RESECTION IN CONGENITAL DISLOCATION OF THE HIP.

Lampugnani. *Centralblatt f. Chirurgie*, May 7, 1887.
 Du Paoli. *Centralblatt f. Chirurgie*, April 23, 1887, p. 337.
 Albert. *Wiener Med. Presse*, 1887, No. 13, p. 434; also, *Berliner Klin. Wochenschr.* No. 22, 1887, p. 398.

CLUB-FOOT.

Beely. Appliance for abduction. *Centralblatt f. Orthopädische Chirurgie*, October 1, 1887, p. 90.
 Scudder. *Boston Medical and Surgical Journal*, October 26, November 2, 1887.
 Schede. Open incision in club-foot in contraction of knee-joint and in torticollis. *Centralblatt f. Orthopädische Chirurgie*, 1887, p. 76.
 Wrench for treatment of club-foot. H. O. Thomas. *Provincial Med. Journal*, June 1, 1886, p. 286.
 Treatment. *Brit. Med. Journal*, November 27, 1876.

OTHER SUBJECTS.

Congenital hypertrophy of foot. Duploux. *Bull. et Memoir de la Société de Chirurgie de Paris*, T. xii, p. 344.
 Flexion of the fingers, toes, Dupuytren's contraction and some senile changes of joints. Arbutnot Lane. *Guy's Hospital Reports*, 1886.
 Spina bifida, cured by a new method after rupture of the sac. *Glasgow Med. Journal*, February, 1887.
 Adhesive plaster in orthopædic surgery. *New York Medical Journal*, June 4, 1887.
 Buttersack. Congenital cartilaginous remains in the neck. *Virchow's Archives*, Bd. cvi, p. 206, ff.
 New osteoclast. Ferrari. *Archiv. f. Orthopædia An.* iv, Fasc. T., *Centralbl. f. Chirurgie*, No. 39, 1887, p. 726.
 Graser. Caput obstipum. Open incision. *Centralblatt f. Chirurgie*, No. 39, p. 729, 1887.
 Schéde. *Deutsche Med. Woch.*, 1886, No. 38.

Clinical Memorandum.**HYDRONEPHROSIS SUPPOSED TO BE OVARIAN TUMOR.**

BY S. H. WEEKS, M.D.,
Professor of Surgery in the Medical School of Maine.

BELIEVING, as I do, that this case will be of some interest to the profession, I have prepared the following report for publication. I am indebted to Dr. Alfred Ring, Surgical House Pupil at the Maine General Hospital, for a copy of the Hospital records.

Mrs. M., admitted to the Hospital November 6, 1884. Age, thirty; married; residence, New Hampshire; nativity, Vermont. Has had three children; youngest seven years old. Labor easy, and she got up from each confinement in good condition. Menstruation has usually been regular in time and amount; at times, would extend over several days, and, at such times, be excessive. Patient has been a hard-working woman; appetite fair, bowels regular, weight 138½ pounds. History: In April, 1880, first noticed a bunch about the size of an egg in the right ovarian region. The pain through this mass was sharp and lancinating. During this time, the patient had lung fever, followed by rheumatism in her lower extremities. The growth of the mass, at first, was gradual; but, during the past year, it has been rapid, and the tumor has greatly interfered with respiration, though, at date, the difficulty in respiration is less than it was; the tumor also presses on the liver, though the size of the tumor is less than formerly. Patient states that the size has varied; that when she would pass much water, that there would be a diminution, and when little urine was passed, that the size of the tumor would increase. As soon as she entered the Hospital, she was ordered pulv. effervescens comp., No. 1, every morning; also pil. quin. sulph. gr 2., after each meal.

November 8th. Examination made by the surgical staff; patient first on back, and then in Sims's posi-

tion. Fluctuation distinctly detected; uterus in normal position, and of normal depth. The diagnosis was ovarian tumor, and an operation for its removal was advised. Examination of the urine showed: color, light straw; odor, normal; specific gravity, 1007; albumen present. She was ordered fifteen grains of bromide of potassium each night at bed-time.

November 10th. Enema given in the morning. At 11 A.M. the patient was etherized, and, in the presence of the surgical staff, and a part of the medical staff, the operation for the removal of the supposed ovarian tumor was commenced. I made the incision in the median line in the usual way, and, on opening into the abdominal cavity, the mesentery was first brought into view, then the bowels and the tumor, covered in front by the peritoneum. Instead of finding an ovarian tumor with a pedicle, I found a cystic kidney. The contents were drawn off by the trocar, which presented a limpid, yellow, and opalescent appearance. About two-thirds of the cyst was removed by the scissors, all hæmorrhage controlled, and the cyst-wall was stitched with silk to the edges of the incision (upper part). The adhesions of the tumor to adjacent structures prevented the entire removal of the cyst. The abdominal wound was closed with four silver sutures. Two rubber drainage-tubes were introduced into the cavity of the remaining cyst, the abdominal cavity being thoroughly shut off from the cavity of the cyst. During the operation the pulse became weak, and f 3i of brandy was given hypodermically. Time of the operation, one hour and ten minutes; weight of tumor, seven pounds.

Recovered well from the ether. No spray was used, but strict antiseptic precautions were observed throughout. 12.30 P.M. f 3i of brandy was given by hypodermic injection. At 12.55, a tablet, ½ morphia, and ⅓ atropia, was injected beneath the skin. Pulse 108, temperature 98½°, respiration 24. Brandy, f 3i hypodermically. 5.45 P.M. ½ gr. morphia, to be repeated every four hours until otherwise ordered. 8 P.M. Urine drawn (as also for the few succeeding days); small amount, some sediment. Pulse 116, temperature 90.8°, respiration 26.

November 11th. 2 A.M. Slight attack of vomiting. Slept some during the night. 7.30 A.M. Pulse 120, temperature 100.4°, respiration 22. Very comfortable. 9 A.M. Detected some oozing from wound. The wound was examined, and a small bloodvessel was found in upper part of wound, from which the blood came. This was readily secured by catgut ligature. The antiseptic gauze was reapplied. Patient began to take lime-water and milk—two tablespoonfuls of milk, and one of lime-water every two hours. 5.45 P.M. Pulse 128, temperature 102.2°; brandy f 3iii during the afternoon.

November 12th. 9.30 A.M. Pulse 106, temperature 100.8°, respiration 20. Slept fairly well during night. Wound ordered dressed three times daily, as there was considerable discharge of a sero-purulent character. Milk and lime-water to be increased. 5.25 P.M. Pulse 122, temperature 102.2°.

November 13th. 8 A.M. Pulse 108, temperature 101°. Slept some during the night; is in good spirits. Wound dressed, and looking well. Since noon, beef-tea has been given alternately with the milk and lime-water. During the day, gas passed the bowels. 9 P.M. Pulse 122, temperature 101.8°. Able to take some lemonade, which she found very grateful.

November 14th. 8 A. M. Pulse 103, temperature 100°. Rested well during the night. The discharge from the wound slightly bloody. 7.10 P. M. Pulse 108, temperature 102.4°.

November 15th. 8 A. M. Pulse 101, temperature 100°. 7 P. M. Pulse 112, temperature 102.8°.

November 16th. 8 A. M. Pulse 98, temperature 100.2°. 7.30 P. M. Pulse 102, temperature 102°. Very comfortable day. Morphia reduced to $\frac{1}{4}$ gr., still continued every four hours.

November 17th. Morning: Pulse 100, temperature 100.8°. Evening: pulse 104, temperature 102°. The silver sutures were removed. Wound discharging freely. At night, ten grains quinine given per rectum, which caused a slight movement from the bowels, which somewhat fatigued the patient. Brandy f 3ss given by the mouth.

November 18th. A. M. Pulse 94, temperature 100.2°. Quinine, gr. x, per rectum, causing a slight movement from the bowels. Pulv. eff. co., No. 1, given at night.

November 19th. A. M. Pulse 100, temperature 100.2°. P. M. Pulse 92, temperature 101°. Enema given in the morning, followed by slight movement. Wound discharging freely. Syringed wound with bichloride solution, 1 to 2500. Amount of morphine given every four hours reduced from $\frac{1}{4}$ to $\frac{1}{8}$ gr. Took solid food (steak, etc.) for the first time since the operation.

November 20th. A. M. Pulse 100, temperature 100°. P. M. Pulse 104, temperature 100.2°. Patient bright, and taking more nourishment. Four silk sutures removed from cyst-wall, ordered wound dressed four times daily, and pil. quin., gr. ii, after each meal. Slight attack of vomiting at night.

November 21st. Slept well during the night. A. M. Pulse 96, temperature 99.8°. P. M. Pulse 108, temperature 100.8°. Ordered beef-tea, one-half cup given per rectum every four hours; also quinine, gr. iii, with each injection. Quinine pill by mouth discontinued. Slight attack of vomiting at night. Pulv. eff. co., No. 1, at bed-time, resulting in movement at 3 A. M.

November 22d. Some vomiting in the night. A. M. Pulse 95, temperature 99.2°. Champagne f 3i given at intervals during the day. Beef enema given every four hours for the day.

November 23d. A. M. Pulse 83, temperature 99.6°. Carbolic acid gauze used on wound. Two beef-tea enemata given in the day. P. M. Pulse 86, temperature 100.6°.

November 24th. A. M. Pulse 90, temperature 99.4°. P. M. Pulse 84, temperature 100.8°. Patient feeling very well.

November 25th. A. M. Pulse 79, temperature 99.4°. Enema given in the morning, followed by movement. Bowels slightly distended with gas. Pulv. eff. co., No. 1, given at night, but not retained by the stomach. Quinine, gr. ii, now given every four hours. Morphia, gr. $\frac{1}{4}$, every four hours.

November 26th. A. M. Pulse 88, temperature 100°. enema given, patient feeling nicely. P. M. Pulse 88, temperature 100.2°. At night had chill, which lasted about half an hour; hot bags and extra blankets applied. Pulse 116, temperature 100°. Quinine, gr. vi, given, and champagne. 10.40 P. M. Pulse 81, temperature 100°. Feeling much better.

November 27th. Patient ate hearty Thanksgiving

dinner. Sleeps well nights. The wound is discharging a fair amount, and is dressed four times daily.

November 30th. Wound now dressed three times daily.

December 2d. Slight accumulation of pus at lower angle of wound, where the lowest silver suture passed through abdominal wall.

December 6th. Since last date, the pulse has not exceeded 92; this A. M. it was 104. Temperature not higher than 100.2°; this A. M., 100°. Pus accumulated again in the lower angle of wound. Poultice applied. In other respects, patient doing well.

December 14th. Exuberant granulations about the edge of the wound. Touched with nitrate of silver.

December 16th. Granulations not as prominent. There has been an increase in the discharge since the caustic was applied.

December 18th. Patient up and on the lounge for the first time.

December 25th. Has been up each day since last date. To-day, was able to walk out to the nurses' room.

December 26th. Nitrate of silver again applied to exuberant granulations.

January 5, 1885. Since last date patient doing well. Wound dressed three times each day; discharge small; drainage-tube still kept in. Menstruation began.

January 7th, 10th, 16th, 20th. Patient able to walk a little each day.

January 20th. Patient removed from private room to the ward. Wound now dressed morning and night. The discharge is small. Appetite still continues good. Is gaining in strength. Bowels are regular.

January 21st. Nitrate of silver again applied to exuberant granulations.

January 31st. Since last date, patient's general condition continues to improve. The wound remains about the same, though the discharge is slightly less. The edges of the wound about the drainage-tube have healed.

February 1, 1885. Patient discharged, her general health all the time improving. The wound still discharges, the discharge being thin and watery, but no odor of urine, although I am confident a large part of the discharge is secreted from the walls of the remaining portions of the cyst, in which there seemed to be portions of the cortical structure of the kidney.

The question would naturally arise: why was not a correct diagnosis made before the nature of the tumor was revealed by the operation? It is a fair question, and should receive an answer. The early history of the case tended to mislead the surgeons. I am satisfied that the organ was a "floating kidney" before it became the seat of hydronephrosis, and that this displacement led to obstruction of the ureter, thus causing a dilatation of the pelvis and calices of the kidney by urine, and atrophy of the renal substance, followed by expansion of the capsule, and of what remained of the cortical and medullary substance of the organ.

It will be noticed that the history of the case showed that four years before the operation, she noticed a bunch about as large as an egg in the right ovarian region. In this respect, it strongly resembled an ovarian tumor. In fact, one of our hospital staff, a very skilful diagnostician, saw the patient in the early history of the growth, and, finding this mass in the right ovarian region, pronounced it ovarian tumor. In my experience, it is something entirely new to find a cystic

kidney in such a position. At the time of the examination, with such a history before us, and finding the whole abdominal cavity filled with a cystic tumor, resembling in every particular an ovarian cyst, I feel sure that such a mistake in diagnosis could not have been avoided. I am free to confess that, when I had finished my examination, I felt morally certain that the tumor was ovarian. The appearance of the cyst at the time of the operation may be of some interest: The anterior part of the cyst-wall was as thin as that of an ovarian cyst. As I approached nearer to the base of the tumor, the cyst-walls were thicker, and, at some points, there seemed to be cortical structure of the kidneys very much expanded. The pyramids seemed to be entirely wasted, and the calices were converted into huge spaces or sacs. The patient has been heard from several times since she left the Hospital, and her reports show that her general health has been excellent, being able to do hard manual labor. The last report, about a year ago, stated that there was then a small, fistulous opening, with some discharge, but not enough to cause much inconvenience.

Reports of Societies.

BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.

E. M. BUCKINGHAM, M.D., SECRETARY.

OCTOBER 24, 1887. The President, DR. O. F. WADSWORTH, in the chair.

DR. ABNER POST showed two cases of
REMOVAL OF THE SHAFT OF THE TIBIA. REPRODUCTION OF BONE FROM THE TIBIA.

The first case was a boy, injured by a blow from a sled, about Christmas. An abscess had formed and had dissected away the soft periosteum from the bone. This was opened in December. The shaft of the tibia became necrosed as a result of the abscess. On the 28th of May all of the shaft of the bone was removed leaving the periosteum. The ends of the channel thus formed were scraped, and the knee-joint was perforated. Bleeding was startling, the blood oozing from every part of the wound. This was controlled by elevation of the part, but it left the patient in a precarious condition. He rallied, however, and the leg which was then limp is now stiff from reproduced bone.

The other case is a girl, upon whom the same operation was done, July 28th. Her leg was kept stiff by means of plaster-of-Paris, and has healed faster, the condition being now the same as that of the boy. She had had rheumatism, but the cause of bone destruction was not so evident in her case as in the other.

DR. W. C. B. FIFIELD said that he was pleased to see these cases. The history of the operation is interesting. It was first done by Graldis in 1861, and was repeated by him up to the time of his death. The disease seems to have been a phlegmonous periostitis. In the case of a child, whose broken tibia had united at an angle, the French surgeon sawed out a wedge-shaped piece, first carefully removing the periosteum, in hopes of getting new bone growth. The case failed with a false joint, and the good sense of Graldis then pointed out the difference in prognosis, accordingly as phlegmonous inflammation has or has

not preceded the operation. If it has, the periosteum is separated or may easily be separated; if not, separation is a work of difficulty and proliferation is less likely to occur. Even if the normal periosteum can be peeled away, it carries with it no granulations for starting points of the new bone. Dr. Fifield had himself done the operation ten years ago or more, in spite of the unfavorable prognosis of those who were conversant with the case. The shaft being still firmly attached to the epiphysis at the upper end of the bone, it was removed by means of a chain saw. This operation was successful, and the speaker had had the pleasure of seeing his patient skating a year later. After that, he had removed the shaft of the femur on both sides from another child. Bleeding was not profuse in his cases.

The whole shaft of the humerus has likewise been removed. In the after-treatment, the necessity of good feeding was emphasized by Graldis.

DR. J. C. WARREN said that he had never seen a tibia that needed this operation. Although such cases occur, the occasion must be rare. The tibia is an especially favorable bone for reproduction, owing to the plexuses of vessels in its lower part. In a case of the speaker's, the shaft of the humerus had been pulled off, previous to amputating the arm, leaving the epiphysis and periosteum. Reproduction had taken place to such an extent, that there had been no more than enough flap to cover it, the amputation having removed the lower half of the arm. Such entire removal of bone must be rare in the United States.

DR. ABNER POST, read a paper entitled,
SOME OF THE LATE MANIFESTATIONS OF HEREDITARY SYPHILIS ILLUSTRATED BY CASES.¹

DR. F. B. GREENOUGH said that treatment is very important in these cases, and that, therefore, diagnosis is very important. Doubtless multitudes of cases of late hereditary syphilis are considered to be scrofula, and are treated with cod-liver oil. He was glad to hear mercury mentioned, for he believed it to be the important drug when it can be borne. Probably if cases of late hereditary syphilis could have been observed early, they would have for the most part presented evidence of the disease early.

DR. J. C. WHITE said that he wished that he felt a greater ability to distinguish between doubtful syphilis and scrofula.

In two or three points he should differ from the reader. He did not find dactylitis common in cases of syphilis; neither is syphilis common with dactylitis, at least three-quarters of the cases of dactylitis seen by him being non-syphilitic. Again we do not know how to distinguish between syphilitic and non-syphilitic dactylitis. Under these circumstances he placed no great stress on the presence of dactylitis alone as proving the existence of syphilis.

Hutchinson's teeth, again, are not a positive proof. When found, they are commonly on the person of a syphilitic, but this, although true as a rule, is not a rule without exception. He has seen them in children where there was no syphilis in three generations.

Further, it is not safe to attach too much importance to the effect of remedies as confirming a diagnosis. He had no doubt but that syphilis is a bacillus disease. Mercury and iodine are both of them pow-

¹ See page 493 of this number of the Journal.