

paræ, but that its uncertainty of action renders it less reliable than chloral. 2. That during the expulsive stage of labour it is useless as an analgesic, in whatever way it may be administered. 3. That in certain kinds of after-pains it is very efficacious. 4. That it is without any ecboic properties, and has little or no effect on the frequency of occurrence of labour pains during the dilating stage, and does not aid dilatation of the os uteri. 5. That the effect of the drug appears to be more marked on impressionable and neurotic women and those of dark complexion and spare frame than on others. 6. That it should never be given by mouth without the addition of a diffusible stimulant.

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## A CASE OF OSTEOMA OF THE FRONTAL SINUS.

By STANLEY BOYD, F.R.C.S. ENG., &C.

SEVEN years ago, in 1883, a swelling appeared on the forehead of M. H—, aged twenty, and was attributed to a kick and blow on the part within a year before, but both of these injuries were too slight to be mentioned at the time. The swelling was painted with iodine for a month, followed by mercurial inunction, with mercury and iodide internally. Since that time it has slowly grown, all treatment being discontinued after a few months. In 1885 the swelling was wide based and diffuse. At the end of 1888 it was much more prominent and defined. For some years there had been a free watery discharge from the nose.

When I saw him there was a prominent swelling of bony hardness, chiefly to the right of the mid-line of the forehead, long diameter (about  $1\frac{1}{2}$  in.) transverse, short diameter (about  $\frac{1}{2}$  in.) situate about half an inch above the root of the nose; base well defined, and as wide as any part of tumour; on the surface two points were separated by a depression. All round the base the frontal bone seemed too prominent, and there was a low rounded eminence running down over the right frontal sinus, suggesting the possibility of a growth in the frontal sinus. The mass was evidently an osteoma, and I hoped from the irregularity of its surface it might prove cancellous. It was sufficiently high on the forehead to make it possible that it had nothing to do with frontal sinuses of ordinary size. On July 11th an operation was performed. The hairy scalp was shaved for about an inch, and disinfected twelve hours previously. A semilunar incision was made, so that the top of the curve lay just below the hair, while the horns descended to the level of the mass, half an inch or so from the ends of its long diameter. Bleeding was very free and difficult to check, the total loss of blood being considerable. When stripped of periosteum the mass looked like a cancellous exostosis, and the protruding part was easily detached by a few blows with the mallet and chisel. The base was now seen to be surrounded by tags of mucous membrane. Evidently the growth had sprung from the posterior wall of the frontal sinus, and had pushed its way through the anterior wall of the space, in confirmation of which a collar was found round the neck of the protruding portion of bone, laid down evidently by the periosteum on the outer surface of the frontal bone. With mallet and gouge the base was removed piecemeal from the sinus, the mucosa acting as a guide to its limits. More than half as much again as the tumour was thus removed, and at one spot, near the middle line, the brain cavity was slightly opened, but the channel leading to the nose was not found. Next, in an endeavour to render the forehead quite symmetrical, the chisel was applied to the descending ridge and to the right, and mucous membrane, undoubtedly that of the right frontal sinus, was exposed, but the sinus was not opened. The flap was fixed in position and a compress dressing of mercurio-zinc cyanide gauze and wool applied. The operation lasted about one hour and three-quarters. Beyond a little headache after the operation the patient had no trouble of any kind. He was up for three hours on the third day, was dressed on the fifth day, when the wound was found completely healed, the scar being absolutely linear. The patient vomited some altered blood soon after the operation, and the discharge from the nostrils was blood-stained for several days. At first the patient thought the discharge diminished in amount, but on the twelfth day after the operation he reported that there was no diminution.

Such a case as the above is of sufficient rarity to merit publication. The tumour has been sent to the College of Surgeons, which possessed no such specimen. In considering the question of operation, the nature of the growth and its relation to the frontal sinus first claimed attention. The irregularity of the surface led me to hope that it would prove cancellous. I was, however, prepared with instruments to deal with an ivory growth. I was not told about the discharge from the nose until after the operation, or I should have concluded with some certainty that the growth sprang from the frontal sinus. Against this was the fact that the discharge came from *both* nostrils, whilst the growth did not occupy *both* sinuses. On the other hand, the blood after the operation tinged the discharge from *both* nostrils, and so far as I know the right frontal sinus was uninjured. I am inclined to think that the osteoma lay in a distended left frontal sinus, the septum between the sinuses being to the right of the mid-line, though I did not find the opening to the nose which evidently existed. I had hoped that this case would prove interesting as demonstrating one cause of persistent watery discharge from the nose, but the evidence connecting the osteoma and the discharge is far from conclusive. With asepsis I anticipated no danger to the patient from an operation, even though the frontal sinus were opened. For mechanical difficulty in removing the mass I was prepared. I had determined, in case of ivory osteoma, to endeavour to work with the chisel in soft tissue round the growth; failing this, to shave off the mass level with the frontal bone rather than enucleate it and leave a gap in the skull. This latter procedure has successfully checked the increase of such a tumour, possibly because the periosteum over it was destroyed in the operation. It occurred to me that the best treatment of cases of multiple osteomata of the facial bones might be the early removal by dissection of their periosteal covering.

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## TWO CASES OF HÆMATO-PORPHYRIN IN THE URINE.

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CASE 1.—Miss A. B—, aged forty-one. Throughout life nervous and hyperæsthetic; has suffered from several shocks. First seen in August, 1889, complaining of menorrhagia, general headache, and pain in epigastric and umbilical regions and insomnia. The tongue was deep-red, denuded, and sore-looking. There was habitual constipation. She was under treatment by rest and feeding. All went well, except neuroses and photophobia and occasional deposits of earthy phosphates in the urine, till the period in October. Though of good colour, the discharge was much less than usual, lasting three days, and leaving vertical headache and confusion, with pelvic distress, which yielded immediately to mustard over the ovarian regions. From this time she became intensely neurotic, complaining of nausea, mental confusion, and hypogastric pain, always distressed because "last period was too little." During the week ending Nov. 16th these symptoms increased, with retching and occasional vomiting of food and mucus. The urine became scanty and uratic, to which was attributed the supra-pubic pain and frequent desire to micturate. On Monday, the 18th, pelvic distress being well-marked and the abdomen being distended, twenty grains of acetanilide were given in three doses within four hours. This caused marked cyanosis and collapse, with scantier urine, which when next passed (about ten ounces) was clear and of a deep port-wine colour, acid, sp. gr. 1031, with strong odour (not exactly urinous), and giving no reaction with  $\text{HNO}_3$  cold, boiling and  $\text{HNO}_3$ , picric acid, guaiacum, and Heller's tests, tincture of iodine, nor  $\text{Fe}_2\text{Cl}_6$ . No spectroscope was available. There were no blood cells nor casts. Under stimulating treatment (hot liquid food with gin) the collapse subsided by Tuesday evening, the 19th, the urine being unchanged. That night she slept well, and the catamenia, due on Thursday, appeared rather suddenly on Wednesday, of a good colour, without clots, and in moderate amount.