sent in this case and there was not even muscular rigidity on palpation.

Incidentally I should like to call attention to the discrepancy between the urinary examination during life and the condition of the kidneys only thirty-six hours later. Although these organs were acutely fattily degenerated, the urinary sediment suggested nothing more than decided renal irritation or hyperemia.

II. RAPID SARCOMATOSIS.

T. S., thirty-six years of age, single, of negative family and previous history, and good habits, entered the Massachusetts Hospital March 6, 1894. He was well until two and one-half weeks before entrance, when he began to have pain in the back and malaise, his work—that of an insurance agent—requiring effort. Several days later he had a sharp pain like a stitch just to the left of the small of the back which made him scream, but soon passed off. Some malaise and pain in the back continued, but he kept at work. March 1st, after a sleighride, he had a chill lasting for ten minutes, not followed by sweating. The two next days he felt miserable, suffered from severe pain in the back and legs but went to business. At night at this time he had no pain. March 4th he thrashed round on the sofa all day on account of pain and nervousness and then sent for Dr. H. P. Jaques of Milton, where he lived. Morphine was given with relative relief to the pain but impairing the appetite and binding the bowels. The pain came in entire side and even when he was lying still.

When admitted to the hospital two days later, physical examination was negative except for tenderness in the small of the back.

March 13th. Several small subcutaneous nodules were discovered over the lower sternum, movable, not tender. The next day others were found in the axillæ, back, front of chest, and over the right biceps. One of these was excised and examined by Dr. Whitney, who pronounced it sarcoma. The skin over some of the nodules was discolored by hemorrhage.

A blood count showed:

Red	2,637,000
White	24,000
Hemoglobin	50%

The differential count of the white by Dr. R. C. Cabot was as follows:

Polymorphonuclear neutrophiles	70%
Lymphocytes	19
Large mononuclear in transition	3
Eosinophiles	1
Myelocytes and small mononuclear neutrophiles	7

March 21st. Decided enlargement of the liver was made out but pain has disappeared and was absent afterwards. The breathing became labored and wheezy, with inspiratory retraction of the soft parts above and below the thorax. The spleen became palpable and April 7th he died. There was almost constant but irregular pyrexia throughout. The autopsy was by Dr. Whitney and may be abstracted as follows:

No nodules below waist line. Some in scalp, over clavicles, and scattered over chest, upper abdomen and back.

Masses, plates and nodules of new growth in mediastinum, heart, lungs, pleura, lower dorsal vertebræ extending into the spinal canal but not into the cord, omentum, mesentery and intestines, spleen, liver, kid-

neys and adrenal bodies. The marrow of the femur was normal. Glycerine-agar cultures from the various organs were negative. This case ran its course in about six weeks from the first symptom, between four and five weeks from the time when a physician was first summoned. The first subcutaneous nodule was found between three and four weeks before death.

It seems probable that the disease started in or near the dorsal vertebra, where pain was first noticed, and thence rapidly spread. The blood examination was remarkable only for the chloranemia and the increase in the percentage of the myelocytes and small mononuclear neutrophiles.

AN IMPACTED GALL-STONE REMOVED BY OPENING THE COMMON DUCT, THE WOUND IN THE DUCT BEING CLOSED BY SUTURES.¹

BY J. W. ELLIOT, M.D.

THE patient, a laundress, aged thirty-nine, had been subject to occasional bilious attacks for fifteen years. Ten years ago she had a very severe attack, and five years ago another. During the last two years they have become more frequent, so that in the last year she has had six or eight. In the last two months she has had an attack with vomiting almost every week. She has lost flesh and strength. Five days before I saw her she had an attack so severe that she left her work and went to bed. She had fever and chills and a severe pain in the right side and middle of abdomen. She thought she had not been jaundiced, and the bowels had moved.

She entered the Massachusetts General Hospital in the evening of February 1, 1893, with a temperature of about 102° and a pulse of 110. Dr. Fitz and I saw her soon after her arrival.

She had a moderate general icterus. The abdomen was full and tympanitic, except in right hyperchondrial region, where there was a pyriform tumor continuous with the liver-dulness, occupying nearly the whole of the right side of the abdomen, extending below the anterior superior spinous process. This was dull on percussion, fluctuating, with rounded borders, and moderately tender. The rest of the abdomen was not tender. The general condition of the patient was one of suffering and exhaustion and seemed to demand immediate relief.

The diagnosis was not made, as we were unable to get any of the above history owing to the patient's critical condition, and the jaundice was not noticed in the electric light.

Operation.—An incision was made above and to the right of the umbilicus over the most prominent part of the tumor. It was found to be a very much enlarged gall-bladder, which contained about three pints of bile and twenty gall-stones. Its contents being evacuated, the gall-bladder wall, which was much thickened, was stitched into the abdominal wound. No attempt was made to clear the ducts of stones, as the pulse had become rapid and weak during the operation.

The patient rallied well from the operation, and gradually improved; but a large amount of thick, tenacious bile continued to pour from the gall-bladder, and the stools remained white. The patient was still jaundiced, but less so. For the next two months the

¹ Read before the Surgical Section of the Suffolk District Medical Society, March 7, 1894.

patient remained in poor condition. There was occasionally a rise in temperature and a chill. She had frequent attacks of pain and vomiting, which were relieved by a copious discharge of bile from the opening. The ducts were twice explored — once by Dr. Homans and by myself with a finger and a sound passed into the gall-bladder; but no stone could be detected.

On May 22d, the above-mentioned attacks continued; the stools were still white, and the patient was losing flesh and looked poorly.

Operation. — The abdomen was opened just inside the sinus which remained where the gall-bladder had been stitched to the abdominal wall at the first operation. After the adhesions about the gall-bladder were cleared away, an examination of the duct was made with one finger in the gall-bladder and the other hand in the abdominal cavity. A large stone was finally found impacted in the common duct near the duodenum. It was found impossible to reach this by an instrument passed through the gall-bladder. The duodenum was in front and adherent to the common duct. The duct was dissected clear, and the region was packed with gauze. The duct was then incised, and a stone as large as a pigeon's egg extracted. Several smaller stones were found in a pocket in the duct near by. The finger was then easily passed back into the cystic and hepatic ducts. The incision in the duct was closed with silk sutures, and gauze was packed about this part of the duct and brought out through the abdominal wound. Two separate dressings were used, one for the operation wound and another for the sinus of the gall-bladder. The wound dressing was kept separate and dry by a collodion partition.

The patient did very well. The wound healed without trouble. The discharge from the gall-bladder soon lost its color of bile, and became a clear, thick, tenacious fluid like glycerine.

On June 1st, there was much less discharge from the sinus, and the stools became yellow for the first time. During June and July the patient improved slowly. She often had attacks of pain in the back and side accompanied by nausea. At the suggestion of Drs. Cutter and Cabot, she took salicylate of soda with great benefit. In August she gained flesh and strength and went to Ireland in good health with a small sinus from the gall-bladder.

According to Murphy² this operation has been done five times with two deaths, a mortality of forty per cent.

This is perhaps the most valuable procedure in gall-bladder surgery, as the common duct must be cleared. In difficult cases incision is less apt to injure the duct than the crushing or needling of a stone. Its hitherto high mortality is its only objection. This success leads me to hope that the mortality can be reduced.

AN OVARIAN CYST SIMULATING A STRANGULATED UMBILICAL HERNIA.

BY GEORGE G. HOPKINS, A.M., M.D.,
Surgeon to St. John's Hospital.

FLORA FADER, aged fifty-seven years, married, Scotch.

Admitted November 27, 1893, for a strangulated umbilical hernia. We were sent for immediately, supposing it to be an intestinal hernia.

² Medical Record, January 20, 1894.

We found a tumor protruding just below the umbilical opening. It was about the size of a walnut, and very dark — almost black. All aseptic precautions having been taken, ether was administered. Assisted by the house staff we proceeded to nick the strangulating band, guarding the tumor with a broad, flat director. The constriction being relieved the tumor at once disappeared; but to our surprise fluid began to discharge by the opening, but there being no odor, we felt sure that our first thought was *wrong*, that is, rupture of the intestine. We enlarged the opening to two inches, and serous and gelatinous matter began to discharge. Exploration with the fingers discovered that a tumor occupied a large portion of the abdominal space.

This tumor proved to be a multilocular gelatinous cyst of the right ovary, of an estimated weight of twenty-five pounds. It was entirely free from adhesions. It was necessary to extend the incision seven inches in order to remove the tumor. The pedicle was secured with sterilized braided silk, cut short and dropped in the abdomen. The pedicle was treated with crystallized carbolic acid, after division. The toilet of the abdomen was made with great care. It was twice irrigated with Tiersch's solution. The wound was closed with deep sutures, including all the tissues. No drainage-tube was used.

This unpromising patient — an ambulance case — never had an unfavorable symptom. The temperature never reached 100° F. She was discharged from hospital December 28, 1893, cured.

Reports of Societies.

SURGICAL SECTION OF THE SUFFOLK DISTRICT MEDICAL SOCIETY.

C. L. SCUDDER, M.D., SECRETARY.

REGULAR meeting, Wednesday, March 7, 1894, DR. ABNER POST in the chair.

DR. LUND showed a

PORTABLE TRENDLENBERG TABLE.

DR. W. T. COUNCILMAN showed two specimens illustrating

LESIONS OF THE INTESTINAL CANAL.

One of these comes from an officer in the late war. The case was as follows: This officer was shot in the right flank by a Minié-ball. The ball entered the right flank a little posterior to the lateral median line and about five centimetres above the crest of the ilium. The course of the ball was backward and a little downward and emerged from the back just posterior to the spine of the second lumbar vertebra. He lay on the field of battle all night. He was removed to a hospital and it was said that evidences of peritonitis appeared. He was supposed to have had a general peritonitis and fecal matter was discharged from the wound in the back. A short account of the history of the case is given in the Surgical Volume of the War of the Rebellion, in Part II, p. 78. The case was supposed to be one of remarkable recovery after gunshot wound perforating the colon. He was in the hospital for some time after that, and finally recovered. It was supposed that the colon had been perforated by the ball, and also that the ball had injured the spinal