

point. In 40 the general peritoneal cavity was opened and in 49 it was not so far as was ascertained. The abscess cavity at the time of operation had not advanced to the anterior abdominal wall, or the incision, if adhesions to the latter were present, did not hit off the adherent area. By taking due precautions to shut off the general cavity before opening the abscess no harm results from the exposure. In 23 cases the appendix was removed at the time of opening the abscess. In some, quite a few, the appendix presented and was dealt with without apparently exposing the general peritoneal cavity. In the majority the latter was known to have been opened. No case of diffused peritonitis resulted. There is no reason why it should if precautions are taken to guard it and appropriate drainage is provided.

3. What is the condition of the appendix in suppurative appendicitis? In by far the majority of cases gangrene, localised or diffused, was present. In four cases only out of 23 was this not so. The appendix in these four showed general inflammatory changes throughout all its coats. In one of the four a concretion was present in the lumen of the appendix. In five gangrene of a considerable part of the appendix was present. The separation of such a slough must mean a longer duration of the time of healing than if the appendix had been entirely removed. Even when a portion is cast off there is a danger that the end may not become soundly sealed over, and this will account for many of the cases of persistent sinus. In the remaining cases there was limited gangrene of a portion of the wall of the appendix. The site of this was by no means constant. Perforation had occurred in several cases. In the majority concretions were present. Localised perforations of the appendix will heal but generally presumably with some narrowing of the lumen. This has been seen in some of these cases. In those in which the appendix was removed at the second time of abscess formation it has been observed. In other cases in which the appendix was removed at the time of closing a ventral hernia it was seen also. In these there was a tendency to dilatation of the distal part of the appendix.

It may be said that the lesions in the appendix in cases of suppuration are such as to lead to permanent and gross changes in the organ which predispose more than anything else to a recurrence of appendicitis. In addition, concretions are very frequently present in cases of suppuration. The concretion may escape through the perforation, but this does not always happen. A concretion remaining in the lumen of the appendix is a certain danger.

The danger of removing the appendix at the time of opening the abscess is more theoretical than real. The advantages to be claimed for the primary removal of the appendix are the following.

1. The time of the healing of the wound is lessened. In calculating this due allowance is made for the size, situation, and depth of the abscess.

2. There is less tendency to imperfect drainage, which is at times seen during the course of the healing of an appendicular abscess. This is so partly because the supply of infection is removed, and partly on account of the fact that the abscess cavity is so thoroughly opened that it may be drained from the most favourable position.

3. The rare complication of portal pyæmia following a persistent sinus may be abolished.

4. An inflammation spreading up the right colon to the subhepatic or subphrenic regions may be anticipated and cut short by a timely lumbar drain.

5. The exploration of the abscess cavity will enable any concretions which have escaped from the appendix to be removed. It is true that often when the cavity is wiped dry these can be detected and removed. But no doubt some will escape detection and will stand a better chance of being removed when the cavity is more thoroughly exposed, as it necessarily must be to remove the appendix.

6. The persistent sinus and frequently recurring breaking down of the scar will be practically abolished.

7. The risk of ventral hernia is by no means increased but may be actually lessened. Ventral hernia occurred in this series more frequently when a drain had to be established for some time. Primary removal of the appendix does not necessarily mean a longer incision through the parietes, nor does it lessen the chance in any way of the healing of the wound in part per primam. When the appendix is situated to the outer side of the cæcum and colon a lumbar drain may be established and the anterior wound closed almost entirely.

The risk in such cases of a ventral hernia is considerably diminished.

8. The permanent changes in the wall leading to stenosis of the appendix, and the very frequent presence of concretions in the lumen which have not escaped into the abscess cavity are most potent predisposing causes to recurrent appendical trouble.

Exceptions may be made to the statement that it is advisable to remove the appendix in all cases of suppuration. A pelvic abscess which can be easily incised through the rectum is better drained through this route. The drainage of a pelvic abscess through a hypogastric incision is most tedious. A much more rapid healing is effected in the majority of cases by means of a rectal drain. An abscess in connexion with the appendix will rarely form primarily in the subhepatic or subphrenic region without any collection of pus in the iliac fossa. Such abscesses, the diagnosis of origin of which must be very uncertain, are better dealt with as primary affections. If for any reason—e.g., age, constitutional disease, or toxæmia—the time of operation should be curtailed as much as possible the abscess may be treated as the primary affection.

Harley-street, W.

Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

TWO CASES OF AN UNUSUAL FRACTURE OF THE RADIUS.

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THE following cases, seen for the first time within a fortnight of each other and presenting an almost identical pathological condition, have seemed to me to present sufficient points of interest, apart from that of coincidence, to justify publication. In both cases the patients were telegraph boys, one aged 15 and the other 18 years, the lesion in each instance, as displayed by the radiographs, being a complete, simple, transverse fracture of the head of the radius 10 millimetres below the epiphyseal line and therefore above the insertion of the biceps tendon.

In the case of the first boy, aged 15 years, there was a history of direct violence applied to the outer side of the elbow as the result of a fall upon a floor; there was no separation of the epiphysis, the whole displacement of the upper fragment being about 5 millimetres forward and downward. When seen on the next day there was no marked swelling, and the limitation of movement was confined to the extremes of flexion and extension, supination, and pronation. The arm was placed on an internal angular splint and passive movements were commenced on the fourth day; active ones were encouraged eight days later, the splint being then omitted, and consisting of the buttoning and unbuttoning of all the waistcoat buttons and the stroking of the back of the hand. The boy was able to use the arm in less than three weeks with almost perfect movement.

In the case of the second boy, aged 18 years, the history was one of indirect violence, the fracture resulting from a fall off a gymnasium vaulting-horse upon the extended palm (after the classical method by which a Colles's fracture is produced). The lesion was identical, both in position and displacement, with the last, the epiphysis, however, having already united with the shaft. In this case there were considerable swelling and ecchymosis, and passive movements were postponed for 13 days. Four days later than this the internal angular splint was omitted, and active movements were combined with the daily passive exercises. He was able to use his arm with comparative freedom of action 27 days after the accident, and at the time of writing has regained an almost normal range.

The chief features of interest, apart from an uncommon position of fracture, would seem to be, in the case of the younger boy, that in spite of the close neighbourhood to it of the line of fracture there was no separation of the epiphysis;

and in that of the second, the rather curious point that there was absolutely no injury to the wrist, notwithstanding the fact that the whole weight of a well-developed body must have been violently thrown for a moment upon the extended palm.

Both cases, perhaps, are instances of the very great value of early and systematic movement, passive and active, whenever in the treatment of fractures this is at all possible, and especially in regions, such as the above, where the formation of a comparatively small amount of callus may produce an altogether disproportionate result in the permanent handicapping of action.

General Post Office.

THREE CASES OF POSTURAL CARDIAC MURMURS.

By E. L. MOSS, L.R.C.P. LOND., M.R.C.S. ENG.,
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THE following cases are examples of a cardiac murmur, dependent upon the position of the patient, a condition which, although fairly common, is not generally recognised. A murmur, systolic in time, heard over the upper part of the sternum, unaltered by respiration, may sometimes be produced by raising the arms to a level with the shoulders, as in the position of holding up the shirt to expose the chest for examination.

CASE 1.—A sergeant of the 2nd Battalion Rifle Brigade, aged 25 years, a well-developed, healthy man, had been diagnosed "disordered action of the heart, accompanied by aortic murmur," and in consequence had been doing only light duties and was warned to be careful about over exerting himself. When seen in March, 1908, a few days after the above diagnosis had been made, there were no symptoms of any kind and the man appeared and felt in good condition. Examinations of his heart in March, 1908, and January, 1909, both standing and lying down, revealed nothing abnormal, but directly he stood with arms raised as if holding up his shirt in front, a loud, rather high-pitched systolic murmur was audible, mid-sternal, about the level of the second cartilage. The murmur was not affected by respiration. It was noted to be synchronous with slight pulsation visible in the suprasternal notch and disappeared immediately the arms were lowered. Simply throwing the head backwards did not produce the murmur.

CASE 2.—A rifleman, aged 25 years, with well-developed muscles, looking "in the pink of condition," also had been warned to be careful about exercise on account of the condition of his heart. On examination he presented exactly the same condition as the patient in Case 1, except that the murmur on raising his arms was even louder. In no other way could it be produced.

CASE 3.—A native employed at the officers' mess had the same condition, but was a poorly developed individual with signs of arrested tuberculous mischief at the apex of his right lung, with scars and enlarged glands on the right side of his neck.

These few cases furnish illustrations of the occurrence of this murmur, which has been noticed many times in healthy soldiers during the past three years.

My attention was first drawn to the condition when endeavouring to decide whether the so-called "retraction murmur" occasionally met with in tuberculous children was really due to pressure of involved mediastinal glands on some of the large venous trunks, or whether it was a sign met with in healthy children as well, for I had noticed a similar murmur in children whom I believed to be quite physically fit. When trying to produce "retraction murmurs" in adults I met with the condition described. At first I thought it might be caused by traction on the trachea and bronchi, causing pressure or kinking of the aorta or pulmonary artery, but since the murmur is produced by raising the arms without backward extension of the head it seems more likely that the position causes an expansion of the lower part of the thorax, increasing the negative pressure within which allows a temporary dilatation of the aortic arch. Whether or not the normal aorta would be affected by this is not easy to say. Whatever the cause may be, it is well to recognise the condition, for misinterpretation might seriously affect the subject.

Shahjahanpur, India.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

MEDICAL SECTION.

Chloroma.

A MEETING of this section was held on Feb. 23rd, Dr. T. H. GREEN being in the chair.

A paper on Chloroma, communicated by Dr. F. DE HAVILLAND HALL, Dr. R. G. HEBB, and Dr. J. M. BERNSTEIN, was read by Dr. DE HAVILLAND HALL, who stated that the paper was based on a case of chloroma which was admitted into the Westminster Hospital on Nov. 8th, 1907. The patient was a girl, aged four years and three months. The illness commenced one month before admission with irritability and pain in the head. A fortnight later a lump developed on each side of the neck, the eyes became more prominent, and the veins over the temporal region were distended. On admission, in addition to the above, there was facial paralysis on the right side and the patient was very anæmic. On Dec. 12th double optic neuritis was noted. The patient gradually became weaker and more anæmic and died on Dec. 24th. The blood was examined on five occasions. On admission there were red corpuscles 4,100,000, leucocytes 40,600, and hæmoglobin was 60 per cent. On the day before death the red corpuscles were 1,140,000, leucocytes 23,900, and the hæmoglobin had fallen to 18 per cent. As usual in these cases there was nothing characteristic about the temperature chart. During the patient's stay in the hospital there was usually slight pyrexia, the highest temperature recorded being 102.4° F. As regards the question of diagnosis, it was pointed out that in this case it was comparatively easy. The anæmic appearance of the child, the masses in the orbital region, which even during life had a greenish tint, and the protrusion of the eyeballs presented a complex of symptoms unlike that met with in any other disease. The examination of the blood also helped to confirm the diagnosis, as there was a leucocytosis affecting the large lymphocytes. If seen at an earlier period, and supposing exophthalmos had been the first symptom, the possibility of a cerebral tumour causing the proptosis would have had to be considered, and the existence of optic neuritis with headache would probably have seemed to clinch the diagnosis. At the post-mortem examination chloromatous growths were seen in the ethmoidal region, in the middle fossa, near the end of both lateral sinuses, in the orbits, and in the dura mater of the vertex. In the trunk chloromatous tissue was found on the internal aspects of all the ribs, the innominate bones, and sacrum, and on the external surface of both scapulæ. The long bones (only one was examined) appeared exempt. All the growths were of an olive-green colour. The liver, spleen, and heart gave a slight iron reaction. Microscopically the growth was seen to be a small to medium-sized round-celled sarcoma. The effect of the following reagents on the pigment was tested: ether, chloroform, turpentine, alcohol, nitric and hydrochloric acids, xylol, ferrocyanide of potassium, caustic potash, and Lugol's solution. Of these, the only one which had a definite solvent or decolourising action was 0.2 per cent. potassium hydrate (KOH), which was allowed to act for 18 hours at 37° C. Special examination was made for the presence of bacteria but none were detected.

Dr. A. E. GARROD said that sarcomatous deposits about the orbit occurring in association with sarcomatous growths in the suprarenals produced symptoms similar to those seen in chloroma.

After Dr. DE HAVILLAND HALL and Dr. HEBB had replied, the meeting concluded.

MEDICAL SOCIETY OF LONDON.

Gastro-enterostomy.

A MEETING of this society was held on March 1st, Sir FELIX SEMON being in the chair.

Dr. SIDNEY H. C. MARTIN delivered the third of the 1909