upper surface, and joined the right innominate, to form the vena cava superior which ran along the right border of the tumour. The aneurism communicated with the aorta by an oval opening near the junction of the ascending and transverse portions of the arch; it then came forward, and spread nearly uniformly in all directions, so that it lay quite in front of the aorta and innominate. The heart was rather larger than usual; apex displaced a little downwards, valves healthy, walls flabby. The aorta was roughened and dilated just above the valves, and in several parts of its course was thickened with atheromatous deposit. The innominate, left carotid, and left subclavian arteries were healthy. The radial arteries on either side were healthy, and of the usual calibre; the right, however, was deeper seated than usual. The aneurismal sac pressed on the trachea and bronchi, and the mucous membrane corresponding seemed rather inflamed. Muco-purulent fluid exuded from the bronchi on section. The other organs were healthy.

This case, the history of which I have now related, was one of those where the diagnosis between the existence of an aortic aneurism and that of a solid mediastinal tumour becomes extremely difficult, if not altogether impossible. There were, doubtless, in this case many of the symptoms which accompany thoracic aneurism—I allude especially to the signs of intrathoracic pressure; the obstructed return of blood evidenced by the enlargement and tortuosity of the superficial veins; the presence of a hoarse, clanging cough, the sense of suffocation, the orthopnoea;—but then all these pressure signs might be equally well produced by a mediastinal tumour which was not aneurismal, while in favour of the presumption that such was really the nature of the disease we had none of those local signs which in the majority of cases accompany a large aneurism close to the anterior chest-wall. There was no impulse over the prominent portion of the thorax, no thrill, no abnormal cardiac or vascular sound whatever. Then, again, the prominence of the chest-wall, though considerable, was more uniform and diffused, and not pointed, as is usually the case with aneurisms in this situation. We also found a most unusual extent of percussion dulness, extending uninterruptedly far beyond the course and situation of the aortic arch, invading both sides of the chest, and extending on the right side to the upper level of hepatic dulness. We had further the history of enlarged cervical and axillary glands, and we had occasional rises of temperature to 102°, a circumstance which has been observed in connexion with intrathoracic growths, but upon which no importance can be placed, as it is commonly caused, as in this case, by intercurrent attacks of pleuritic inflammation.

Taking all these circumstances into consideration, we were led to prefer the opinion that this patient was suffering from a large and rapidly-increasing intrathoracic growth, occupying chiefly the anterior mediastinum—an opinion which the sequel of the case proved to be incorrect. The case was, however, altogether an anomalous one, and the deviation from the symptoms usually observed in such cases may be, to some extent, accounted for by the spreading character of the aneurismal tumour, and by the fact that it was nearly filled with fibrinous clot, while pressure on the trachea and right bronchus had led to collapse and condensation of a great portion of the right lung, and produced a corresponding amount of percussion dulness.

I may just allude, in conclusion, to the bold, and to my thinking perfectly justifiable, expedient which our house-surgeon, Mr. Roche, had recourse to, of opening one of the jugular veins when the symptoms of pulmonary obstruction became very threatening—a proceeding which, for a time, gave the patient much relief.

St. James's-street, May, 1872.

BEQUESTS, &c., TO MEDICAL CHARITIES.—Mr. Thomas Holme, of the City-road, bequeathed £5000 each to several charities, among which are King's College, the London, St. Bartholomew's, and Charing Cross Hospitals; he also left £1000 to the Cancer Hospital, Brompton and Piccadilly. The Royal Free Hospital has received £100 from the Grocers' Company. Miss Mary Jenny Prideaux Brune, of Padstow, bequeathed £100 each to the Royal Cornwall Infirmary, Truro, and the East Cornwall Hospital and Dispensary, Bodmin. Miss Mary Marples, of Tiptonville, bequeathed £100 to the General Infirmary, Sheffield.

PURULENT PERICARDITIS.

A CASE IN WHICH THE PERICARDIUM WAS FILLED WITH PUS.

By JAMES GREY GLOVER, M.D.

THE following case is one of considerable rarity, and perhaps worthy of being recorded.

On the 12th of April I was called to see a little girl, Grace W—, aged twelve, who had complained occasionally, but not severely, of pain in her left side for two or three months, had been ill for two or three weeks, and under the care of a homœopathic practitioner. I was told that her illness began with a slight shivering. There was no rigor throughout. She was pale and emaciated, and had a higher temperature than normal; on the second day of my attendance it was 101°. The most noticeable complaint she made was that of excessive tenderness when touched anywhere, but especially about the chest. This made physical examination impossible. Her respiration was rather quick, and her nostrils were dilated more or less on breathing. She generally sat up in bed, with her shoulders much rounded. I could not make out the indications of tubercular disease, which I suspected, either in the lungs or the abdomen. The first day or two of my attendance there was sickness, vomiting of almost everything taken, and a tendency to diarrhoea. The upper part of the abdomen was swollen and tender, and hard as far as could be ascertained. She became gradually weaker. She was clear and intelligent, but was occasionally excited in a semi-hysterical sort of way, and on the occasion of my visit the day before her death, went for a few minutes into a very curious trance-like condition, on coming out of which she sang in an Ophelia-like fashion. This nervous element in the case was very noticeable throughout, but I confess to being more impressed with the emaciation, the high temperature, the short breathing, &c. Though I had to content myself with a somewhat vague diagnosis, I had no difficulty in giving a very serious prognosis, which was verified by death in seven days. It is remarkable that two days before her death she managed to walk, after a fashion, a few feet from the sofa to her bed.

The treatment consisted in attempts to introduce nourishment, and, in the way of medicine, the administration of a drop or two of tincture of opium every three or four hours, which soothed and had a beneficial effect on the vomiting and diarrhoea.

At the post-mortem the above facts received the following pathological explanation:—*Thorax*: On percussing the chest and abdomen prior to opening them, extensive cardiac dulness, and dulness and hardness of the hepatic and epigastric region, were marked. On opening the chest the pericardium was found very much distended, as if with a large quantity of fluid. This fluid turned out to be very thick greenish-yellow pus—what the old pathologists would have called laudable pus,—which welled up out of a little opening made, till occasionally the opening became plugged with lymph. I collected a tumblerful of it, and much more remained. There must have been at least two tumblersful altogether. Much purulent lymph then appeared adhering to the inner surface of the pericardium. The substance of the heart seemed pale and soft. The endocardium and the valves were unaffected. The lungs were congested and adherent to the side, but did not contain tubercle. There was a quantity of serum in the pleura, but not pus.—*Abdomen*: The liver was enlarged very much and universally congested. There was a good deal of straw-coloured fluid in the abdomen; but no other morbid appearance was noted.

Remarks.—I never saw pus in the pericardium before, and from what I can gather from books and physicians and pathologists of authority, the case is one of rare occurrence. Clinically, it is curious to notice that such a quantity of pus can accumulate in the pericardium without more distress of the circulation, without more acute local symptoms, and without the coexistence of acute rheumatism.

Dr. Wilks kindly sends me the following comments on

my written account of the case, which will be read with interest:—

"Your case is an interesting one; I have seen two or three of the kind, and in none was the pathology very clear—i.e., there was not the history, as one might have supposed, of rheumatic pericarditis, but the disease was insidious and undiagnosed. We have amongst our drawings in the museum an enormously distended pericardium of a case under the late Dr. Hughes. He thought the physical signs caused thereby indicated pleuritic effusion. The same thing occurred under Dr. Addison.

"In the Pathological Transactions for 1869 is a case of mine where a lad died with pericardial effusion. This was evidently the result of an acute affection, although the history extended over some months. His symptoms were due to impairment of the heart's action, and such as are met with in ordinary cardiac disease.

"I suppose the question is—whether such insidious and generally undiagnosed effusions are of a peculiar kind and have a pathology of their own, or whether they are simply the exceptional and accidental consequence of an ordinary pericarditis from some constitutional peculiarity on the part of the patient, just as a pleurisy will now and then end in an empyema, or a peritonitis in a purulent effusion in the abdomen. I apprehend that the chances are in favour of this explanation. Paracentesis of the pericardium has often been proposed, and even practised; but, unfortunately, in the three cases which I have seen where it would have been feasible the diagnosis was not made."

Compton-terrace, N., June, 1872.

Medical Societies.

OBSTETRICAL SOCIETY OF LONDON.

WEDNESDAY, JUNE 5TH, 1872.

DR. BRAXTON HICKS, F.R.S., PRESIDENT, IN THE CHAIR.

THE following gentlemen were elected Fellows of the Society:—C. J. Bracey, M.B. (Birmingham); G. B. Denton, Esq. (Liverpool); H. M. Fernie, Esq. (Macclesfield); C. Leonard, Esq. (Bristol); M. Tuchmann, M.D.; and C. B. Waller, Esq.

A report by Drs. Black and Potter on the growth attached to the mouth of a fœtus, and exhibited at the last meeting, was read. It was found to spring from the body of the sphenoid bone, and was composed of numerous pieces of bone and cartilage united together into a compact mass, with here and there little deposits of fat. The reporters believed that it probably represented a secondary fœtus.

Dr. SQUAREY read an account of the cases of three sisters in whom the uterus and ovaries were absent. The congenital defect seemed to have been derived from the mother's family. The first patient was twenty-six years of age, and had never menstruated. She suffered from pain across the back occasionally, but not regularly. The vagina was represented by a cul de sac one inch and a half or two inches long. No sign of uterus by vaginal or rectal examination. The pubes was devoid of hair; the breasts were well developed. The second patient was eighteen years old. Menstruation had never appeared. A vaginal examination disclosed exactly the same condition as in her sister, except that the vaginal cul de sac was shorter and smaller. The third sister, aged sixteen, was also the subject of a similar deformity. There was nothing in the external appearance of either of them to lead anyone to expect that such a malformation existed.

Dr. PHILLIPS said that in 1870 there were two sisters under his care at Guy's Hospital in whom no trace of a uterus could be found. One was twenty years of age, rather diminutive in stature. The external genitals were well formed, and the mammary glands were well developed. The vagina was represented by a short canal, about an inch long, terminating as a cul de sac. So far as an examination during life could decide, there was no uterus, and the ovaries could not be felt. Her sister, aged twenty-one, was found to be the subject of a malformation similar in every respect. Neither of them had ever menstruated. It was worthy of notice that in Dr. Squarey's cases and his own

the breasts were developed. It was, of course, possible that the ovaries existed, but in one case he saw the breasts were large, though it was in the highest degree probable that all the internal genital organs were absent. There was no opening between the urethra and the rectum, and the intervening septum was about the natural thickness of the urethro-vaginal septum. The finger in the rectum and the hand above the pubes met easily.

Dr. HEYWOOD SMITH referred to the case of a woman aged thirty who had not menstruated, and in whom there was found merely a small knob about the size of half a filbert to represent the uterus. In another case there was no uterus, as far as he could ascertain. A very short vagina existed, and a wide urethra, through which menstruation occurred. In a third case there was a normal uterus, but total absence of menstruation, and she had full whiskers and beard.

Dr. ROGERS had had under his care three cases of absence of the uterus in otherwise well-formed and healthy women. The vulva, the labiæ, and the mammae were well developed, but the most careful examination, even with the hand in the rectum, the patients being under the influence of chloroform, failed to find a trace of a uterus.

Dr. TILT was not prepared to admit that the ovaries were absent in women who owned to sexual feelings and presented a normal development of the mammary glands; probably in such cases the ovaries were placed beyond the reach of the observer's finger.

Dr. BARNES said that Kussmaul declared that the uterus and ovaries were rarely altogether absent. There was a specimen, however, in University College Hospital from a girl aged twenty-one who had never menstruated. No ovaries could be seen, and the uterus retained the characters of that of a young child. In one case he had dissected up an artificial vagina a year ago, and by means of an elastic dilator this was well preserved.

Dr. WILTSHIRE agreed with Dr. Phillips that cases of various degrees of malformation of the female genitalia were not very rare. He suggested that some information might be obtained by external measurements of the pelvis and by the condition of the breasts. He mentioned cases where patients had borne children after treatment of malformations supposed to be irremediable.

Dr. MATTHEWS DUNCAN read a paper on Long Delay of Labour after Discharge of Liquor Amnii. A patient was expecting her confinement in June, 1872. On the 10th of March there occurred during the night a copious flow of liquor amnii, and slight irregular pains were felt. The liquor continued to discharge freely, but not constantly. The uterus gradually diminished in bulk, and in a fortnight's time it felt not much bigger than a large adult foetal head. On the 25th of April regular pains came on, and the child was born alive, but survived a very short time. There appeared no doubt that pregnancy continued for forty-five days after the discharge of some of the liquor amnii; and the fœtus continued to live for several weeks in a very contracted uterus. The author considered that the hypothesis resorted to by Burns in explanation of such cases, that the torn membranes may be healed, was not only without rational grounds, but contrary to all we know. Among the conditions which may be mistaken for premature evacuation of liquor amnii Dr. Matthews Duncan mentioned discharges of urine, watery discharges, such as are sometimes observed in virgins, and whose source may be Cowper's gland or the cervix uteri, discharges from the uterus of a fluid occupying the anatomical position of hydroperionic fluid, discharge of liquor chorii, discharge of the liquor amnii of one ovum, discharge of the fluid in a cyst described as occurring between the chorion and the amnion. In the above case, however, that the discharge was liquor amnii was proved by the subsidence of the uterine tumour, by the diminution of its bulk, by the increase of its hardness, by the complete absence of discharge of liquor amnii at the time of labour, by the compressed state of the child, and by the almost complete rubbing off of the vernix caseosa. Here the discharge of liquor amnii in occasional gushes took place till labour came on; and long after it was evident that the uterus had been for the time as completely evacuated of this fluid as it could be. But this circumstance was easily explained by the accumulation of newly secreted liquor amnii. Winkler's researches proved that the amniotic