The parents (who are intelligent persons) say that the child has eaten no sausage and no tinned or preserved food of any kind. The case seems to resemble those described in Paris under the heading "Lethargic Encephalitis" more than those in London described by Dr. Batten and Dr. Still under the heading "Epidemic Stupor." In regard to the recent correspondence on the subject of "botulism" it has, I think, escaped attention that on the continent, about 1906, the *Bacillus botulinus* was found to grow not only in sausages, tinned meat, &c., but likewise in tinned vegetables.

In regard to the possibility of my case and similar cases being epidemic cases of acute polio-encephalo-myelitis (the Heine-Medin disease) I should like to recall the following papers, all published some years ago, when the latter disease was rarer in England:—Sydney Stephenson: "The Oculomotor Type of Polio-encephalitis," *Proceedings of the Royal Society of Medicine (Children Section)*, 1911, vol. iv., p. 87; Payan Dawney: "Double Third Nerve Palsy due to Acute Poliomyelitis," *ibid.*, 1912, vol. v., p. 13; K. K. Lundsgaard: "Acquired Ocular Palsies in Children (? Heine-Medin Disease)," *Hospitalstidende*, 1912, vol. iv., p. 854.

London, W.

III.—BY T. H. PARKE, M.R.C.S., &C.

Patient, aged 23, came home for Easter on March 28th. A message came to me on Sunday night to call next day, April 1st. House isolated on moor. Sanitation good and food ample. Patient had been in bed since Thursday night. Very listless, apathetic and drowsy, subconscious, and when roused would answer questions correctly but with difficulty. Eyelids closed, unable to open them; with manual assistance vision was good. No diplopia; dull, flat facial expression. Imperfect muscular grip of hands. Knee-jerks rather active; no Kernig. No headaches, vomiting, gastric disturbances, or general pains; "feeling very tired." Temperature and pulse not much disturbed. Some inclination to constipation. No active delirium, but some confusion of ideas.

This condition continued with few slight changes for about 18 days. The symptoms did not conform with any true meningeal affection, and inquiries did not point to any hysteric or neurotic condition. My difficulties were all cleared up after reading the article by Dr. A. J. Hall, of Sheffield, and in correspondence he has kindly confirmed my diagnosis.

Later inquiries as to food, &c., are very indefinite. Sardines, a little tinned food (salmon), not much fresh meat (no cheese) had been regularly partaken of by a household of five without any ill-effects, and no other case could be traced in her working neighbourhood. She had continued her work as a clerk till the Thursday, but made stupid entries.

When recovering the patient had no recollection of the last two miles of her walk, arrival home, or of my earlier visits. The earliest remembrances are of happenings on April 20th. In the third week of illness recovery was steady, but a left-sided ptosis, with an upward and external squint, still remained. She was unable to write. On May 1st, while in the neighbourhood, Dr. S. M. Ross, assistant county medical officer of Derby, kindly saw the case with me. It was decided that any bacteriological examination at this stage would prove very inconclusive.

On May 7th steady progress was maintained; taking outdoor walks. Ptosis and squint passing away and now able to write, but with difficulty and unsteadiness.

There were no marked tremors at any period, and even in her most drowsy period would always swallow and take her food excellently.

Tideswell.

A CASE OF CONGENITAL DEFORMITY OF HANDS AND FEET.

BY BARBARA G. R. CRAWFORD, M.B., CH.B. GLASG.

A MAN, aged 49, seen on Nov. 8th, 1917, presented the following conditions:—

Right hand: Terminal phalanx of third finger, half of terminal phalanx of fourth, and terminal and second phalanges of fifth finger absent; thumb and second finger normal. Left hand: Second and terminal

phalanges of second, third, and fourth fingers absent; thumb and fifth finger normal. The third and fourth fingers of right hand carried vestigial nails; the ends of other deformed digits were broad and presented the appearance seen after a good amputation. An X ray photograph (unfortunately faulty) shows that in some of the incom-

plete digits the phalanges are entirely absent, and in others they are represented by rudimentary bones.

Right foot: Distinct talipes equinus; foot and leg considerably wasted, cold, and slightly cyanosed. Left foot: Normal except for an extra fleshy pad about size of bean at end of each of third and fourth toes.

The deformity has been present since birth, but patient has followed his occupation from age of 10, maintaining himself as successfully as his more normal comrades. He said he had never found the condition of his hands a drawback, but he could not get about very well on account of right foot, he felt the cold of winter very much in it, and had to wear a protective dressing.

The family history is as follows. He is the eldest of a family of 14; others normal, father and mother both normal. He is married, with six children, all normal. The eldest of the family, his only daughter, has a normal child 15 months old.

Such a case occurring in the East or even in Scandinavia or Iceland would immediately raise the suspicion of leprosy. Here, however, the man has never been abroad, and the deformities have been present from birth, so such a suspicion does not arise; syphilis, a potent cause of deformity at birth, may also be contraindicated. The history and nature of the deformity point to intra-uterine amputation as the probable cause, the result either of amniotic bands or of posture at a very early stage of development. Acquired characters being non-hereditary, intra-uterine amputations do not lead to a deformity with a positive family history; this is as might be expected in this case. The bony nodules in two of the digits in place of the missing phalanges, seen in the X ray photograph, may represent an effort at replacement after amputation, such as occurs in many other forms of life, notably in the arthropoda.

Queen's Ferry, Chester.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

SECTION OF GYNÆCOLOGY AND OBSTETRICS.

Acute Uterine Inversion.—Myoma of the Uterus.

A MEETING of this section was held on May 2nd, Dr. G. F. BLACKER, the President, being in the chair.

Mr. OSWALD DINNICK read a short paper on an unusual case of Acute Uterine Inversion.

Dr. HERBERT R. SPENCER gave an account of two cases of Myoma of the Uterus treated by total abdominal hysterectomy, in which cancer of the body was present. The first was a case of recurrent cancer in which the growth had invaded the peritoneum. The recurrent mass was removed, together with the lower end of the ureter and the right half of the bladder. The kidney became infected subsequently and was removed. There was a second recurrence which was inoperable. Death occurred two years and two months after hysterectomy. In the second case the growth had advanced to within 1 mm. of the peritoneum. The patient was well and free from recurrence after five years. The speaker was an advocate of total abdominal hysterectomy for myoma. He had never amputated a uterus for cancer of the body, whether complicated with myoma or not. Three experienced gynaecologists, advocates for amputation for myoma, had overlooked cancer of the body as a complication, and performed amputation (or, in one case, incision before removal) in 14 out of 18 cases (77 per cent.), and in no case was a five-year after-history given. Two of these three gynaecologists had overlooked cancer of the body, uncomplicated with myoma, and performed amputation in 3 out of 12 cases (25 per cent.), two of the three cases recurring (66 per cent.). Advocates for amputation for myoma needed to take greater care than advocates of total hysterectomy in making the diagnosis of cancer of the body as a complication, and should clamp the uterus before dividing (with the cautery). Total abdominal hysterectomy by Doyen's method, the vagina being opened and severed with the galvano-cautery, was superior to amputation for myoma in lessening the risk from cancer of the body should it have been overlooked.

In the course of the discussion the PRESIDENT said that he had seen only one case of cancer of the stump after the supravaginal operation. Most operators considered that they did not get such a good result from total hysterectomy as from this operation, which was safer and simpler. The number of cases of cancer of the stump was so few that the danger to the patient from the more severe operation of total hysterectomy was greater than the possible chance of