive any pulsation from the aorta.

June 20th.—Up to this date the patient had gradually got worse, suffering much pain in the lumbar region; this pain was lancinating, and shot round on either side to the front of the abdomen, and was unrelieved by position or any external applications. He was still subject to diarrhoea, and now occasional attacks of vomiting distressed him, while the weakness and loss of flesh were considerable. An irregular tumour could be felt below the liver and stomach, and dulness on percussion was present between the nipple lines on either side from the edge of the ribs to about the umbilicus. There was also great pain and tenderness over the tumour. The patient suffered from no symptoms referable to the brain. The temperature varied from normal to 99.6° F. Hypodermic injections of morphia, and such articles of food as the patient could most easily digest, were administered, and every effort made to mitigate his sufferings until his death, which took place on July 19th.

Necropsy.—Great emaciation of body. Brain and membranes healthy. Appearance of organs in thoracic cavity normal; no diseased condition of liver or spleen. The peritoneum bore traces of inflammation, being matted and tying down coils of intestine, binding them to each other and to a large mass of lymphatic glands which occupied the greater part of the abdominal cavity, pushing aside and compressing the intestines. This tumour formed a large nodulated mass with a circumference of about twenty-five inches. The intestines were normal, with the following exceptions: a small ulcer was found in the jejunum, the