invading the muscular wall, a solid process of cells being seen above and to the right infiltrating the muscle.

There are one or two points of special interest in this case that are worth emphasising. While carcinoma of the appendix in itself is a rare condition, the situation of the tumour in this case is quite unique. The appendix has been divided into two segments, in all probability the result of cicatrisation, and in the sequestered distal portion the carcinoma is situated. This is of interest in view of Ribbert's theory of tumour formation—viz., that tumours arise from a partial or complete separation of cells or groups of cells from their organic continuity, in other words, from mechanical isolation. Although the condition has never been diagnosed, two cases in addition to the one reported above have been suspected beforehand. These two cases are mentioned by C. B. Lockwood in his article on appendicitis in Allbutt's "System of Medicine." In one instance cancer was suspected on account of the family history of cancer; and in the other on account of the marked anæmia, wasting, and loss of energy. This latter corresponds to the present case, in which there were obviously considerable loss of strength, progressive failure of health and weakness, in addition to the localising symptoms, all of which raised Dr. Monro's suspicions. In nearly every instance the symptoms have been those of one or other form of appendicitis, and as all medical men are now alive to the dangers of this condition and the advisability of early removal of the appendix, it is probable that to this is due the favourable prognosis in these cases. I am indebted to Dr. J. H. Teacher, Dr. Monro, and Mr. Rutherford for permission to publish this case.

Glasgow.

Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

FATAL CASE OF SEPTICÆMIA ILLUSTRATING AN IMPORTANT FACT WITH REGARD TO THE LYMPHATICS OF THE UPPER LIMB.

BY W. BARRIE BROWNLIE, M.B., CH.B. GLASG.

A FARM labourer, aged 25 years, was seen on May 22nd by my chief, Dr. C. N. Thomas. The patient was suffering from a painful swelling below the left clavicle. It had appeared two days before Dr. Thomas saw him. As the patient looked very ill it was thought advisable to remove him to the Lydney Hospital, to which place he was taken the same night. The temperature on admission was 100° F., and the pulse was 130. When I saw him on the following day I found that the infraclavicular fossa on the left side was filled up by a diffuse, hard, red swelling shading off into the surrounding skin. There was no fluctuation even on deep pressure. Considerable cedema was present, especially at the margins of the swelling. The shoulder-joint was quite free from pain on movement. There was no thickening of the clavicle, nor was any pain elicited when deep pressure was made over that bone. The axilla was quite free from glandular enlargement, and the inflammatory swelling had not invaded that region. Examination of the lungs showed nothing abnormal. The state of the pulse suggested that there was some severe microbic infection. There was a history of the man having had some inflammatory lesion which had gone on to suppuration round the nail of the left forefinger a fortnight ago, and although this had now quite healed up one could easily make out that there had been some acute inflammation in that region. As we could find no other point of infection we came to the conclusion that this was a case of acute lymphadenitis of the costo-coracoid glands following on a paronychia of the left forefinger. On the evening of the 23rd the patient seemed a little better, the pulse having somewhat subsided. On the 24th the pulse had again risen, this time to 140; the temperature still remained 100°. The swelling and cedema had now extended over the sternum to the right side of the chest, downwards to the nipple, and over the clavicle and shoulder. The same night the patient had a rigor, the temperature shooting up to 104°, and although no fluctuation could be

made out it was decided to open up the parts. The swelling was now covered with large vesicles filled with blood-stained serum. An incision about 3 inches in length was made in the interval between the pectoralis major and the deltoid muscles. Although a deep incision was made and the parts were opened freely by Hilton's method, no pus was found, only blood-stained serum coming away. Owing to the gangrenous condition of the parts, the muscles being swollen and flabby and the patient not feeling the incision, a bacteriological examination was made of the fluid which came away, but only streptococci were found. A large drainage-tube was inserted and the region was kept moist by a wet cyanide gauze dressing. On the next morning (the 25th) the patient had another rigor, and another swelling, of a similar nature to that on the chest, appeared on the right side of the neck behind the angle of the jaw. The nature of this was somewhat obscure; probably it was a thrombosis of the internal jugular vein. The pulse was scarcely perceptible and the patient died on the night of the 25th, the intellect being perfectly clear to the end.

In a general way we understand that an inflammation of the finger may spread to the glands of the axilla, although it is mentioned in some anatomical books that some of the lymphatics from the backs of the fingers may go along with the cephalic vein to the costo-coracoid group of glands in the infraclavicular fossa. This is a point which is not sufficiently emphasised, and several of these cases have been demonstrated to me, as a student, by Dr. Farquhar McRae of Glasgow. The lymphatics of the posterior aspect of the thumb, forefinger, and radial side of the middle finger frequently, though not invariably, with those of the radial side of the back of the forearm and back of the shoulder, go to the costo-coracoid glands, and this was the path of infection in this case. This state of affairs is perhaps more dangerous to the patient, as the costo-coracoid glands are nearer the great veins of the neck and also a step nearer the thoracic duct, as some of their efferent lymphatics empty directly into the subclavian vein (Quain). Perhaps one might argue that the paronychia of the left forefinger had not caused the blood-poisoning in this case, as that lesion had occurred a fortnight ago and the wound had quite healed up by the time the swelling on the front of the chest appeared; but we know well enough that organisms can lie quiescent in a gland until some slight injury may cause them to set up a severe inflammation. This seems to have been the sequence of events in this case, as the clear history of the paronychia a fortnight ago and the presence of a recent scar at the time of examination decided us in coming to no other conclusion.

I do not think that an earlier incision into the swelling would have saved the patient's life, as it was an inflammatory cedema and could scarcely be called an abscess, a condition of affairs which we would quite expect from an organism like the streptococcus. The infection was of such a virulent nature that I do not think antistreptococcal serum would have done any good in this case.

Lydney, Gloucestershire.

A CASE OF TUBERCULOUS TESTICLE IN A CHILD AGED SIX MONTHS.

BY W. F. CHOLMELEY, F.R.C.S. ENG.,

HONORARY SURGEON TO THE WOLVERHAMPTON GENERAL HOSPITAL.

ON July 24th I was consulted about a child, aged six months, with a swollen, red, and very painful scrotum. The history given was that the swelling had been first noticed on the 19th and was supposed to have come on after an injury. On examination the scrotal tissues on the right side were found to be very inflamed and swollen but so painful that it was not possible to say if the testicle was affected. The child looked healthy and had been so since birth. The cord seemed to be slightly thickened. The child was admitted into the hospital and I ordered hot fomentations. The case improved very quickly, but on account of an outbreak of measles in the ward the child had to be sent out on July 28th before he was quite well. While outside the pain and swelling increased and became so bad that I had to admit the child again on August 4th.

The note made at that time is as follows: "The skin covering the left half of the scrotum is much reddened, and there is a large tender swelling occupying the natural position of the testicle, evidently an inflammatory enlargement of

that organ. The cord feels thickened; the vas deferens cannot be felt. The temperature is normal." Thinking that it might be a case of torsion of the cord I decided to explore. On August 6th an incision was made in the inguinal region and the testicle in its thickened and distended tunica brought out into the wound. The layers over the tunica were much thickened and on opening it a quantity of turbid fluid escaped. The opening was enlarged and the epididymis was seen to be much enlarged and overlapped the body of the testicle. Under the globus major was a small collection of tuberculous-looking pus. I therefore removed the testicle. A section of the organ after removal showed numerous small caseating foci in the epididymis; the body of the testicle appeared to be healthy. Unfortunately, on August 11th the child developed measles and later broncho-pneumonia and died on August 19th.

A post-mortem examination was made and tubercle was found in the following organs: in some bronchial glands, in the left pleura, in both lungs, especially in the left, where there were some caseating foci, in the mesenteric glands, and in the left kidney, which was hardly developed at all. There was no tubercle found in the head or in the region of the bladder. Part of the testicle was sent to the Clinical Research Association and they reported as follows. "This testicle shows large inflammatory areas and a considerable degree of fibrosis. The inflammatory areas contain caseating foci and show some atypical giant cell systems. Although we cannot find any tubercle bacilli we feel sure the lesion is tuberculous."

Wolverhampton.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

SURGICAL SECTION.

President's Address.

A MEETING of this section was held on Oct. 13th, Mr. RICKMAN J. GODLEE, the President, being in the chair.

The PRESIDENT, in delivering his Address, said that prognosis in some of the common inflammatory diseases of the chest belonged at least as much to the physician as to the surgeon. The first and simplest condition was that of serous effusion into the pleura associated with acute pleurisy. They would all agree that patients who had had one attack of acute pleurisy with effusion and had been tapped once or twice, or not tapped at all, usually left the court without a stain upon their characters. They were admissible by insurance companies at normal rates, and the only record that remained (and that not always) was a slight departure from the normal physical signs, and perhaps of the mobility of the side that had been affected. The acute onset usually stamped their simple character. It was different when the onset was insidious. It had sometimes been suggested that most of the insidious cases were tuberculous. But it was no more true that they were all of that nature than it was that all the tuberculous effusions were insidious in their onset. He would expect an acute case to be caused by some septic organism and would be suspicious that a chronic one would turn out to be tuberculous even if no tubercle bacilli were found microscopically or by inoculation, with the mental reservation, however, that it might depend on a new growth. What was the outlook if a normal pleura was opened and drained? It had often been stated that an abscess of the liver might be safely opened through a normal pleura without any special precautions for closing the opening. This was not his experience. He had seen it followed by fatal results in septic cases or by very slow healing in amœbic ones. That was why he avoided injuring the pleura if possible and carefully closed the wound if it had been made. Were they justified, then, in incising and draining serous effusions that re-accumulated? To that different answers would be supplied. For himself, he was so afraid of leaving a permanently open pleura with collapsed lung that he advised repeated tapping, even up to seventy times seven, tedious though the process was. An effusion which was undoubtedly

tuberculous need not necessarily involve a very grave prognosis, one tapping being sometimes enough to effect a cure. Passing to the subject of empyema, he first offered some general remarks about the acute empyema of infancy. In 1886 he gave statistics when he was surgeon to the North-Eastern Hospital for Children and the average time for closure was six weeks. But that did not represent the usual course of things, three or four weeks was a common time for an acute empyema, and ten days or a fortnight was not rare, while a good number were cured by a single aspiration. The average was obtained by including the chronic cases. He did not gather that much better results were obtained now, although one might imagine that each successive writer on the subject had discovered some new panacea. A free opening, good drainage in the recumbent as well as the erect posture, the complete removal of all fibrinous masses, and the exercise of a wise judgment in removing the drainage-tubes were essential to success. The precise spot to half an inch at which the opening was made, the introduction or not of the gloved finger, and the presence or absence of an antiseptic material in the dressings were matters of less vital importance. The soft chest walls of children and the elasticity of all their structures, and perhaps their more active vital power, seemed to favour the rapid closure of an empyema. Such cases were, he believed, common, almost typical, and he wished the medical officers of insurance companies would tell them something about them. They must apply for life insurance, and one would like to know whether any increased rate was imposed upon them. He should himself not advise it. He was afraid the particular answers desired were not to be obtained from insurance companies. It did not help them to know the average age of the patients insured (say in the Scottish Widows' Fund) who died from pleurisy and empyema, and it did not seem possible to obtain information as to the results from the point of view of the insurance companies of accepting proposals from those who had suffered from hydrothorax or empyema in childhood. Turning to acute empyemas in adults following acute pneumonia or pleurisy, the immediate prognosis as regards life depended upon the extent of the preceding disease and the amount of septic poisoning. The latter was indicated by the character of the pus; if that was sweet and only contained pneumococci the patients did not necessarily present what might be called an obviously septic appearance. If they did, and the pus was odourless it probably contained streptococci or staphylococci. If it stank there had probably been a rupture of a pulmonary or subdiaphragmatic abscess into the pleura. The pneumococcus cases if treated carefully antiseptically he thought did the best, especially if the lung was still somewhat solid from the pneumonia and the cavity was localised; but he had often seen (especially in hospital) a secondary pyrexia associated with a secondary septic infection. It was remarkable how well many of the stinking cases did. Some of the very worst septic ones might be snatched from death by continuous or repeated saline infusions or transfusions. Undoubtedly the great majority of those cases survived the operation, and he was not concerned with the small number who died within a few hours or days of it. An accurate prognosis as to the date of closure was impossible. Speaking generally, it might be said that the least favourable cases were those in which the cavity was large, or the lung was much collapsed, or the chest walls were very rigid, and those in which there was a very free communication with a bronchus. His own opinion was that those which were opened laterally were more likely to be slow in healing or to require a second opening than those which were incised posteriorly. So he thought that the prognosis was to some extent governed by the surgery. One would naturally expect that old people would do worse than young ones, but some healed remarkably quickly. Of the cases that healed the great majority remained well or had very slight inconveniences left behind. A small number had recurrences and some developed bronchiectasis. Although it was an undoubted fact that a small proportion of empyemata which burst into a bronchus recovered completely in the course of a few days or weeks, and that such a cure might be permanent (he had records of one case who remained well after 17 years), it might be stated that the majority of them required an external incision. But in most of those the fistula quickly closed and healing occurred as if there were