TRANSACTIONS

OF THE

NEW YORK SURGICAL SOCIETY.

Stated Meeting, November 10, 1909.

The President, DR. JOSEPH A. BLAKE, in the Chair.

CRANIOTOMY FOR CEREBELLAR CYST.

DR. CHARLES A. ELSBERG presented a man of 22 who was admitted into Mt. Sinai Hospital in May, 1909, with the history that six weeks before he had begun to suffer from occipital headache and to have attacks during which he saw double. The headache became more severe, and was accompanied by vomiting. For the past three months he had been deaf in the right ear, and his eyesight had become much impaired.

When admitted to the hospital, the patient had coarse nystagmus to the right, marked weakness of the right external rectus muscle, areflexia of the right cornea, weakness of the right facial muscles, slight weakness, ataxia and hypotonia in the right upper and lower extremities and exaggerated knee-jerks. There was marked choked disc on both sides.

During one week the symptoms became much aggravated, so that operative interference became imperative. The diagnosis of a lesion in the right cerebellar hemisphere was made, and a right suboccipital craniotomy, with removal of the bone, was performed. The right cerebellar lobe was found to contain a cyst the size of a goose egg. The cyst was opened and its contents evacuated, the cavity swabbed out with the tincture of iodine, and the dura and skin flaps sutured into place.

The patient made an uneventful recovery from the operation. When presented, he was free from all symptoms and was entirely well. His eyesight was normal, and the paralysis of the right external rectus, the areflexia of the cornea, the ataxia and weakness of the extremities on the right side had entirely disappeared.

DR. ELSBERG presented another patient upon whom he had

operated for cerebellar cyst, and who was well after one year. The history of this second patient was similar to that of the first with the exception that there had been marked mental disturbance and very little optic neuritis. The left cerebellar lobe contained a small cyst which was probably due to an old hemorrhage. In this case, the operation was done in two stages: the first consisted of removal of the bone, the second of the opening of the dura, the examination of the cerebellopontine angle, the incision of the hemisphere and the evacuation of the contents of the cyst.

The patient made a very satisfactory recovery from the operation; the mental symptoms disappeared rapidly the day after the operation, and with the exception of a persisting slight ataxia in the left lower extremity, the patient was perfectly well.

HEMITHYROIDECTOMY AFTER LIGATION OF THE SUPERIOR THYROID VESSELS FOR EXOPHTHALMIC GOITRE; HYPERTHYROIDISM.

DR. ELSBERG presented a woman, 35 years old, in whom, for the relief of a severe form of Basedow's disease, he had ligated the superior thyroid vessels four months before under local anæsthesia and had sent the patient to the country for a rest. A month later the patient returned to the hospital with her symptoms unrelieved. Under ether anæsthesia, the right lobe of the thyroid was removed without difficulty. An hour after the operation the patient had a pulse of 240, with great dyspnœa and delirium. Severe symptoms of hyperthyroidism persisted for two days; they then gradually disappeared, and the patient thereafter made an uninterrupted recovery. All of her symptoms disappeared within two months: the pulse was now slow and regular, the exophthalmus had disappeared, there was no longer any tremor and the patient had gained more than thirty pounds in weight and felt perfectly well. In this case there was absence of a lymphocytosis in the blood—a condition which Kocher considered of grave prognostic significance.

HEMORRHAGE INTO THYROID CYST; HEMORRHAGE INTO OVARIAN CYST.

DR. ELSBERG presented a young woman who was admitted into Mt. Sinai Hospital with severe dyspnœa from a large swelling of the thyroid gland, of two hours duration. Under ice appli-

cations the swelling was partly reduced, and the interference with breathing overcome. The right lobe of the thyroid was exposed, and a cyst which contained a large recent blood clot was removed. The patient made an uneventful recovery, and was discharged well two weeks after the operation.

Two weeks later she was readmitted with acute abdominal symptoms of a few hours duration. At the operation, a large ovarian cyst filled with a recent blood clot was removed. The pedicle of the cyst was not twisted and looked normal. From this operation the patient also made a good recovery. Two months later she returned with similar symptoms on the opposite side of the abdomen. She refused operation and left the hospital against advice. Her symptoms gradually disappeared.

This patient, Dr. Elsberg said, had had an attack of articular rheumatism some weeks before the hemorrhage into the thyroid cyst had occurred, and the connection between rheumatism and hemorrhage into thyroid cysts was well known. It was of interest that there seemed to exist in this patient a tendency to bleeding into existing cysts. There was no other hemorrhagic tendency.

MODIFIED TALMA OPERATION FOR CIRRHOSIS OF LIVER AFTER THREE YEARS.

DR. ELLSWORTH ELIOT, JR., presented a man, 55 years old, who was admitted to the Presbyterian Hospital on October 9, 1906. He had been a moderate drinker, and gave no specific history. Four years before he had symptoms of indigestion, from which he completely recovered. One year later he had a second similar attack, with loss of appetite and fever, associated with swelling of the legs and abdomen. A course of treatment with hot baths improved his condition to such an extent that he could work the following summer. Two months later his symptoms recurred, and since then he had done no work.

Eighteen months before admission his abdomen was tapped for the first time, and since then this had been repeated about twenty times, from three to six gallons of fluid being removed at each tapping, with some relief to the patient. More recently he had suffered from dyspnoea, and his general condition was not so good.

Operation by Dr. Eliot, October 16, 1906: Through an

incision midway between the symphysis and umbilicus all fluid was evacuated. The thickened omentum together with the gut adjacent was then sponged off and allowed to come in contact with the wound, and after the insertion of a long cigarette drain to the bottom of the pelvis, the wound was closed.

After the operation, the patient's general condition was satisfactory. There was a very free serous discharge from the wound for ten days, when it suddenly ceased. Three weeks after the operation the ascites had recurred to a sufficient degree to give rise to a fluid wave, but this gradually disappeared in the course of a week, the patient passing large amounts of urine. During the three years that had elapsed since the operation there had been no further recurrence of fluid. The patient was able to travel and do a moderate amount of work. Eighteen months ago he returned to the hospital on account of irregular heart action and dyspnœa, and he was discharged at the end of three weeks much improved. His liver now was smaller than prior to the operation, but it still projected below the free margin of the ribs and had an irregular surface.

Dr. Eliot said he had another case, a woman, upon whom he did this operation four or five years ago, and who was still alive and able to do her housework. More recently, however, he had discarded this operation because of the rather high mortality. For a time, he thought the high death rate might be due to the use of a general anæsthetic, and he did the operation under cocaine, but the results were still unsatisfactory. For the past year he had given up the use of drainage altogether, making his incision above the umbilicus, allowing the greater part of the fluid to escape, suturing the omentum to the abdominal wall between the parietal peritoneum and the posterior sheath of the rectum and then closing the wound without drainage. With this method, his mortality was considerably less, but at the same time it had not produced so rapid a cure, for the fluid recurred, necessitating an occasional tapping, but at much longer and increasing intervals than before the operation, until finally, with the establishment of a satisfactory venous collateral circulation further recurrence ceased.

DR. CHARLES N. DOWD said he had done one of these operations in a manner similar to that described by Dr. Eliot, suturing

the omentum into the abdominal wall and then closing the wound. The ascitic fluid was withdrawn by tapping as it accumulated. This, however, was not necessary for a very long time, and an ultimate cure resulted.

DR. ALEXANDER B. JOHNSON said that while he agreed with Dr. Eliot that the mortality of this operation was considerable, yet the result in a certain proportion of cases was extremely gratifying. He had a woman under observation upon whom he had done the operation at least five years ago who at the time of the original operation was in a pitiable condition. He had seen this patient within the year, and during the four years that had elapsed since the operation she had never required another tapping. While the abdomen contained a small amount of fluid, the patient's general health was good; she was able to resume her household duties and she had improved to such a degree that one would scarcely have recognized her. In that case he had simply rubbed the diaphragm and liver with a nail-brush, and sutured the omentum to the abdominal wall.

In another case, a man with a marked alcoholic habit and cirrhosis, the abdominal cavity contained a large quantity of fluid and the general health of the patient was much impaired. He sutured the shriveled omentum to the undermined subcutaneous tissues of the abdominal wall and the patient recovered a fair degree of health. When he returned a year later to have an umbilical hernia operated on there was a very small amount of fluid in the abdomen. The hernia was operated on successfully and the man was still in fairly good health.

In a third case, Dr. Johnson said, he did the regular Talma operation, and during the year and a half that the patient was kept under observation there was no necessity for retapping, and the patient was able to resume his work and enjoyed very fair health.

RESULT OF OPERATION FOR HEPATOPTOSIS AFTER FIVE YEARS.

DR. ELLSWORTH ELIOT, JR., presented a woman who was admitted to the Presbyterian Hospital December 7, 1903. She was then 38 years old. She had had two pregnancies, nine and seven years before. Eighteen years previously she had had an attack of severe pain in the epigastrium, with jaundice, confining

her to bed for three weeks. A similar attack occurred three years before admission, with severe pain in the right hypochondrium, and vomiting. The jaundice persisted for a month. In November, 1900, a ventral fixation was performed by Dr. Eliot. At that time there was retroflexion and some menstrual difficulty, which was relieved by the operation. In April, 1903, the patient had an attack of fainting, with chills and fever, and severe pain in the back, but no vomiting nor jaundice. Since then she had had frequent attacks of fainting, with abdominal pain after eating, and occasional jaundice. For several months past she had been unable to do any heavy work.

On examination, the wall of the abdomen was soft and retracted. The lower border of the liver could be felt two inches below the free costal margin. On bimanual examination, in the right lumbar region, the right kidney could be felt to be slightly movable.

Operation: On opening the abdominal cavity, the transverse fissure of the liver was found to be in close contact with the lesser curvature of the stomach. The greater curvature was opposite the umbilicus. The right kidney enjoyed an excursion of two inches during inspiration. The gall-bladder and ducts were normal. The liver was raised a distance of two inches by suture of the round ligament, and the abdominal wound was closed after denudation of the opposed peritoneal surfaces of the diaphragm and liver.

No unusual nausea or vomiting followed the operation. The bowels moved on the third day. The pain decreased and finally disappeared, with steady improvement of the appetite. On the tenth day, slight pain in the back alone remained. The patient continued to improve, and left the hospital in excellent condition. Six months after the operation she was enjoying very good health. There was occasional pain after eating and some obscure pain low down in the pelvis, but her general condition remained greatly improved.

He had seen this patient from time to time during the past five years, and the improvement in her condition had continued, so that she had been able to do her household work and support her family. She still had occasional attacks of abdominal pain, but these were not severe, and her attacks simulating gall-stone colic had entirely disappeared.

CALCULOUS PYONEPHROSIS: NEPHRECTOMY.

DR. ALEXANDER B. JOHNSON presented a man, 51 years old, who was admitted to the New York Hospital on March 23, 1909, with the diagnosis of renal calculus and pyonephrosis of the right kidney. The case was shown to illustrate the frequent error in diagnosis made when the symptoms of a kidney lesion were referred almost entirely to the bladder and urethra.

The previous history of the patient was as follows: Twenty-five years ago he had a specific urethritis and since that time he had suffered from urinary disturbances consisting of frequent and painful micturition, with (as was alleged) occasional attacks of retention of urine. During the greater part of this time he had been treated for stricture of the urethra by gradual dilatation. For the past two years he had suffered from occasional attacks of severe pain in the right lumbar region.

During the past twenty-five years the patient's urine had been constantly loaded with pus. For the past two years the quantity of pus had greatly increased and for the past six months he had had a continued fever of a septic type, and had rapidly lost flesh and strength.

Upon admission to the hospital, the patient's general appearance was that of a man seriously ill with chronic septicæmia; his skin had an ichteroid tinge, his breath was foul, his tongue was coated, he was markedly anæmic, his urine was heavily loaded with pus and had a musty odor, with a specific gravity of 1016. It contained many colon bacilli; no tubercle bacilli.

In the right loin a tumor of considerable size was palpable; it was tender and gave the characteristic signs of an enlarged kidney. Dr. Johnson said the patient had been referred to him by Dr. Roper, the Associate Attending Physician to the New York Hospital, who had made a diagnosis of probable suppurative lesion of the kidney and had had a radiograph of the kidney region taken by Dr. Caldwell. This picture showed a large branching calculus in the right kidney.

Upon exposing the right kidney, it was found to be composed of a thin-walled sac, from which all secreting substance had disappeared. Its capsule was very tough and adherent, and during its removal it ruptured and the wound was bathed with pus. The ureter was much enlarged and dilated, but basing his action upon his experience with former cases of this character, Dr.

Johnson decided that it would not be necessary to remove more than a small portion of it.

The patient made a good convalescence, and left the hospital at the end of about thirty-three days. At that time his urine still contained a large amount of pus, which probably had its source in the remnants of the dilated ureter. As the latter contracted, the amount of pus gradually decreased, and the patient's urine to-day was almost entirely clear. His general health at present was excellent, all urinary symptoms had disappeared and examination showed that he had no stricture of the urethra.

CARCINOMA OF THE RECTUM; UNUSUAL METHOD OF ANASTOMOSIS.

DR. JOSEPH A. BLAKE presented a man 50 years old, who was admitted to the Presbyterian Hospital on May 20, 1909, suffering from adenocarcinoma of the rectum which had given symptoms of hemorrhage and partial obstruction for about seven weeks. The examination revealed a growth extending upward about three and a half inches above the anus, and therefore above the levator ani muscle.

Operation, May 25, 1909: The abdomen was opened through a median suprapubic incision eight inches long, with the patient in the Trendelenburg position. The growth was found to lie above the level of the reflexion of the peritoneum on the levator muscles, and it occupied about two inches of the length of the intestine. The superior hemorrhoidal arteries were located and tied, and the left ureter identified. About eight inches of the intestine, including the growth, was then excised, together with the retroperitoneal tissue. This was done in the following manner:

The lateral reflexions of the peritoneum having been divided, the gut with its lymphatics was loosened from its bed. Double heavy silk ligatures were then placed about the gut at the points of division, and securely tied. The gut was then divided between them with the Paquelin cautery. It was then found that the ends could be easily brought together, but that there was not sufficient room above the levator ani muscle to carry out an end-to-end anastomosis without great difficulty and soiling of the wound. Therefore, with some misgiving, the cut-off ends, including the ligatures, were stitched together, and the upper and lower segments of the gut were united about them so as to infold the closed ends. Interrupted silk sutures were used for this purpose.

This re-established the continuity of the bowel, with the exception that its lumen was closed by a double diaphragm consisting of the tied ends. The peritoneal reflexions were sutured over the intestinal anastomosis so as to exclude it from the peritoneal cavity. A stab-wound drainage, with a double rubber drainage tube, was carried up from behind and to one side of the rectum to the line of suture. A left inguinal lateral colostomy was made by suturing the sigmoid flexure into a small intermuscular wound, and introducing a tube into the intestine. The abdominal wound was then closed without drainage.

After the operation, which consumed over two hours, the patient's condition was good. At the time of the operation there was considerable doubt as to whether the ligatures tied about the end of the intestine would cut through and the continuity of the canal be re-established. If this did not occur, it was Dr. Blake's intention to break through from below at a later date, when the wound surface had commenced to granulate and infection would therefore be limited. This was found to be unnecessary, as the ligatures and part of the suture line gave way, so that the feces began to come through both the drainage wound behind the rectum and through the anus itself on the fourth day. At first there was as much fecal discharge from the drainage wound as there was from the anus, but the former gradually closed and in four weeks' time the entire feces escaped through the normal passages. The colostomy wound closed of itself.

The patient was discharged from the hospital on July 3, 1909, with normal defecations. There was a postoperative rise of temperature to 101.5, and a return to normal on the sixth day. After that there was a more or less continued temperature from infection of the perirectal tissues, but this gradually subsided.

The histological examination of the growth showed it to be an adenocarcinoma.

At the present time, nearly six months after the operation, there is only a slight narrowing of the calibre of the intestine at the point of anastomosis.

In discussing this case, Dr. Blake said it probably would have been better if a complete colostomy had been done, so that the fecal current would have been entirely diverted from the lower bowel. Healing would then probably have proceeded with less infection.

EXCISION OF THE RECTUM FOR CANCER BY THE PERINEAL ROUTE.

DR. CHARLES H. PECK read a paper with the above title, for which see page 242.

In connection with his paper, Dr. Peck presented two patients upon whom he had operated by this method.

DR. ARPAD G. GERSTER said he thought the most notable feature of the operation described by Dr. Peck was to leave the gut closed after the proximal end had been stitched into the sphincter. This had been found very useful to prevent early infection of the wound, which was most to be feared in the after-treatment.

DR. FREDERIC KAMMERER said that during the past few years he had practically abandoned the operation of resection of the rectum. In his experience, he had only had one case of resection without a preliminary artificial anus in which primary union had occurred throughout. Generally, the sutures gave way at the posterior border of the bowel, where there was no peritoneal covering, and these posterior fistulæ were not so easy to close as one would be led to believe from a perusal of the literature on the subject. As a matter of fact, the correction of deformities resulting from infection and the separation of sutures in amputations as well as resections of the rectum was one of the most difficult problems of plastic surgery. Of course, such mishaps could be to a great extent avoided by establishing a preliminary artificial anus, which, however, condemned the patient to three distinct surgical procedures, a point worthy of consideration.

Dr. Kammerer was furthermore inclined to believe that recurrences were more frequent after resection than after excisions. Considering everything, the best results could be obtained, in his opinion, by the establishing of a permanent inguinal anus and the excision of the rectum, the question being simply how that was best accomplished. He had, during the past five or six years, established a permanent inguinal anus in every case of cancer of the rectum, even of the third uppermost portion. If it appeared necessary, a digital exploration of the pelvis, to determine the question of a possible radical operation and the presence of secondary deposits higher in the bowel, might be made at this time, an advantage claimed for the first step of the

combined operation. After two or three weeks the tumor was then removed by the posterior or sacral route, the lower portion of the bowel having been meanwhile irrigated with normal salt solution several times a day. The change that would very often occur, not alone in the condition of the patient, but also in the size and mobility of the tumor under this treatment was a point not sufficiently insisted on in late surgical literature.

The objections generally raised against preliminary colostomy were the three operations, as against one in the case of a temporary anus, and the fixation of the loop in the inguinal region, preventing a drawing down of the upper end of the bowel to the anus or sacrum after removal of the tumor. The first of these objections has fallen with the permanency of the artificial anus, and as to the second, Dr. Kammerer's experience had taught him that it was much exaggerated. However, in doing a secondary excision it is only necessary to close the stump of the rectum with sutures and to attach it to the incised peritoneum of Douglas' pouch. There is no occasion for an approximation of the stump to the original anal orifice.

This procedure may not be as brilliant as the combined operation in one sitting, but it is an eminently safe operation with a very low mortality, indeed, and it accomplishes practically the same thing. The small stump of the sigmoid that remains had never proved a source of annoyance in the speaker's cases. As a matter of fact, an exploration of the pelvis later on was possible through this opening, when the natural anus is missing.

Dr. L. W. HOTCHKISS said that in two of his cases where he brought down the divided segment of the gut through the anus with excision of the mucosa, sloughing occurred at the posterior point of union, as it usually did. In both instances, however, the wound had healed by granulation. In one of these cases seven years had now elapsed without any recurrence, and in this case there was originally a small stricture, which was easily dilated by means of bougies and gave no further trouble.

Dr. Hotchkiss said that if it was possible to secure union between the cut ends of the gut above the sphincter, without complete division through the sphincter, the functional results were generally very much better.

Dr. JOHN A. HARTWELL said he wished to emphasize the importance of the points brought out by Dr. Kammerer. Three

or four years ago he read a paper on this subject before the New York Surgical Society in which he reported about fifty cases of cancer of the rectum collected from the work of seventeen different surgeons, and of that number of cases the cures after three years were less than 20 per cent. The recurrences were practically all local. In most of the cases that had been reported at the present meeting, the time that had elapsed since the operation was too short, though the primary results were most satisfactory. Personally, he was in favor of a preliminary colostomy, in order to get the patient into the best possible condition, and he was opposed to cutting too close to the malignant growth. In these operations, in considering the immediate comfort of the patient, we should not lose sight of the ultimate outcome. Excision of the whole rectum for any growth that can be reached with the finger from the anus is better than resection and anastomosis.

DR. BLAKE said he had come to the conclusion that the better operation was to excise the entire growth with the end of the bowel. His own procedure had been to establish an artificial anus at the time of the operation. He had operated on twelve or fourteen cases by this method, without mortality. In the case he had shown at this meeting, Dr. Blake said, the patient had told him that there was a slight narrowing at the point of junction, and it was possible that a stricture would develop later on.

DR. HOTCHKISS said the point had been raised in regard to bringing down the sigmoid, whether the operation was done by the high or low method. The old method of skinning back the peritoneal investment was apt to give rise to necrosis and the same was true if the mesocolon was ligated too close to the bowel. The further back from the gut the ligature was placed, the less tendency there was to necrosis.

DR. PECK, in closing, said he had had one rather disastrous result in a combined operation, in attempting to tie the vessels some distance back, near their origin, in the hope that the circulation would be established in the gut below through the loops. Having been rather impressed with the favorable reports of that method, he ligated the vessels close back to their origin. The result at first seemed to be satisfactory, but death from necrosis occurred six days after the operation. That case, he thought could have been saved by an operation from below, or by estab-

lishing a permanent inguinal anus. That experience had discouraged him from further trials of that method, which was advocated by Moynihan.

In regard to splitting the sphincter posteriorly, he favored that method because it gave a rather free exposure and afforded a better opportunity for excising the mucous membrane.

Stated Meeting, November 24, 1909.

The President, DR. ELLSWORTH ELIOT, JR., in the Chair.

CHOLECYSTECTOMY FOR CHOLELITHIASIS.

DR. ALEXANDER B. JOHNSON presented a man, 34 years old, who was taken sick two weeks prior to his admission to the New York Hospital with a dull, aching pain in the right hypochondrium. It shifted for a short time to the epigastrium, but soon reverted to the first location, where it had persisted. He had vomited once with the onset of the pain. There was no history of jaundice; no definite chill nor sweating.

Upon examination, there was slight rigidity and the sensation of a rounded, smooth mass, about as large as a medium sized orange, in the right hypochondrium. The mass, which was not very tender, seemed to extend about two inches below the free margin of the ribs, just below the position of the gall-bladder. The abdomen was otherwise normal, and there was no rigidity outside of this area.

On October 18, 1909, the gall-bladder was exposed through an incision three inches in length. It was then found that the mass was composed largely of adherent omentum, which was in a condition of inflammatory infiltration. Upon separating the adhesions, the gall-bladder was found to be much enlarged; it was necrotic in spots and almost ready to perforate. Upon aspiration, its contents were found to be purulent. The pedicle of the gall-bladder was then clamped, and the sac removed *in toto*. The orifice of the cystic duct was sutured to a piece of rubber tubing which was left for drainage, and the wound was then closed.

The patient made a good convalescence, although he still had a biliary fistula which was rapidly closing. Drainage of the

cystic duct was continued for nine days, and there were no further evidences of infection of the biliary passages. The wound healed by primary union throughout and the patient was now in good condition. The excised gall-bladder was found to contain about 163 stones, nearly all of the same size and shape; *i.e.*, imperfect cubes, the sides one-third inch in length.

FRACTURE OF THE ANATOMICAL NECK OF THE HUMERUS,
WITH DISLOCATION OF THE HEAD INTO THE AXILLA.

DR. JOHNSON also presented a woman, 63 years old, the widow of a physician, who four weeks prior to her admission to the New York Hospital fell in alighting from a railway coach, a distance of about 2½ feet. She struck upon her left shoulder, side and hip. Upon rising, she noticed that her left arm, aside from paining her very severely, was fixed in a slightly abducted position. She consulted a physician, who manipulated the arm and succeeded in getting it adducted, although he heard no click as if the head of the bone had slipped back into the glenoid cavity. Three weeks later the arm was again manipulated for diagnostic purposes, without any result.

When Dr. Johnson first saw the patient, the arm was fixed in a fairly normal position. There was a slight forward axial deviation of the shaft of the humerus. There was no inward displacement of the upper extremity of the shaft; no crepitus nor false point of motion. On passive rotation the tuberosities moved with the shaft. The head of the bone was felt in the axilla. Two X-ray pictures were taken, which established the diagnosis of a fracture through the anatomical neck of the humerus, with dislocation of the head into the axilla.

An operation for the removal of the dislocated head was done eleven days ago by Dr. Johnson, and considering the brief time that had elapsed, the result was very satisfactory. The dislodged head of the bone was approached by a curved incision through the pectoralis major muscle. This exposed the brachial plexus and the axillary vessels, which had to be drawn inward before the bone could be seized and extracted with the lion-jawed forceps. An axillary drain was inserted, which was removed on the second day, and the wound healed in five days. The intense pressure pain from which the patient had suffered was immediately relieved by the operation, although she still

complained of some tingling in the distribution of the ulnar nerve. There was no actual anæsthesia nor definite loss of power.

Dr. Johnson said he hoped that with time and use and under suitable local treatment, the loss of function entailed by the injury would be greatly diminished. So far as he had been able to learn less than 40 of these cases were reported in surgical literature in which the diagnosis had been verified by operation, and the total number, whether verified or not, was under 50.

DR. ELLSWORTH ELIOT, JR., said he had seen two cases of fracture of the anatomical neck of the humerus, with dislocation of the head into the axilla. One of them, which he still had clearly in mind, was operated on three months after the accident. The head of the bone was in the same position as that in the case shown by Dr. Johnson, and over it was stretched the neurovascular sheath. The glenoid cavity was filled with reparative material. The head of the bone was removed, and three years later the movements of the affected arm were equal to those on the opposite side. In this case the pointed extremity of the lower fragment was brought into apposition with the partly obliterated glenoid cavity, and this had evidently established a satisfactory joint. In his second case, Dr. Eliot said, the head of the bone was also removed, and when the patient left the hospital there was a considerable range of motion, especially of abduction, which was the most difficult movement to recover.

CYST OF THYROGLOSSAL DUCT.

DR. ALFRED S. TAYLOR presented a man of 40 years who for three years had had a cyst just above the larynx which gradually became more annoying, so that he asked to have it removed. The operation for this purpose was done on June 18, 1909. A transverse incision was made over the cyst, which extended from the upper border of the larynx to the under surface of the hyoid bone. From this point a small fistulous opening penetrated the hyoid bone and extended to the base of the tongue. The cystic growth was shaped somewhat like an Indian club above the hyoid and ran up to the dorsal surface of the tongue. The cyst below the hyoid had pushed the thyrohyoid membrane backwards until it almost touched the posterior wall of the pharynx. Although the patient is a singer this had not interfered with his voice. The cyst was entirely removed, no drainage was used,

and primary union resulted. The scar can now scarcely be found.

DR. ELIOT said that in young people, particularly, it was quite possible to remove that portion of the cystic tract that penetrated the hyoid bone, as in the case shown by Dr. Taylor. In one case that came under his observation in a child of six or seven years, the hyoid bone was easily divided, and the cyst in its centre was removed. The portion of the cyst behind the bone was then readily removed, and at the completion of the operation the divided hyoid bone was sutured, rapid union taking place, with complete restoration of function. The speaker said he did not know whether after a similar procedure in an adult union could always be relied upon.

PERFORATING DIVERTICULUM OF ASCENDING COLON.

DR. JOHN A. HARTWELL presented a woman, 43 years old, who was admitted to the Presbyterian Hospital on August 30, 1909. For the past ten years the patient had suffered from attacks of abdominal pain coming on at night, which were usually relieved by vomiting. The pain was general in character, but more severe in the epigastrium. It recurred two or three times yearly. Two years ago she had her first attack in which the pain was localized in the right lumbar quadrant; this was accompanied by fever and vomiting and lasted one week. Since then she had had similar attacks every three or four months. She was constipated. Blood had never been noticed in the stools.

The patient, upon her admission to the hospital, was fairly nourished, and her general appearance was good. Examination of the abdomen revealed a mass in the right lumbar quadrant; this was hard, and firmly adherent to the border of the ileum. The vagina and uterus were somewhat fixed posteriorly, and there was tenderness in both quadrants.

Operation, September 12, 1909: After a preliminary curet-tage of the uterus, Dr. Hartwell made a midsuprapubic incision. The uterus was found to be fixed posteriorly by recent adhesions; there were small cysts in each ovary, and a larger one, about the size of a walnut, in the left broad ligament. The cysts were removed, and the uterus lightly suspended. An intermuscular incision was then made over the mass, which was found to consist of the appendix turned up outside and behind the cæcum and

colon, and buried in adhesions. The appendix was greatly thickened, but not acutely inflamed. Its tip was buried in a thickened, hard mass in the wall of the colon, just anterior to the outer half of the mesentery, and when it was dug out the mass was found to have a perforation large enough to admit a probe, which communicated with the lumen of the bowel.

The appendix was removed, and the thickened area in the wall of the colon, about an inch and a half in diameter, was excised and the opening closed with three layers of sutures. The abdominal wall was then closed in layers, with drainage. The patient made an uneventful recovery from the operation, and left the hospital in four weeks, a small fecal fistula having remained opened for about two weeks.

The pathologist's report showed that the specimen removed consisted of the appendix and two sections of the wall of the cæcum, both of which were considerably thickened. In one of the sections there was a small saccule, 8 mm. in diameter, lined with mucous membrane, which appeared to have been pushed through the muscularis. A small perforation was found in the blind end of the saccule. Microscopically, the sections showed a small sac lined with normal intestinal mucosa which was thrown up into small folds. The wall of the sac was composed of fibrous tissue, densely infiltrated with polymorphonuclear leucocytes and lymphoid cells. No muscular coat remained in the wall. Its point of termination on either side of the sac was sharply defined. The terminal muscle fibres showed signs of atrophy, and were being replaced by fibrous tissue.

Diagnosis: Acute suppurative diverticulitis, with chronic appendicitis and typhlitis.

The case showed two points of special interest: first, the absence of the causes usually considered operative in diverticular development, advanced age, excessive fat or excessive emaciation; and second, the locations of the disease in cæcum or the ascending colon instead of the descending colon or sigmoid.

SIGNIFICANCE OF THYROIDISM.

DR. JOHN ROGERS read a paper on the above subject, for which see page 145.

In connection with his paper, Dr. Rogers showed a number

of patients which illustrated the various types of thyroid enlargement.

Dr. Rogers, in reply to a question, said that patients who were suffering from thyroidism usually took ether badly and were poor subjects for operation. When an operation on them was necessary, he thought it should be done under nitrous oxide anæsthesia.

In reply to Dr. Moschowitz as to how he explained the exophthalmus in these patients, Dr. Rogers said he could not explain it. He regarded that as the most obscure feature of the symptom-complex.

Dr. ELIOT said he recently saw in consultation a patient aged 40 years, with thyroid enlargement of six years' standing, who had been operated on for chronic appendicitis. Ether was used; the operation lasted less than an hour. At its completion the patient failed to regain consciousness and developed alternate delirium and stupor. The pulse ranged about 80 for six hours and then rose to 120 or 130. The delirium became more violent, requiring the use of morphine to control it. The temperature gradually rose, and the patient died fifty-six hours after operation, without having regained consciousness. He asked whether the symptoms in such a case could be ascribed to acute thyroidism? This patient had an exophthalmic goitre in a quiescent condition, a moderate acceleration of the pulse being the only symptom associated with a slight increase in the size of the gland, which was readily controlled by weekly applications of the Faradic current.

Dr. ROGERS replied that in the case mentioned by Dr. Eliot there was undoubtedly an acute toxæmia from the effect produced by the ether, probably on the liver. The speaker said he had heard of several similar cases. No remedy for the condition had been suggested.

TUBERCULOSIS OF THE KIDNEY.

Dr. ALEX. B. JOHNSON showed a tubercular kidney with numerous submaxillary tubercles in the cortex and a large superficial tubercular ulcer in the pelvis. Tubercle bacilli were found in the urine before the operation. The lesion was a very recent and acute one. He had never seen a specimen of a tuberculous kidney removed at so early a stage of the disease.