was no history of any constipation. A sinus led down to the right hip, which was in an advanced state of tubercular disease. On Feb. 3rd an ileo-colostomy was performed. The appetite returned, and the patient could eat anything. She put on weight, the skin staining cleared up, and she was discharged very much improved, with the hip trouble most definitely clearing up and the sinus closed. She has certainly most definitely improved both as regards her general health and her local hip affection.

CASE 7.—The patient, a female, aged 4 years, had started to limp 12 weeks previously to admission with pain in the left hip-joint. The condition had got worse in the last few weeks and gave doubtful signs of an abscess. An X ray examination showed marked destruction of the head of the femur and acetabulum. An ileo-colostomy was done on March 31st, 1911, and the patient's condition is quite satisfactory up to the time of writing.

CASE 8.—A boy, aged 12 years, was admitted to Guy's Hospital on Dec. 15th, 1910, with a long history of pain in the left hip-joint. Twelve months previously it had been noticed that it was swollen. The abscess had burst and on admission there were three sinuses leading down to the left hip-joint which was in a state of advanced disease. The right hip was also affected and some pus was present in the joint, which was swollen, tense, and shiny. The patient had been treated for four years in various homes. He was definitely constipated and had required liquorice powder nightly. He was deeply stained, had a very poor appetite, and although it was Christmas-time he was too ill to be at all interested in anything. He was sent in with a question of amputation at the left hip, but his condition was considered too grave and he was thought to be dying. In January, 1911, an ileo-colostomy was performed. Since then the patient has steadily improved. The staining has almost gone, there has been an increase in weight and the general health is very much better. The right hip has cleared up and now is easily moveable, giving no pain. The sinuses leading to the left hip are definitely healing, and altogether the improvement is very marked.

Guy's Hospital, S.E.

A CASE OF LYMPHADENOMA IN A WOMAN AGED 63 YEARS.

By ERNEST P. STRATFORD, M.R.C.S. ENG.,
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MY main reason for recording the following case is the unusual age of the patient—viz., 63 years. It is admitted that lymphadenoma is three times as frequent in men as in women, and I have failed to find a record of a case in either sex over the age of 50. Further, in view of its close simulation of another condition, I am of opinion that a brief account may not be entirely valueless as a warning and a guide to other medical men should they meet with anomalous cases.

The patient, who had been twice married, and was 63 years of age, was herself one of 13 children, and had borne nine children, all healthy. There is no definite disease in any member of the family, no history or sign of syphilis or tubercle. Twelve months ago I was first called in to see her. The tongue was foul, the temperature was 101° F., and there was persistent vomiting with epigastric pain. She had had a rigor. There was no definite tenderness except over the region of the gall-bladder. Slight diarrhoea was present; there was no jaundice, but a general cachexia with colour of a yellowish, pallid type, not unlike pernicious anæmia. This attack passed off under treatment (but not necessarily as the result of the same) by ice-bag to the epigastrium with bismuth et ammon. cit. cum tr. opii. The temperature gradually decreased and the vomiting ceased in five days. The tongue became clean, and the patient's condition was apparently normal except for obvious cachexia and debility. My attention was directed to the condition of the teeth, in consequence of a complaint of pain in the cervical region. On examination masses of glands were to be felt in the posterior triangles bilaterally, and also some of the supraclavicular glands were enlarged. There were eight teeth in the lower jaw; the sockets were affected with pyorrhoea alveolaris and the teeth were loose. I removed these and an artificial set was fitted. The glands

did not improve, but increased in size, and after about three weeks a second attack of pyrexia occurred associated with vomiting, foul tongue, and epigastric pains of the most agonising character, accompanied by rigors and lasting for several hours. The sclerotics were definitely tinged yellow, but no general icterus occurred. Whenever the temperature rose and vomiting occurred the glands enlarged, the periadenitis increased progressively, and during the third pyrexial period fluctuation could be detected.

Owing to the periadenitis I decided to incise and not excise the glands, which I accordingly did on both sides, obtaining pus which, on blood serum agar, gave a culture of staphylococci. This I surmised was a secondary infection, and after two injections of 500,000,000 of an autogenous vaccine my surmise proved to be correct, a complete cessation of suppuration followed, and in subsequent pyrexial attacks the glands, although they became definitely enlarged, did not again suppurate.

It would be tedious to go in detail through the whole course of events, but the salient points are worthy of mention. The glandular enlargement has extended, and between June and Dec. 6th or 7th, 1910, recurrences of pyrexia, lasting for four or five days and associated with vomiting, acute epigastric pain, and an enlargement of the cervical and supraclavicular glands, took place. During these recurrences the temperature ranged between 100° and 103° . And on two occasions at least the epigastric pain was so acute that I came to the conclusion that a laparotomy, with a view to examination of the gall-bladder, was advisable. This was done in January, 1911. Somewhat to my surprise everything in the abdomen was absolutely normal, except that the liver was somewhat shrunken and there was a gland in the portal fissure which was obviously enlarged. No stones were present in the gall-bladder or either of the ducts. The gall-bladder was normal in size and structure.

Recovery was uninterrupted except by another attack of pyrexia exactly similar to the preceding ones. Potassium iodide in 20 grain doses was prescribed three times a day after food. From then until now she has had repeated recurrences of pyrexia accompanied by vomiting and a foul tongue, but these periods of pyrexia are diminishing both in frequency and duration. Meanwhile the cervical glands are progressively enlarging, and there are palpable glands in the supraclavicular and axillary regions.

To sum up, during 12 months the patient has had between 20 and 25 attacks of recurrent pyrexia varying between 100° in the morning and 103° at night, in each case accompanied by vomiting and epigastric pain. These attacks have been associated on each occasion with a mild tingeing of the sclerotics and a recrudescence of enlargement of the cervical, supraclavicular, and latterly the axillary glands, and at the same time the tongue rapidly fouls, to clean up as the temperature falls.

Having seen and handled all the abdominal organs, I can say with certainty that there is no malignant disease. Under moderate doses of iodide with 10 grains of sodium salicylate the temperature always comes down. During the last attack I palpated the splenic region and found the spleen definitely enlarged, which it certainly was not 14 days previously.

Syphilis, tubercle, and malignant disease are put out of court by the family history, and the findings at the laparotomy. And I am now reduced to the conclusion that the case is one of lymphadenoma, mainly involving the abdominal glands, but commencing, as is almost classically the case, in the glands of the posterior triangle.

The patient is progressing rapidly on the down grade, and a differential blood count negatives a lymphatic-leukæmia. The counts give 11,000 whites, polymorphs 58 per cent., lymphocytes 38 per cent., and large mononuclears 4 per cent. There are one or two red blood corpuscles which show some signs of nucleation, and there is marked poikilocytosis. Unless I am much mistaken these symptoms and physical signs, taken *en masse*, point to the fact that the patient is suffering from lymphadenoma affecting the mesenteric glands, probably mainly those in the portal fissure and the duodenal area. Personally, I can see no other diagnosis which covers the whole field of symptoms, so that, subject to correction or suggestions, I regard this case as one of lymphadenoma. That being so, I am unaware of any record of a similar condition occurring in an otherwise healthy woman of

63 years of age, and I would call special attention to the fact that in its earlier stages the case presented an absolutely true clinical picture of gall-stone colic, so much so that it was only after a negative laparotomy and a consequent revision of the diagnosis that I was forced to the conclusion which I now advance.

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TWO INTERESTING CASES OF ACUTE INTUSSUSCEPTION AND APPENDICITIS.

By L. C. MARTIN, M.R.C.S. ENG., L.R.C.P. LOND.

I THINK the two following cases are of sufficient interest to be recorded.

The first, a case of acute intussusception, was brought to me with the ordinary symptoms of blood and mucus passed per rectum and vomiting. The patient was a female child, between 6½ and 7 months old, breast-fed, and healthy-looking. The passage of blood and mucus had set in early in the morning and the vomiting some hours later. The intussusception could be made out by external palpation, and its apex by rectal examination about 2 inches from the anus.

I had the child removed at once to the Hounslow Cottage Hospital, and I operated on the same day in the afternoon. I was able at first to reduce the intussusception a good deal by hydraulic pressure, using a mixture of 2 parts of milk and 1 of water. This mixture was injected slowly—the time occupied being 12 minutes—with the pelvis well raised, by means of a soft indiarubber tube. The amount used was a little under half a pint. I next made an incision in the region of the cæcum and by intra-abdominal manipulation reduced the intussusception sufficiently to bring it out of the abdominal cavity, where, after some trouble, I reduced it completely. I then stitched up the abdominal wound, having previously irrigated the peritoneal cavity with warm saline solution.

For the first 24 hours I kept the child on sips of hot water, as the vomiting was very troublesome. During the greater part of the second day the vomiting continued, and I entertained very little hope of saving the child's life. As a last means of controlling the sickness I washed out her stomach with warm water and sodium bicarbonate (10 gr. to 3i) until the contents were returned clear. The effect was most remarkable: the vomiting stopped and the child slept for three hours. I then directed that she should be fed with egg albumin and water. From that time the child made a rapid recovery and has now left the hospital.

The interest of this case lies chiefly in the remarkable result obtained by the lavage of the stomach in controlling constant vomiting, and also in the fact that so very few children under a year survive such a severe operation.

The other case was that of a young woman, married only seven weeks, who had been complaining for a day or two previous to my visit of severe abdominal pain. The history was unimportant, save for the fact that she had had a similar attack about two months before she was married, had been under medical treatment, and ultimately recovered. When I first saw the patient her temperature was 102°F. and her pulse was 110, and she complained of pain in the region of the appendix. There was no sign of any peritonitis. The next morning both pulse and temperature were below 100 and the pain was not so acute. I decided then to await events, and not to operate, as I intended to. She remained in much the same condition as regarded pulse and temperature for the next two days. On the fourth day the temperature went up slightly, but the pulse remained below 100. On the evening of the fifth day the pulse went up to 120 and the temperature to 102°.

As it was very late when I saw her I could not have her removed before the next morning, but I operated the next day early. I released the appendix, which was bound down by recent adhesions deep in the pelvis, and removed it, but little difficulty being experienced in breaking down the adhesions. The appendix measured a little over 4 inches and was greatly congested, but it showed no sign of any perforation. There was some free clear fluid in the peritoneal cavity. In the evening the patient looked fairly

comfortable, but had been sick several times. The next morning at 9 o'clock I was told that she had vomited all night until 4 A.M., but that subsequently she had had some sleep. Her pulse then was very weak and fast. I injected strychnine hypodermically, but though her pulse got stronger and was not so rapid for a few hours, she sank rapidly and died at 6 P.M.

The unusual and rapidly fatal ending of this case very greatly puzzled me and pointed obviously to something beyond acute appendicitis. I was allowed to make a post-mortem examination so far as the abdominal cavity was concerned; this I did two days after death. There was no septic peritonitis present; the organs looked healthy, but to my great surprise I found a double pyosalpinx, the left ovary healthy, the right diseased and having both on its surface and inside several small cysts, some of them hæmorrhagic. I feel sure that the appendicitis was secondary to the pyosalpinx. Was the first attack she had due to salpingitis? I am inclined to favour that view. If so, it seems as if the process had gone on slowly from the time of her first attack until it culminated in a suppurative condition at the onset of the second attack, when the appendix became secondarily involved. Another question arises as to what was the cause of the salpingitis. Whatever cause may have been at work, it was, I can confidently assert, not due to the gonococcus. I may say that I never suspected any inflammation of the tubes and I always looked upon the case as one of appendicitis.

This case has taught me one great lesson, and that is the necessity of inspecting the right tube when operating for appendicitis in women.

Hounslow.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

CHLORATE OF POTASSIUM IN REPEATED MISCARRIAGE.

By J. F. JEFFERIES, L.R.C.P. & S. EDIN.,
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THE use of chlorate of potassium in cases of repeated miscarriage is so little recognised that the success attendant on its use in the following cases is sufficient to warrant their publication.

CASE 1.—The patient, married at the age of 25, had a series of miscarriages and full-term confinements as follows. The first child (female), born 16 months after marriage, reached full term and lived only two days. The mother says that the child was healthy looking at birth, and she attributes its death to prolonged labour, necessitating the use of instruments, resulting in cyanosis of the child. Then followed four miscarriages in succession—each occurring about the end of the fifth month of pregnancy. After this run of miscarriages she gave birth to a full-term child (a female) who is still alive and healthy (aged 10). Labour was normal. The seventh pregnancy again terminated in a miscarriage between the third and fourth months and was attended by a great deal of post-partum hæmorrhage. The next pregnancy also ended in a miscarriage in the fourth month. Thus there were six miscarriages and two full-term deliveries.

As the patient was anxious to have some children she consulted me. On examination the uterus was found much enlarged, with great thickening of the cervix—a condition of subinvolution possibly resulting from her first confinement, which, as I have said, was a difficult one. There was no evidence of syphilis or renal disease. I told her to come back again if she should become pregnant. When I saw her the second time she was two months gone, and forthwith I put her on chlorate of potassium, 5 grains three times a day, and told her that she would have to persevere with it throughout her pregnancy, which she did without any