

Present condition, December, 1920, more than 12 months since illness commenced: In good health. Tumour right lumbar region disappeared about Jan. 16th. Urine normal, slight congestion of penis remains. Weight 15 st. 9 lb., as compared with usual weight 15 st. 2 lb. Can walk well and play golf. Very slight oedema over the tibiae occasionally and some blueness about the ankles at night, never present in the morning. Slight dilatation of superficial veins of anterior surface of abdomen. No varicose veins anywhere. He has discarded his truss and feels no inconvenience in consequence.

#### Remarks.

The cause of the condition in this case is obscure. The purging by daily doses of magnesium sulphate may have caused the original phlebitis in the hæmorrhoidal or veins of the vesico-prostatic plexus. The attack of influenza in April, 1919, or the appendicitis and operation in August, 1918, may have left some smouldering trouble, or pressure by the double inguinal truss worn regularly from April, 1918, up to the time of the operation, and after the operation up to Nov. 5th, 1919. The first signs were abdominal distension, congestion of penis, difficulty in passing urine, and pain in right groin about the position of Scarpa's triangle; then followed tenderness over the colon, much distension and partial paralysis of it, evidently due to interference with the venous supply, oedema of right foot, pain in right thigh followed by pain, swelling, and oedema of the whole leg, but no apparent inflammation of the femoral veins. On Nov. 14th the left thigh became painful, swollen, and oedematous, with pain along the course of the vessels. It is reasonable to conclude that the initial lesion was thrombosis of one of the veins of the vesico-prostatic plexus spreading to the internal iliac and thence probably to the inferior vena cava. It is difficult in this case to decide how far in this direction the thrombosis advanced, as there was no swelling or oedema of the back, or higher than Poupart's ligament in front. As the course of the case ended in recovery it is difficult to explain how resolution came about, and why the thrombus was non-infective. The highest temperature was  $101.2^{\circ}$ ; it became normal about the nineteenth day of the illness and remained so. The diagnostic alternatives were malignant tumour, inflammatory tumour (diverticulitis), fibrous tumour or contracting cicatrix obstructing the inferior vena cava.

### A SECOND ATTACK OF CHICKEN-POX.

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MOST authorities in this country consider that a second attack of chicken-pox in the same individual is rare. For example, J. MacCombie, in his long experience, had never seen a case, and some observers seem inclined to be sceptical of its occurrence. Therefore, the following case may be of interest and seems worth recording:—

A. K., aged  $5\frac{1}{2}$  years, was admitted to this hospital in November, 1917, suffering from scarlet fever and with a history of having suffered from chicken-pox. On his chest and forehead were old scars identical with those left by chicken-pox.

In the ward in which he was resident the following cases of chicken-pox arose: L. B., aged 6 years, showed the eruption on Dec. 24th; R. F., aged 6, and D. V., aged 4, on Dec. 26th. A. K. developed a typical eruption of chicken-pox on Jan. 10th, 1918.

#### A NOTE ON

### THE "STERNO-HYOID" ARTERY.

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Kocher believed one of the most important factors in operations for exophthalmic goitre to be avoidance of hæmorrhage. Referring to excision, he states: "The result really depends for success on the most careful arrest of hæmorrhage," a view thoroughly endorsed by Mr. James Berry and others. Apart from Graves's disease and old toxic goitres (so-called secondary Graves's disease), operations for simple goitres are

often associated with much blood loss, and since thyroidectomies of varying extent are becoming more frequent, it may not be inappropriate to draw attention to a source of hæmorrhage in an unnamed, but relatively large, vessel shown by recent dissections to be a muscular branch of the superior thyroid artery. Moreover, reference to the literature has revealed only the briefest mention of the muscular branches of the artery.

The superior thyroid, after giving off its hyoid, superior laryngeal and sterno-mastoid branches, frequently divides into two trunks of almost equal calibre. This bifurcation has been noticed in the carotid triangle

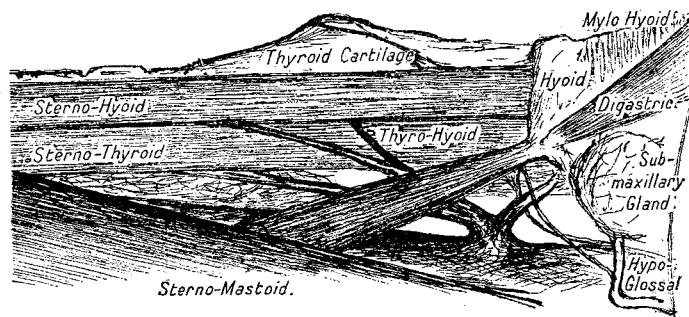


Diagram of artery.—In this case there is a common origin for the superior thyroid and the lingual. The branch to the sterno-hyoid is marked in black.

or immediately behind the anterior belly of the omohyoid but may occur farther forward in the muscular triangle. Of the divisions, the larger runs downwards and inwards behind the sterno-thyroid to end in the gland, the other superficial to this muscle lying in a groove between the insertion of the latter and the thyro-hyoid. In this position it gives off branches to the infra-hyoids and continues downwards in a more nearly vertical course, giving rise to the crico-thyroid artery, and may here give off twigs either to the lateral lobe or the pyramid where one exists. Of the muscular branches proceeding from this division by far the largest is that to the sterno-hyoid (see diagram). This branch enters the muscle high up, roughly at the junction of the upper and middle thirds, and on its posterior aspect.

Professor Thomas Yeates is aware of the existence of the artery, and has noticed it repeatedly, and Mr. Berry tells me that when he has to divide the sterno-hyoid muscle this vessel usually requires a ligature. Professor Kocher refers to the large anterior branch as a guide to the main trunk of the superior thyroid in ligating the latter, and it is from this branch that the sterno-hyoid twig arises. It is hoped that the description may be of use to workers in this region, since it would appear that this vessel is liable to damage in thyroid operations, particularly when division of the infra-hyoids is found necessary.

#### A CASE OF

### CHRONIC HYDROCEPHALUS SIMULATING HYSTERIA.

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THE following case appears of sufficient interest to be recorded:—

The patient, a man of well-marked neurotic temperament, enjoyed average good health until he joined the R.N.V.R. in 1914 at the age of 46. Exposure on anti-aircraft service caused frequent attacks of bronchitis, so that he was invalided out of the Navy. In the spring of 1917, he had a severe attack of influenza followed by meningitis according to the diagnosis of Dr. Philip Birch, who was then attending him, and of Dr. F. W. Tunncliffe. He first came under my care in the spring of 1918 with the following symptoms: Chronic headache (dating back to the meningitis) and "a curious pain from between the shoulders up the spine to the back of the head." The pain was associated with nausea, and there were occasional attacks of retching, but no actual vomiting. He walked with difficulty, like a