the septum, local atrophy or hypertrophy of the mucous membrane of the turbinated bones or of the septum, disease of the turbinated bones themselves, foreign body in the nose, &c.; and (2) those cases in which the nasal changes are not primary, but are themselves the outcome of some central neurosis. In the latter class of cases the local treatment of the nares, such as the use of the galvano-cautery, stops the reflex symptoms, not because it removes the irritation, but because it acts as a powerful counter-irritant. McBride[9] advocates this latter theory.

There can be no doubt that intra-nasal irritation can and frequently does give rise to reflex symptoms, such as asthma, hay fever, megrim, vertigo, and epileptiform attacks, but it does not by any means follow that it is always the cause of these symptoms. We know that in many cases gastric or uterine irritation can give rise to similar symptoms. It follows, however, that it is absolutely necessary that in all these and similar cases the nares and post-nasal space should be carefully and thoroughly examined. If we can find any obstruction to the free passage of air, such as hypertrophy of the mucous membrane, polypi, deviation of the septum, post-nasal growths, &c., or any changes in the mucous membrane (hypertrophy or polypoid degeneration, &c), these must be treated and cured. Even if the treatment does not remove the symptoms it cannot do the patients any harm, but must be of benefit in other respects. I need not refer to the connexion between these diseases and those of the ear and throat, and how any nasal obstruction prevents the normal development of the lungs and arrests the growth of the body and of the mind. Innumerable cases of asthma, hay fever, megrim, and supra-orbital neuralgia have been cured by intra-nasal treatment, and a large number have been recorded. I can call to mind a series of typical cases of asthma, hay fever, sneezing, megrim, and redness and swelling of the nose, which have come under my notice, and which have been cured in most cases by removal of nasal polypi or by the application of the galvano-cautery to the diseased mucous membrane of the lower turbinated bones.

Bradford.

A CASE OF POST-PARTUM TUBO-OVARIAN ABSCESS IN A PECULIAR POSITION.

BY FREDERICK EDGE, M.D. LOND., F.R.C.S. ENG.

THE patient was a woman twenty-one years of age, of slight but active frame, and generally sound. Four months previously she was confined of her firstborn child, and she informed me that she had had a severe confinement. There was no special cause of obstruction or hæmorrhage, neither was laceration to any degree of the parturient canal noticed. After the birth of the child the patient did not gain strength and recover quickly, but had a severe illness with fever, pain in the left side of the pelvis and down the left leg, and a mass in the left side. When admitted there was no fever, but the pulse was from 90 to 100. She complained of pain in the left side and general debility. The pain was much increased if she was up for a short time. On examination of the abdomen a prominence in the iliac fossa was seen; this could be felt as a firm, rounded, crescentic mass, in which fluctuation was doubtful, and it was dull on percussion. Per vaginam the uterus was felt to be fixed to a mass on the left side which spread to the pelvic wall. Bimanually the uterus could be felt distinctly, and a boundary marking it from the lateral mass, but not separating it by any division, was perceived by a difference in consistence and roughness of outline. By the sound the uterine cavity was found slightly enlarged and dilated, but not more than one would find often at the same period after labour. The mass did not push down the posterior fornix, and the posterior wall of the uterus was free. As there were no urgent symptoms the patient was kept at perfect rest for six weeks, and her bowels were constantly emptied by saline aperients; alteratives and absorptives, counter-irritants, with ichthyol-glycerine applications in the vagina and hot douches and enemata, were all carefully tested, and their conjoint action was accompanied by a gradual lessening of the swelling, and would, perhaps, have attended its disappearance if the patient could have been rested indefinitely. At the end of six weeks she was allowed up for a couple of hours, and she next morning noticed a great increase in the size of the mass and in the pain and discomfort. From the shape of the swelling, its position, the absence of fever, and its history, I diagnosed the condition as one of pyosalpinx with cellulitis of the broad ligament, and as I could not keep the patient on her back indefinitely, she being a labouring woman, I thought it would be good practice to explore, and, if found, to remove the pyosalpinx. On opening the abdomen great adhesions were separated, and then for some time I could not make out the condition of the parts, or what I had to deal with, or what I was going to do. The pouch of Douglas was free, which rather put me off pyosalpinx, and I was inclined to think that I had to deal with a simple plastic cellulitis of the left broad ligament. The omentum was in a column or rolled bundle, and was adherent widely in the left iliac fossa, which is uncommon in simple cellulitis. I tried to separate its adhesions, but failed, as the bleeding became severe. I then tied the whole omental bundle in two places, cutting between. It was evident now that the tube and ovary were implicated, and the resulting mass, which contained a fluctuating cyst of Tangerine orange size, was fixed high on the left pelvic wall and in the left iliac fossa, where the omentum had covered it and adhered to it and the parietal peritoneum. The tube and ovary and broad ligament with omentum were removed, together with some parietal peritoneum which was torn off. The attachments were tied off in two pedicles, one at the horn of the uterus and the other at the pelvic wall. The separation was very difficult, and the sigmoid flexure, which was intimately adherent, was badly torn, but not sufficiently in any place, so far as was noticed, to require suturing. A Keith glass drainage-tube was used after washing out with Mr. Lawson Tait's apparatus. The patient's pulse and temperature before operation were 90 and 98° F. respectively. There were collapse and great pain, so that an injection of morphia was given (in my own abdominal sections I have only given morphia twice before, and each patient died, so that necessity is great before I use morphia). An enema of one teaspoonful of common salt, half an ounce of brandy, one ounce of milk, and five ounces of water was given three times in the night. On the evening of operation the pulse was 124 and the temperature 98°. The next day the pulse was 140 and the temperature 98·8°. Slight distension was treated by calomel and enemata of soap, turpentine, glycerine, and castor oil. At 9 P.M. the pulse was 152 and the temperature 99·2°. The bowels did not act either with flatus or fæces, and two days afterwards fæcal matter exuded from the abdominal wound freely. As the enemata were irritant they were changed into free irrigation of the rectum with normal saline solution, which, passing upwards, helped to clear the abdominal channel. The patient gradually improved, and although the fæces passed through the abdominal incision alone for three days she felt better. Gradually more passed per anum, and now the fistula is almost closed. She is walking about at present and gaining strength and flesh.

These fistulæ are very chronic, and no doubt the silk ligatures act as setons. The points of interest in this case are to my mind as follows. 1. The absence of fever when the patient was kept resting. This seems to point away from pus in any cellular tissue and is more in accord with pus contained in a cavity lined by mucous membrane or its homologue as an ovarian follicle. 2. The peculiar position of the mass of exudation and adhesions around the cyst containing pus. In these cases of post-partum suppuration of the appendages it must be remembered that the germs have already gained access to these parts often at or before conception from the other side has taken place. They are generally unilateral; hence the tube which is carried up into the level of the iliac fossa during pregnancy, if inflamed, would form adhesions at this level, and after labour the descent of the uterus would tend to drag upon the adhesion and permit leakage, which would excite peritonitis and fix the omentum. A condition similar to this, if not the same, was described by Mr. J. W. Taylor, and he pointed out in certain cases the difficulty of making out such a tube sac owing to its position. 3. The frequence of post-partum suppuration in the tubes and ovaries. When we reflect on the possibilities which the corpus luteum of the ovary, a mass of lowly organised clot, offers, the widely patent tube in which ciliated epithelium must be merely side fringes at these times, and the uterine and vaginal states, we cannot be surprised at this. The abscess usually distends the ovary, but the tube mouth is spread on the ovary, and if detached the

[9] Brit. Med. Jour., Jan. 22nd, 1887.

abscess ruptures, as did the abscess cyst in this case. 4. The passage of fæces and flatus through the fistula alone for three days. This only shows the extent of the deficiency in the bowel wall, and perhaps the collapse of the distal bowel. This exercised my mind somewhat as to treatment. At first I put a glass, then a thick rubber, drainage-tube into the rectum, thinking to prevent the passage through the fistula by providing a constant escape per anum; but I afterwards removed it because it occurred to me that by keeping the distal bowel always collapsed I might entirely defeat my purpose, since the laceration in the bowel would thus be brought to gape more widely, and thus offer a direct passage into the fistulous track. This is merely theory, but it may be useful to think of these *minutiæ* in certain cases. It may be asked whether the operation has been of use at all, and I can answer that I believe it has, because it has removed a sac of pus from the pelvis. This sac would not have become absorbed quickly (the lessening by treatment was of the surrounding inflammatory exudation and adhesion chiefly). It could not without rupturing an organised cellular wall escape externally, as a cellulitic abscess does, and finally heal after long discharge. If it had subsided for a time so far as to allow conception again to take place there would have been trouble during pregnancy and every possibility of rupture and fatal peritonitis at the confinement. Should the fistula not close within six months I shall, with the patient's consent, reopen and remove the silk ligatures if possible. At such a depth I should not try to find the opening in the bowel and close it, unless, indeed, I am mistaken as to the remoteness of the fistula. The fistula has now healed up (July, 1895).

Wolverhampton.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Procemium.

ST. THOMAS'S HOSPITAL.

THE SURGICAL REPORT OF A CASE OF JACKSONIAN EPILEPSY WITH APHASIA, INTELLECTUAL IMPAIRMENT, AND PARTIAL HEMIPLEGIA, TREATED BY TREPHINING.

(Under the care of Mr. W. ANDERSON.)

IT is difficult to state the nature of the lesion which caused the symptoms in this case, but there can be no doubt as to the benefit which the patient has derived from the operation. It will be interesting to learn the ultimate result of the operation. For the notes of this case we are indebted to Mr. Cuff, late house surgeon.

The patient, a boy aged thirteen, was admitted into Arthur Ward, St. Thomas's Hospital, under the care of Dr. Payne, in September, 1894. He was the fifth and only living child of his mother, whose other infants were stillborn. Shortly after birth he manifested undoubted signs of congenital syphilis, including snuffles and sores on the nates and around the anus, which were treated successfully by mercurial inunctions. Up to the age of ten he was regarded as a bright boy; but from this period his mental and physical evolution came suddenly to a standstill without any apparent cause, and he became silent and morose. A year later he was seized by a fit of tremors and twitching of the mouth, followed by partial loss of speech and shuffling gait. He imperfectly recovered from this and continued to go to school, but six months afterwards he had an epileptic fit. Again an interval of improvement followed; but a few weeks later he suddenly became aphasic, and the defects in his intellect and gait became strongly marked. On admission to hospital he presented the aspect and development of a boy nine or ten years of age. His head appeared to be of good conformation, but his frontal eminences were unduly prominent, and his expression was stupid and rather vicious. The incisors were pegged, but there were no other marks of congenital syphilis. The intellect was gravely impaired; he was childish and irritable in manner, his speech was thick and hurried and usually limited to "Yes" or "No," but he appeared to understand when spoken to. He called things by the wrong names and did not recognise letters, although he could repeat words correctly when he heard the sounds. His legs showed a tendency to involuntary and sustained contraction of the extensor muscles, and in walking he kept the limbs widely separated. The arms were normal. The pupils acted to light and the right was smaller than the left. He improved up to Oct. 12th last, when he was attacked by epileptic fits, three in the day. On the 13th the fits were fourteen in number, and on the 14th as many as twenty. From this time they recurred in numbers of fifteen or twenty every day. During the fit the eyeballs turned to the right, the right arm was slowly raised and pointed forwards, the elbow was extended, the wrist flexed, the thumb flexed and adducted, and the third and fourth digits were bent. The right side of the face, with the right arm and sometimes the right leg, twitched, and the right pupil was dilated. The attack lasted for about two minutes, leaving the boy drowsy, with partial paralysis of the right side of the body. After the fits had set, in the right arm was found to be almost useless, all power of walking was lost, and the intelligence became infantile. After a consultation between Dr. Payne and Mr. Anderson it was decided to trephine over the motor area and explore the condition of the brain and membranes at that point. On Oct. 27th a circle of bone an inch and a half in diameter was removed from a point in front of the lower end of the fissure of Rolando, on the left side, exposing the membranes over the convolution of Broca and the lower parts of the precentral and second frontal gyri. The dura mater was found to be normal in aspect, and on incising this the brain with its arachnoid and pia mater bulged strongly into the wound, and it was noticed that the cerebral pulsations, at first indistinct, quickly assumed their natural character. The arachnoid was somewhat opaque and presented yellowish lines opposite the sulci. A grooved needle passed into the brain tissue in two or three directions revealed no abnormality. The incision in the dura mater was not closed, but the scalp wound was sutured and dressed. On the night of the operation the boy was very quiet, but spoke one or two words when addressed and seemed to be quite conscious of his surroundings. On the 31st the strength of the right arm appeared to have become greatly restored. No fits had occurred since the operation, but his temper was very irritable. The wound healed by first intention. From the time of the operation the patient made unbroken progress. The fits did not return, speech steadily amended and within a few days became fairly connected, the memory for names became stronger, and he was able to tell his own name and to write it, but there was still much to be desired. He recollected recent events vividly, and not only recognised a fellow patient who had just returned from a convalescent home, but mentioned the place from which he came. The irritability of temper subsided, and the power of observation and reasoning power rose daily to a higher plane. The gait became firmer, although in walking the legs were still kept somewhat wide apart, and the arm completely recovered its utility. When discharged on Jan. 6th, 1895, the restoration of his powers was still progressing, but he had not reached the full standard of his age. It was decided to await the course of events. The last report states that he is in good health, free from fits, and from paralytic symptoms, but his intelligence is still incomplete and his education at a standstill.

Remarks by Mr. ANDERSON.—Omitting all comments on the medical aspect of the case, it is sufficient to notice that the good effect of the operation, marked as it was by so rapid and extensive an amendment in the intellectual and motor powers of the boy and by the complete abolition of his epileptiform attacks, followed the mere removal of a portion of bone with a division of the dura mater, which could do little more than diminish intracranial tension and allow a better nutrition of the previously compressed structures. The bulging of the brain into the aperture and the speedy restoration of the normal pulsation immediately after the operation were significant in the same direction. It still remains to be seen whether a second operation over the upper precentral and frontal gyri may not be advisable with a view to influence further the still defective intellectual functions. It is not many years since cerebral surgery, except in cases of traumatic injury, was practically non-existent. It is true that in prehistoric times trephining was practised apparently as a remedial measure and without necessarily killing the subject of the experiment, and the operation was