

small fragment of a bone minus its main support, both bony and muscular, cannot be said to afford the patient any great advantage. There is some likelihood of this fragment undergoing necrosis from diminished blood-supply. If thorough asepsis is maintained and if the wound heals by first intention, and if active and passive movements are practised after the first week, complete excision will certainly compare very favourably with partial excision. In my case active and passive movements were not commenced till the twenty-ninth day after the operation on account of the critical condition of the patient. Even then the amount of movement obtained was remarkable. I dare say if movements had been practised early the results would have been much better. Regarding recurrence the weight of evidence, though not much, points to local recurrence, even in total excision. If such be the results after total excision then the chances of local recurrence after partial excision must be much greater. If there be any signs of internal dissemination before the operation then I do not see any utility in subjecting the patient unnecessarily to such a severe operation. The detachment of the origins of the biceps and triceps from the glenoid fossa need not necessarily weaken the movements of the elbow-joint because fresh adhesions in suitable position are sure to form as in my case.

On the other hand, the retention of the glenoid fossa and the coracoid process must be, to my mind, a disadvantage, because the fragment is not likely to supply that firm support necessary for the easy movement of the head of the humerus as in the normal joint, but is likely to move bodily with the head of the humerus acting as a new head, or a traumatic or infective synovitis may take place in the joint and lead to adhesions between the articular surfaces. In such an eventuality the rough edge of the sawn-off fragment cannot be said to offer the best articulating surface for the movement of the humerus. On the contrary, the movements will be limited and attended with a certain amount of pain.

With regard to non-malignant growths of the scapula the line of treatment would depend on the size and situation of the growth. Where it is small and limited one will be content with removing just the involved portion. If, for instance, it occupied the infraspinous fossa, one can safely leave the upper third of the scapula with its spine and muscular attachments; but if it involves the upper half then the whole scapula will have to be removed.

*Conclusions.*—1. The T-shaped incision is the best suited for excision of the scapula.

2. In all malignant tumours of the scapula, whether in its early or late stage, total excision is to be preferred, as the chances of local recurrence after partial excision are great.

3. The retention of the glenoid fossa and the coracoid process, instead of being an advantage, may render movements of the head of the humerus painful on account of the rough surface of the remaining piece of the scapula pressing on the surrounding parts or may limit its movements by its irregular surface. A traumatic or infective synovitis may take place or the fragments may undergo necrosis on account of the diminished blood-supply rendered unavoidable by the necessary dissection of the surrounding parts. This fragment cannot take the place of the normal scapula even to a small extent, as it is no longer connected with the chief muscles which give stability to the normal scapula during the wide range of movements of the humerus—viz., the serratus magnus, trapezius, levator anguli scapulae, rhomboidei, omo-hyoid, so that it is likely to move with the head of the humerus. Moreover, the long head of the biceps and the triceps and the coraco-brachialis will tend to draw the fragment downwards and to keep it well fixed to the head of the humerus, so that during the movements of the joint there will be no movement between the head of the humerus and the glenoid cavity, but the whole piece will move as a whole.

4. The operation must be completed as quickly as possible otherwise there will be a lot of hæmorrhage from the surface of the tumour which cannot be effectively stopped even after ligaturing the main vessels.

5. In innocent growths our aim should be to preserve as much of the scapula as compatible with safety. Only that portion of the scapula to which the tumour is attached should be excised but the rest should be left intact. The larger the portion of the scapula left the greater is the movement of the joint.

6. Success of the operation largely depends on strict

asepsis and the early adoption of systematic active and passive movements of the shoulder. A false joint is sure to form round the head of the humerus in course of time.

Bangalore.

## Clinical Notes:

### MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

#### A CASE OF ENTERIC FEVER, RUPTURE OF BOWEL (?), FOLLOWED BY CIRCUMSCRIBED AND SUBSEQUENTLY DIFFUSE PERITONITIS AND RECOVERY.

BY THOMAS LAFFAN, M.R.C.P. IREL., M.R.C.S. ENG.

A DELICATE-LOOKING woman, aged 30 years, was admitted to the Fever Hospital, Cashel, on Oct. 3rd, 1908, suffering from enteric fever. She came from a house where several of the family were laid up with enteric fever. She was positive that she was only two or three days sick before admission. Her temperature was only 101° F. when admitted and her pulse was over 100 and she vomited once or twice. She had all the other symptoms of enteric fever with the exception of the spots. She had diarrhoea, which only lasted a couple of days, after which the bowels were either confined or natural. After a week both the temperature and the pulse became normal and remained so. A circumscribed swelling was present in the abdomen exactly of the appearance of a seven months pregnancy. Some pain was certainly present, but neither pulse, nor temperature, nor any other symptoms, if we except pain in the left iliac fossa, indicated the real nature of the trouble. A careful examination of all the local parts failed to disclose the real state of things. Palpation, percussion, &c., were equally at sea and there was a total absence of any sign or symptom that would point to perforation when, pending an exploratory puncture and while the pulse and temperature were normal and the bowels acting naturally, the circumscribed swelling unexpectedly gave way and a diffuse collection of matter took its place. The abdomen was then opened and 76 ounces of purulent matter were let out. The abdomen was subsequently washed out on several occasions with antiseptic solution. During one of these irrigations the patient fainted and remained in that condition for some hours. From that time onwards she gradually improved and now she is quite well.

Some of the fluid which was withdrawn was subjected to careful examination. Nothing was mentioned either about typhoid fever or a possible bowel rupture to a London expert. He identified the typhoid fever bacillus. As regards the bowel rupture he reported that there was a considerable amount of finely emulsified fat present; he added that this latter suggested the presence of faecal matter but that he was not able to prove this by the detection of any gross faecal constituents. He went on to state that he found a rod-like organism which might be the bacillus coli. In a further communication he reported that after cultivation he found an organism having all the characters of the bacillus coli. It would thus appear to be probable that there must have been some leakage from the bowel. Some circumscribed abdominal inflammation was first thought to be responsible for the swelling. The extraordinary pulse and temperature maintained during and after the leakage occurred seem to me to make this brief record worthy of publication.

Cashel.

#### A CASE OF LEFT-SIDED INGUINAL HERNIA CONTAINING THE APPENDIX VERMIFORMIS.

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THE patient, a married woman, aged 31 years, was admitted to the Royal Free Hospital on May 20th, 1908, under the care of Mr. E. W. Roughton, to whom I am indebted for permission to publish these notes. The patient first noticed a swelling in her left groin five years previously,