

negated by culture. Reference to the register shows that, among the last 574 cases admitted under certificate of diphtheria, repeated cultures proved negative in 172. Of the remaining 402, in which the diagnosis was confirmed by the bacteriological examination, 231 had exhibited in the swab-smear diphtheria bacilli with polar granules, a percentage of 57.

South Tottenham, N.

## Clinical Notes:

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

#### A LARGE HYDROCELE OF THE TUNICA VAGINALIS.

BY C. LLOYD WORRALL, L.R.C.P. LOND., L.S.A.,  
DISTRICT SURGEON, BARBERTON, TRANSVAAL.

ON May 30th I was called to see a native (at the office of the Commissioner of Native Affairs) who was reported to be "suffering from an extraordinary enlargement of the testicles." Visions of elephantiasis of the scrotum flashed across my mind but these were soon dispelled on examining the case. The history briefly was that the tumour had been gradually developing for four years and that it had never given much pain except that on walking there was a general ache. The patient had no recollection of any injury whatsoever to the parts.

I found on examination an enormous scrotal tumour of fairly regular outline, the left side being considerably the larger—it was quite dull all over on percussion and had that elastic feel which strongly suggested fluid. An examination for translucency proved quite negative. There was no impulse on coughing and the spermatic cord could easily be traced to the external rings. The penis was merged into the tumour in such a way that the prepuce alone was in evidence. As I was convinced that the tumour could be no other than an enormous hydrocele I decided to tap it and drew off in all slightly over 78 ounces of fluid. This was contained in two sacs. In the larger one the fluid was dark from what appeared to be disintegrated blood and in the other sac it was the ordinary straw coloured hydrocele fluid.

I venture to report this case as it has one or two points of interest—its enormous size and yet causing little pain or discomfort. Again it was noteworthy that notwithstanding the fact that this hydrocele had been forming for something like four years and reached such a size, the testicles seemed quite normal in size and apparently showed no sign of atrophy. One would have thought that the abnormal pressure of the fluid would have tended to make these organs degenerate and shrink. Another little point worth mentioning is that this native had come in to see the commissioner to report his wife having run away with another native. What a domestic tragedy could possibly have been avoided had this wretched man thought fit in good time to call in the services of a surgeon.

I regret that I am not in reach of any special work on the diseases of the generative organs and therefore am not able to determine the frequency or otherwise of these enormous hydroceles. I note that Erichsen quotes "that Gibbon the historian had an enormous hydrocele, which was tapped by Cline, who drew off six quarts of fluid."

Barberton, Transvaal.

#### A CASE OF ZONA OF THE FOREARM AND HAND.

BY R. E. P. SQUIBBS, M.R.C.S. ENG., L.R.C.P. LOND.

THE notes of the following case may be of interest on account of the rarity of zona of the forearm and hand. R. Liveing in his "Handbook of Skin Diseases," writes, "On the forearm and hand zona is but rarely seen," and Hilton Fagge says, "In some instances of brachial zoster the vesicles reach down to the finger but this is very exceptional."

On June 15th last I was sent for to see the patient, a stout married woman, aged 61 years, and found her suffering from

a typical attack of zona of the left forearm and hand. She complained of severe pain of a neuralgic character. The eruption consisted of several clusters of vesicles on inflamed patches of skin, and were situated on the anterior surface of the forearm, and followed roughly the course of the internal cutaneous nerve. In the palm of the hand a large pemphigus-like bleb had developed and into this some hæmorrhage had evidently taken place. There were also some vesicles on the inner side of the arm, one of which was followed by a small ulcer. The case was successfully treated by the application of hazeline cream and fuller's earth and the internal administration of tonics.

New Lenton.

## Medical Societies.

### GLASGOW AND EDINBURGH OBSTETRICAL SOCIETIES.

#### *Secondary Operation for Complete Rupture of the Perineum.*

THE combined summer meeting of these societies was held in Glasgow on June 21st, Dr. J. K. KELLY, President of the Glasgow Obstetrical and Gynæcological Society, being in the chair.

Dr. C. J. CULLINGWORTH, Honorary President of the Glasgow Society, read a paper on the Secondary Operation for Complete Rupture of the Perineum. He said that owing to the new possibilities which have been opened up by advances in abdominal surgery the interest in the older gynæcological operations had of late years somewhat dwindled; and yet some of these, especially the plastic operations, ministered quite as much to the comfort and well-being of the patients as the more showy achievements of modern times. In tracing the history of the operation Dr. Cullingworth mentioned those of Langenbeck in 1853, Jonathan Hutchinson in 1864, Delere in 1876, and those associated with the names of Emmet, Hegar, Hildebrandt, and Lawson Tait. Emmet's operation, or some modification of it, was the one usually practised in the United States, while in this country the flap-splitting operation of Lawson Tait was perhaps the one most generally adopted. The splitting of the flap by angular scissors instead of laboriously dissecting with a knife simplified and shortened the operation. The weak point was that it left unsutured both the rectal wound and the vaginal wound. In order to be satisfactory any method of operation should fulfil the following conditions: 1. It should restore the perineum as nearly as possible to its original size and shape. The gynæcologist should familiarise himself with the size and shape of the average perineum by taking mental notes of these during his ordinary examination of patients. It was always a temptation to the inexperienced, partly from anxiety lest the new perineum should not be long enough, to carry the new perineum too far forward. This might cause difficulty during labour or dyspareunia. 2. There should be brought into apposition a sufficiently large area of raw surface on the two sides as to make union almost certain. 3. The edges of the rectal side of the tear and those of the vaginal side should be severally brought together by careful suturing. 4. The patient's convalescence should be rendered as free as possible from pain and discomfort. Lawson Tait drew attention to the fact that if the skin was not sutured the patient suffered no pain. Dr. Cullingworth includes only a narrow edge of skin in the sutures and this produces very little pain if there is no tension when they are tied. If no skin is included in the sutures they get buried and the stitches are difficult to get out. 5. The operation should be easy of execution and uncomplicated in its character. 6. The operation should have the result of restoring to the patient efficient control of the bowel. Dr. Cullingworth begins his operation after the method of Lawson Tait by dividing with scissors the cicatricial line of the lower end of the recto-vaginal septum, then upwards on either side and to a less extent backwards, the whole incision roughly representing a capital H. The lateral incisions should be carried forward to the end of the cicatricial tissue, or if that should be indefinite, then to the point where the labia minora commence. The backward cuts are much shorter and facilitate the exposure and union of the divided ends of the sphincter. The vaginal flap should be reflected backwards by scissors or by a knife with the