always spoke of dislocation of the tibia or tibia and fibula; while others, and especially the eminent French surgeons Petit and Boyer, referred the displacement to the foot or to the astragalus; and many recent authors have perpetuated the confusion by adopting one or other classifications exclusively. In conformity with the more modern and generally accepted nomenclature, the dislocation should always be described as affecting the distal and more movable portion of a limb, although the followers of Sir A. Cooper might very fairly claim that in cases like the subjoined the dislocation really does affect the tibia and fibula, because, the foot being firmly fixed upon the ground at the time of the injury, the tibia and the fibula are driven outwards by the force of the direct violence.

For the following notes we are indebted to Mr. Fredk. Treves, house-surgeon.

The subject of this somewhat unusual accident was a brewer's cooper, a heavily-made man of somewhat enfeebled health from excessive drinking. He was, however, sober at the time of the accident, which occurred in the following manner:—The patient was standing in the yard while near him a man was swinging round a "bed," or oval pad of about twenty-eight pounds weight, used for breaking the fall of casks. The "bed" slipped from the man's hand, and struck the patient with much force on the inner side of the right leg, about its middle third. The patient at once fell, exclaiming that "his foot was out," and was at once carried to the hospital on a stretcher. He had on heavy "bluchers" at the time, but of such capacity that the boot was easily removed from the injured foot by simply loosening the laces. On examination, a distinct bruise was seen on the inner side of the right leg at the point struck by the "bed," so that from the direction of the force the case appeared to be one rather of dislocation of the tibia outwards. The foot was carried inwards, so that the interval between the second and third toes was in a line with the inner margin of the patella; the dorsum was directed outwards, and the sole so turned inwards that the foot appeared to rest almost entirely on its outer margin. The foot was nearly at a right angle with the leg, and there was but a very trifling pointing of the toes towards the sound limb, so that its long axis differed but little from the normal. On the outer side was a large projection caused by the very prominent external malleolus, which, at its extremity, threatened to come through the skin, but it was not fractured, the whole fibula being quite intact and unaltered in position. So extremely was the sole of the foot twisted inwards that, in the sitting posture, the limb appeared to rest on the external malleolus. On the inner side there was a still larger projection, at the most prominent part of which the tip of the internal malleolus could be felt, while at the point where the swelling joined the leg crepitus was present. The symmetry of the heel was unaffected, and none of the tendons about the part appeared to be abnormally stretched. There was no great amount of pain, but, of course, total inability to move the foot. forcible extension failed to reduce the dislocation, but reduction was effected under the influence of chloroform, although not without difficulty. The patient remained in the hospital three weeks, the foot being fixed by a splint, and an ice bag kept on; at the end of that time the limb was put up in gum and chalk, he was made an out-patient, and had good use of the foot two months after the accident.

It would appear that in this case there was an oblique fracture extending from the base of the internal malleolus obliquely downwards and outwards to the articular surface, so as to completely sever, not only the whole of the internal malleolus, but some portion also of the articular surface of the tibia. As the blow was on the inner side of the leg this fragment would appear to have been broken off by the internal malleolus having been violently driven against the astragalus, which, together with the rest of the foot, was firmly fixed at the time of the accident. The fragment was displaced considerably inwards as regards its tip or lower extremity (a result of the direction of the force), and into the angle formed between the displaced fragment and the remaining portion of the lower end of the tibia the astragalus, together with the whole of the foot, was drawn up.

BRISTOL ROYAL INFIRMARY.

TUMOUR OF THE LEFT SIDE OF THE CEREBELLUM;
AMAUROSIS; PARAPLEGIA; SPINAL LESIONS.

(Under the care of Dr. EDWARD LONG FOX.)

THE subjoined case, beyond presenting many features of extreme clinical interest, has, as explained by Dr. Fox, an important bearing on the question of the coexistence of paraplegia with one-sided lesions of the cerebellum.

Emily T—, aged forty-five, married. On admission she had been suffering for twelve months with intense headache, and for two months had been quite blind. The pain in the head seemed to begin in the temporal regions, and to go round to the occiput. She had partially lost the senses of hearing, taste, and smell on the left side only. The right eye showed optic neuritis, the left well-marked atrophy of the disc. She walked with some difficulty, and suffered much from cramps in the legs.

She lived two months in the infirmary, and gradually lost all power over the sphincters, and became absolutely paraplegic. The upper extremities were not implicated.

Post-mortem examination.—On removing the dura mater cerebri, there was some lymph lying over the membranes of the convex surface. A large gliomatous tumour was attached to the anterior border of the left lobe of the cerebellum. At its outer side the tumour had become myxomatous. On section it was tolerably firm, with several small hæmorrhages in its substance; and the inner side of the tumour was just beginning to be myxomatous. The pons Varolii was much flattened on the left side from the pressure of the tumour, and the left fifth nerve was compressed. The lateral ventricles were full of fluid. The spinal cord looked to the naked eye healthy; but, after the usual preparation, it showed a large growth of connective tissue throughout a great portion of the cord, especially marked in the upper dorsal region. This connective-tissue growth existed throughout the entire structure of the cord, but it was best seen in the white substance, and perhaps more in the posterior than in the antero-lateral columns. Many of the bloodvessels were somewhat thickened. Some few of the nerve-cells were granular.

Remarks by Dr. E. L. Fox.—As Dr. Brown-Séquard has given a series of most interesting cases in which lesion on one side of the brain was accompanied by paraplegia, I venture to think that this case would have added another illustration to his views *had the spinal cord not been examined*. It does not seem that the cord had been examined in a large majority of cases quoted by Dr. Brown-Séquard in THE LANCET of Sept. 30th, 1876. I am far from saying that lesion on one side of the cerebellum may not induce paraplegia. I only say that most of the cases so quoted by Dr. Brown-Séquard prove nothing, because the condition of the spinal cord was not investigated. In seeking to effect a total revolution in the explanation of the connexion between nerve lesion and nerve phenomena, it would be well to draw conclusions only from those cases in which the chief nervous centres have been carefully explored.

NORTH STAFFORDSHIRE INFIRMARY.

CASE OF RUPTURE OF AORTIC VALVE.

(Under the care of Dr. ORTON.)

THE following case, for the notes of which we are indebted to Dr. M'Aldowie, house-physician, is interesting alike from the unmistakable character of the evidence of the cause and nature of the injury, and the peculiar symptoms which supervened.

James C—, aged forty, married, was admitted on Oct. 19th, 1876. He had always enjoyed good health, never had had rheumatic fever, or any other severe illness. At Christmas, 1875, while lifting a heavy weight, he felt something suddenly snap in his chest. He immediately fainted, and was conveyed in an unconscious state to the Liverpool Infirmary, remaining insensible till next day. Ever after the accident he could hear a sound in his chest, which he described as like a "pigeon cooing." About a week after the injury he had a severe attack of cough and hæmoptysis. The cough did not trouble him for more than about three

months, but the hæmoptysis continued. He was not able to get out of bed from the first, and had to be propped up with pillows to relieve the dyspnœa. He gradually lost flesh, and became very weak.

On admission he complained of pain in left mammary region and epigastrium, and of great palpitation. There was slight cough, with scanty expectoration, the sputa being tinged with bright blood. He suffered from orthopnœa. There was no œdema of ankles. Urine sp. gr. 1005, no albumen. The heart's impulse was very strong; the left cavities were hypertrophied. A loud, harsh bruit could be heard with the second sound, loudest over the aortic valves, but transmitted to the apex, and also round towards the axilla, and up the carotids. The "water-hammer" pulse was marked; pulsation was visible in the carotids, radial, brachial, and other superficial arteries. Giddiness and faintness supervened on the slightest exertion.

The treatment adopted did not differ from that of an ordinary case of aortic valvular insufficiency.

HÔPITAL ST. LOUIS, PARIS.

NECROSIS OF THE LOWER HALF OF THE FIBULA, CONSECUTIVE TO FRACTURE.

(Under the care of M. PÉAN.)

THE following notes are equally interesting, whether we consider the rarity of the complication or the happy termination of the case.

Alphonse S—, twelve years of age, was admitted on the 3rd October, 1876, with a fracture of the left fibula. The previous history of the case was, briefly, as follows:—Father and mother alive and healthy; his three sisters all enjoy good health. He stated that he had suffered previously from measles and fever, but denied ever having had scabs on the head or enlarged glands in the neck. The general aspect of the patient was, however, that of a scrofulous person. On the 3rd of August last, whilst playing at school, he struck his left leg against a form, about half way down the bone, and a little outside the anterior ridge of the tibia. He experienced some pain at the time of the accident, but did not hear anything snap. He was able to walk home that evening, but he limped. After reaching home his leg was put on a splint, and poultices were applied to the bruised part. The next day the swelling extended up to the knee, so that a complete examination of the parts was impossible, and the surgeon who attended him was unable to pronounce the nature of the mischief till three or four days after the accident. It was then found that the fibula had been fractured about half way down the diaphysis. Eight days afterwards two abscesses formed, one behind the knee, the other a little above the internal malleolus. Several incisions were made in the vicinity of these purulent collections, and shortly afterwards the leg diminished considerably in volume.

During the whole month from this time suppuration continued to be abundant, and there were no signs of the wounds closing. M. Péan, who was then called in consultation, thinking that the bone was necrosed, tried to extract a portion of it by means of gentle traction, and was surprised to find the whole of the inferior half of the bone come away through the opening which he had made near the seat of the fracture. The whole of this portion of the bone was necrosed. The next day the patient was carried into the hospital. On admission into the hospital it was thought that it would be necessary to remove the superior half of the fibula, but the patient having been put on genial diet, and the wounds having been well cared for, matters progressed favourably, and M. Péan decided on no further operative interference.

On Dec. 8th only one fistulous opening, which gave a very small quantity of pus, remained. The other wounds were all healed. Three days afterwards the patient was completely convalescent; he had gained a considerable amount of flesh, and his general health was satisfactory.

MR. JOHN D. LAWRIE, President of the Bradford Medico-Chirurgical Society, and one of the surgeons to the Bradford Infirmary and Dispensary, has died from blood-poisoning contracted in performing a surgical operation.

Medical Societies.

PATHOLOGICAL SOCIETY OF LONDON.

THE annual general meeting of this Society was held on the 2nd inst., Mr. George Pollock, the President, in the chair. The greater part of the evening was occupied with the administrative work of the Society, which is referred to elsewhere, but sufficient time was gained for a case of xanthelasma by Dr. Pye-Smith, and a specimen of compensatory hypertrophy of the larger cusp of the mitral valve by Dr. Gowers.

Mr. C. F. Knight, Dr. D. B. Lees, Dr. G. R. Leeson, Mr. E. Milner, Dr. Felix Sémon, and Dr. H. Tibbits were elected members of the Society.

Dr. PYE-SMITH exhibited photographs from, and read notes of, a case of General Xanthelasma which had been under the care of Dr. F. Smith, late of Sheffield. The early history of the case is given in the *Journal of Cutaneous Medicine* for 1869, and a cast of one of the hands is preserved in the museum of the Royal College of Surgeons. The case is now completed by an account of the examination of the body after death. The patient, a female, when first seen in 1867, was twenty-eight years of age, and had always been of delicate health. Her first confinement was accompanied by severe flooding, and followed by jaundice, which persisted until her death in 1872. After the jaundice had lasted a few months, patches of xanthelasma appeared on the eyelids. The urine at this time contained albumen, but no biliary colouring matters. The patient had an attack of facial erysipelas during this time. The xanthelasmic eruption spread to the hands, forming nodules in the palms; later the elbows were attacked, the eruption being nodular on the extensor aspect, and in ridges and lines on the flexor. It also occurred very abundantly on the feet, chiefly on the heel, and dorsal surface of the toes. Two years after the appearance of the disease, Dr. F. Smith removed one of the tubercles and examined it microscopically. He found it to be of the nature of a highly vascular fibro-cellular growth, with hypertrophy of the cuticle, rete mucosum, and true skin. In the rete mucosum the cells contained yellow-coloured granules, soluble in ether. This description agrees with that given by Moxon, Howse, and Kaposi, but differs from that published by Hebra in the first edition of his textbook, in which the sebaceous follicles are made the starting-point of the morbid process. The patient was seen at intervals for five years, dying in 1872 from exhaustion due to hæmorrhage from the stomach, bowels, and into the skin. It was noticed that some of the xanthelasmic lines and patches had become decidedly less—a fact of interest, seeing that Mr. Hutchinson has stated his belief that the eruption never retrogresses. The liver was enlarged, weighing eighty-eight ounces; it was of reddish colour, smooth, and tough, and on section exhibited absolutely no trace of its normal secreting structure, but only bloodvessels and tracts of fibrous tissue, the latter disposed in patches with groups of small cells. Many crystals of tyrosin and of uric acid were observed in the liver. Dr. Pye-Smith remarked that the condition of the liver was certainly peculiar; it resembled that described under the head of "red atrophy" by Drs. Wilks and Moxon allied to acute yellow atrophy, with which the liquefaction of liver-cells, the appearance of tyrosin in the liver and the urine, and the occurrence of fatal hæmorrhages, certainly seemed to connect it. But it was a condition very different from simple senile atrophy, which by others was called "red atrophy." Sufficient facts were now at hand to show that xanthelasma was not allied with any peculiar liver disease, but was simply the result of long-continued jaundice, whether this be due to cirrhosis, stricture of bile-ducts, cancer, &c. The present case was quite peculiar, for in it, although the jaundice was so marked, there was no obstruction to the outflow of bile. Cases of multiple xanthelasma were rare, and the nodular form of the affection was also very uncommon. With the exception of a doubtful case in