which may be looked upon as a myxo-sarcoma. At the same time, it is noteworthy that Holmes does not mention myxomata amongst the tumours occurring in early life in his separate work upon the Surgical Diseases of Childhood. Leubuscher, however, gives the details of a case of a gelatinous myxoma situated in the brain of a child aged seven, and Schuh fully records another example of a soft myxoma met with in the neck of a child of five months old, the latter case in many respects most closely resembling the one I here place on record.¹

These constitute all the recorded cases I have been able to find which are presumably of this nature. At the same time I must confess to a feeling of doubt whether these growths are really so rare as it would appear; for, being of so simple a texture—akin, indeed, to embryonic structure,—the inference is that we ought often to encounter such tumours in early childhood, and I cannot but incline to the belief that the apparent rarity is due to two causes—first, to their nature being overlooked, being mistaken for lipomata, or even fibromata; and second, to the fact that such tumours, if allowed to remain, may probably change their nature, undergoing a true evolution, with the growth of the child, whose tissues are changing more and more from their early or embryonic type, so that when they come to be examined at a later period, we have no longer a soft and viscid myxoma, but a tumour with quite different histological characters, and which would properly be classed among the sarcomata.

A few words as to treatment and prognosis, which I will take in the order named. The fact that tumours of connective-tissue origin often grow quickly renders their early removal advisable, and this general rule is the more imperative in childhood because here pressure frequently produces disastrous results, and, further, because the growth nearly always interferes, and that to a marked extent, with the nutrition of the child. Nor is the removal of these tumours surrounded with any serious difficulty in early childhood. They are nearly always completely encapsuled; the free use of the director or the finger removes the gravest objection to extirpation, that of hæmorrhage; whilst the absence of any nervous shock preceding the operation, and, as a rule, the inconsiderable nervous shock which follows, render recovery highly probable if the child survive the immediate effects of the operation. Indeed, we are probably justified in saying that no age is too early to remove such tumours, if they be evidently increasing in size. It is, however, wise to note this feature of increase very carefully, as certain growths, congenital hypertrophies of cellular tissue for the most part, after remaining stationary for some time, spontaneously disappear. If removal be determined on, doubtless the proper plan is to completely enucleate the tumour, capsule and all, and not, as Mr. T. Holmes advises,² to open the capsule and dissect away the tumour from within. Such a procedure would, in all likelihood, be followed by a recurrence of the growth, the capsule being left behind. Of course, much depends on the diagnosis being correct, and to ensure this it is a good plan to insert an exploring needle in these nuchal tumours, when, if the growth is cystic, setons may prove successful, provided that at the same time the solid portions be attacked by injections of iodine, but if the tumour is solid throughout, then excision should be recommended.

And now as to prognosis—that is to say, what is the probability of recurrence in myxomata in early childhood? There is no doubt that, as a class, myxomata are prone to return, although this tendency seems to be worn out after several removals; but I think in early childhood the tendency to recur is more governed by heredity than by the special histological characters of the growth itself. In the debate which took place at the Pathological Society on Cancer in 1874 this point was brought out with special clearness: for example, it was shown that if a parent died of carcinoma, and the child inherited a sarcoma, that this latter growth would possess many of the peculiarities of its predecessor, and that the proneness to recurrence was handed down from parent to offspring with greater regularity than any special anatomical character. Now, in the case related above, I was not able to trace any hereditary taint what-

soever, and, therefore, I am inclined to prognosticate that the first operation will be the last, partly on account of the absence of heredity, and partly because it was completely extirpated before the system had time to be impregnated to any noteworthy extent with growing germs.

Manchester.

RÖTHELN.

By JULIUS POLLOCK, M.D., F.R.C.P.,

SENIOR PHYSICIAN TO CHARING-CROSS HOSPITAL.

THE disease known as "Rötheln," or German measles, is perhaps sufficiently rare to make a well-marked outbreak of some interest. It occurred in a family in the N.W. district of London, and nothing is known as to how the infection was originally introduced.

On the 7th of April, one of the boys, aged twelve, came out in a rash about 11 A.M., which had much increased by the evening. He had a warm bath, and was sent to bed. The next morning he was covered with a red papular rash looking very like measles; the head, face, and neck were a good deal swollen, and the glands in the neck enlarged. There were symptoms of coryza, the eyes were suffused, and the throat rather sore. The rash was nearly gone the next day, and he was soon well.

No other case occurred until the 22nd of April, when one of the girls, aged fifteen, was found to have a mottled-looking rash under the skin upon getting up in the morning. After she was sent to bed, the eruption appeared to come out in red blotches, and then gradually spread all over the body. There were just the same symptoms of coryza in this case; the throat was sore, the tonsils enlarged, and the head, face, neck, and cervical glands a good deal swollen. She had violent headache, and felt very ill for one day and night, after which the symptoms subsided, she gradually became better, and the rash faded away, but left a mottled appearance of the skin, which lasted for several days.

On the evening of the 22nd, another daughter, aged eleven, developed the same symptoms, but in a much milder form, and was well again in a day or two. In this case there was no mottling of the skin left.

On the 24th of April another of the girls, aged sixteen, began to show symptoms of the disorder, and passed through a very severe attack. She was not able to get up until the 29th, when she still felt very weak, and the face remained mottled for some time.

On the 25th another boy, aged nine, came out with the rash, and had a mild attack of the disease, which left no mottling.

On the 30th of April the eldest daughter, aged nineteen, who had been absent from the house for six days, came home with a raised mottled rash under the skin, and feeling very sick and ill. After getting warm in bed the rash came out very freely all over her; and the face was swollen, the eyes suffused, the glands in the neck enlarged, the pulse 100, and the temperature in the mouth 101.2°, at 5 P.M. The rash was papular and mottled, not crescentic in arrangement, and looked in places much under the skin, in other parts standing out boldly as red spots. The tonsils were red and swollen; the tongue slightly coated with a brown fur, its papillæ being enlarged and red as in scarlet fever. At the end of a few days she was a good deal better, and was allowed to get up on the 3rd May and lie on the sofa; but the attack left her very weak, and the face was much mottled for some time.

In all the severe cases some amount of "peeling" took place about the lips and nose. The treatment employed was of the simplest kind: rest in bed, light diet, and some saline mixture every four hours.

Remarks.—In the more severe cases the symptoms and appearance of the disorder were well marked, and it was readily recognised as "German" measles. The period of incubation would seem sometimes to be very long, as the first case occurred on the 7th April, and the next not until the 22nd. It may be assumed that the cases which developed on the 22nd, 24th, and 25th, were the result of contagion taken from the first case; but the last, which began on

¹ For the first case vide Virchow's Arch., vol. xliii., p. 194, and for the second, Die Krankhaften Geschwülste of Virchow, p. 417. For both these references I am indebted to my friend Dr. Dreschfeld.

² Surgical Diseases of Children, p. 376, 1868.

the 30th, was probably taken from one of the cases of the 22nd, as the patient left home on the 24th, and returned ill on the 30th. Thus the period of incubation varied from six or eight to fourteen or sixteen days. It may be noticed that the disease was more severe in the older, less severe in the younger, members of the family.

Harley-street.

CASE OF RENT ULCER.

By CHARLES HIGGENS, F.R.C.S. E.,

OPHTHALMIC ASSISTANT-SURGEON TO GUY'S HOSPITAL; LECTURER ON
OPHTHALMOLOGY TO GUY'S HOSPITAL MEDICAL SCHOOL.

Nov. 1st, 1875.—Mary H—, aged fifty-four, married, has had four children, three of whom are living and quite healthy, one died in early infancy from an unknown cause; has had one miscarriage; her general health has been excellent; no signs or history of syphilis; knows of no case of tumour or cancer amongst her relatives, but says her daughter has an obstinate ulcer on the face.¹ Thirteen years ago first noticed a pimple on the left side of her nose; five years later had a blow on her face, after which ulceration commenced at the site of the pimple, and gradually spread, involving the eyelids and cheek.

There is a large, deeply-excavated, ulcerated patch, involving the left side of the nose, upper part of left cheek, and inner two-thirds of left eyelids, the whole thickness of which is destroyed for a considerable extent. There is some thickening of the tissues at the margin of the ulcer, but no definite growth. The left eyeball is exposed, but is quite healthy, and vision is perfect. The eyeball was excised, and the ulcerated surface covered with a paste of chloride of zinc and starch spread upon strips of lint. After the separation of the sloughs the ulcer cicatrised to some extent.

May 29th, 1876.—The ulceration has again spread to about the same extent as at the time of application of the chloride of zinc six months ago, but has extended more deeply, opening the left cavities of the nose. Whole ulcerated surface destroyed with galvanic cautery.

Sept. 28th.—Wound cicatrised after separation of sloughs made by cautery; remained healed till quite recently. During the last three weeks ulceration has commenced afresh, and spread rapidly in all directions. She complains of great pain, and is unable to sleep at night. For the first time during the whole course of the disease her general health has begun to suffer; she has lost a stone in weight during the last three weeks.

An anæsthetic having been administered, a good-sized sponge attached to a strong piece of silk was pushed through the cavity into the back of the nasal fossæ, so as to prevent the blood from running back into the pharynx; then with a scalpel the whole of the diseased tissues with a good margin of the adjoining healthy structures, including the skin of the cheek, the remains of the eyelids, the mucous membrane, portions of the turbinated bones, and septum of the nose, were removed. The bleeding, which was very free, having been stopped by the cautery, the walls of the large cavity left were covered with a paste of chloride of zinc and starch in equal parts spread on lint. The patient was put to bed, and a hypodermic injection of morphia given. Ordered to take as much beef-tea and milk as she can swallow.

Oct. 18th.—During the week immediately succeeding the operation there was obstinate vomiting, much constitutional disturbance, and great prostration. The greater part of the slough has now separated; portions of the frontal and superior maxillary bones are exposed and dead; the wound is granulating healthily. There is some infiltration of the skin at the lower part.

Nov. 13th.—Two pieces of dead bone removed; all the surface has cicatrised except at the site of the removed portions of bone.

20th.—Another small portion of bone removed.

Dec. 18th.—There appears to be a small patch of ulceration at the outer side of the left nasal cavity. Chloride of zinc paste applied.

Jan. 1st, 1877.—Small slough has separated. Wound granulating.

Feb. 12th.—There is no sign of ulceration; her general health is excellent; has entirely lost sensation in the forehead and upper lip and other parts supplied by the supra- and infra-orbital nerves.

Brook-street, Grosvenor-square.

A Mirror

OF

HOSPITAL PRACTICE,

BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum, tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

UNIVERSITY COLLEGE HOSPITAL.

INJURY TO PELVIS, WITH RUPTURE OF BLADDER AND ABDOMINAL AORTA; DEATH; REMARKS.

(Under the care of Mr. CHRISTOPHER HEATH.)

FOR the following notes we are indebted to Mr. Gould, surgical registrar.

C. C—, aged thirty, an iron dresser, was assisting to turn over an "engine bed" weighing about one ton, when it fell upon him striking the lower part of his abdomen. He lay some time under the iron before it could be lifted off. He was at once conveyed to the hospital.

On admission (6 P.M., Dec. 8th), he was suffering from severe shock; the face was blanched; he complained of pain over the pubes, and there was very marked tenderness in the left inguinal region; the scrotum was swollen. No fracture could be detected by the examination that was considered justifiable. There was repeated vomiting. A catheter was easily passed into his bladder, and about two teaspoonfuls of bloody fluid drawn off. The catheter was tied in, and a tube for drainage attached. Poultices were applied to the belly, and hot bottles to the feet. Ordered to suck ice.

During the night there was slight wandering delirium, and the man vomited several times, but no blood was seen. About half a pint of bloody urine passed through the catheter. At 11 A.M. the patient was quite conscious; extremely blanched; there was no pulse at the wrist, although the brachial pulse could be felt, 150. The belly was not distended, but there was slight general tenderness, most marked at the left groin. The patient gradually sank, and died at 7 P.M. on Dec. 9th, exactly twenty-six hours after the accident.

Autopsy.—The peritoneal cavity contained several ounces of blood mixed with a small quantity of serous fluid. Blood was effused under the peritoneum in both lumbar and iliac regions, extending down into the pelvis. The intestines and omentum were glued together with soft recent lymph. The pleura was separated from its mesentery in three places for a distance of one to three inches, and the mesentery was torn, but there was no rupture of intestines. The bladder was quite detached from pubes; the peritoneum over the apex was torn through, and there was a longitudinal rent in the anterior wall of the bladder, just behind the upper part of symphysis pubis, large enough to admit the little finger. The bladder was quite empty. At the bifurcation of the aorta, rather on the front of the artery between the common iliac vessels, was a hole through all the coats the size of a split pea, plugged by a soft adherent coagulum. The peritoneum over this was not wounded. The other vessels and all the other viscera were uninjured. The symphysis pubis was separated, the cartilage being adherent to the right os innominatum; there was also separation of left sacro-iliac synchondrosis.

In commenting upon this case Mr. Heath drew attention to the exsanguine condition of the patient as showing that some serious lesion had occurred, which proved to be nothing less than a rupture of the aorta, notwithstanding which the patient survived twenty-six hours owing to the fortuitous plugging of the aperture. On the patient's first admission

¹ I have been unable to see the daughter.