

erect position, the left half of the abdominal wall was considerably bulged outward, even during normal breathing.

The excised neoplasm, weighing 4100 grammes (9½ pounds), proved to be a spindle-celled sarcoma.

Prof. Sklifosovsky mentions that the first patient from whom he in 1877 removed a large sarcomatous growth, involving likewise the whole thickness of the abdominal wall (see the *Voyenna-Mediz Jurnal.*, July, 1877), is still in excellent health. She also wears a supporting apparatus, preventing eventration, and feels quite comfortable.—*London Med. Record*, May 15, 1883.

### *Healing of Wounds of the Spleen.*

A. DANNENBURG (*St. Petersburg Inaug. Dissert.*, 1882) wounded, in various ways, the spleen in fourteen dogs, killed the animals in periods varying from 24 hours to 108 days, and examined numerous specimens (taken from twenty-eight wounds) microscopically. He sums up his results as follows: 1. Incisions into the spleen are prone to rapid union; some amount of gaping occurs only on the surface of the organ. 2. Incisions into the pulp are prone to heal without suppuration. 3. Suppuration of the splenic tissue, in the course of a wound, occurs only as a rare exception. 4. Adhesion of the splenic capsule to the omentum, which develops very rapidly, is one of the conditions leading to healing of wounds of the spleen. 5. Perforating wounds heal slowly, and always through development of granulation-tissue. 6. Punctured wounds heal by the first intention. 7. Amputation-wounds of the spleen heal by its adhesion to the omentum, resulting from the formation of connective tissue between the parts. 8. In the formation of a scar, both the proliferating elements of the splenic pulp and the epithelioid elements of the reticulum take part. 9. Hypertrophy of the subserous layer of the capsule depends on the proliferation of cells of connective-tissue. 10. There is proceeding an extremely active proliferation of capsular epithelioid tissue around the edges of a wound. 11. There is proceeding a complete regeneration of the epithelioid covering on the surface of a cicatrix left by a wound. 12. Under certain conditions, common epithelioid cells may undergo transformation into cylindrical and cuboid epithelioid elements.—*London Med. Record*, May 15, 1883.

*A Case of Nephrectomy for Rupture of the Kidney where Lateral Cystotomy was also subsequently performed for the Relief of Cystitis caused by Retained Blood-Clots.*

Dr. HENRY G. ROWDON reported, at a late meeting of the Royal Medical and Chirurgical Society (*British Med. Journal*, May 26, 1883), the following case of this:—

Charles M., aged 12, was admitted into the Liverpool Infirmary for Children on December 7, 1882. The previous day he had fallen into a stone basement, a distance of about eight feet. On admission he was found to be passing blood in his urine. He complained of some pain in his right side. The only other evidence of an injury was a small bruise-mark over the crest of the ilium. The diagnosis was that rupture of the right kidney had been caused by the injury. The hæmaturia for the first few days diminished, but it subsequently increased, and was followed by acute cystitis. With the object of preventing blood from entering the bladder, on the seventeenth day after the injury, the injured kidney was removed by a lumbar incision, and then it was found to have been torn nearly completely across. Relief followed the operation. Subsequently, symptoms of acute cystitis again showed themselves. On the twenty-first day after the injury,

and four days after the nephrectomy, lateral cystotomy was performed, when fetid clots were removed, and a free drain of the urine was established. Relief was afforded by the cystotomy so far as the symptoms directly traceable to the bladder were concerned. The patient died on the fortieth day after the injury. The cause of death appeared to have been pyelitis and circumscribed suppuration of the left kidney, lesions probably traceable to an extension of the cystitis which had been occasioned, partly by the presence of decomposing clots, and partly by attacks of retention of urine. It was suggested that, if cystotomy had been performed earlier, the latter consequences might have been averted.

#### *Case of Excision of an Enlarged Cancerous Kidney.*

SIR SPENCER WELLS, at the same meeting, narrated the case of a gentleman, aged 58, whose left kidney he removed last December. It measured six inches by four, and was the seat of the soft cancer. The patient died on the fifth day. The operative procedure was described, and the author urged the importance of uniting, in all cases of nephrectomy by abdominal section, not only the divided peritoneal coat of the anterior abdominal wall, but also the divided peritoneal covering of the kidney. In this case he was content with letting the two edges fall together, and he thought that blood or serum exuding from the tissues behind the peritoneum might have passed into the peritoneal cavity, or that some portion of intestine might have adhered there. This might have been prevented by a few sutures. He had not seen this detail in the operative proceeding referred to in any previously recorded case of nephrectomy.—*British Med. Journal*, May 26, 1883.

#### *Nephrectomy.*

The narrative of the preceding cases gave rise to a very interesting discussion at the Royal Medical and Chirurgical Society's meeting of May 22, 1883.

DR. DICKINSON expressed as a physician, his sense of the great debt of gratitude which was due to the surgeons who had brought stone in the kidney within the list of curable diseases. As to the excision of tumours in the kidney, there was more to be said. These were chiefly sarcomata of a very malignant type. He had examined the *post-mortem* records of 19 cases, and found one point prominent, namely, that there were secondary growths in all of them but three. That showed their malignancy; and he was, on the whole, against their excision, for it was impossible to estimate them until they were far advanced, and then an operation was only rendered justifiable by some such accident as hemorrhage. Sir Spencer Wells's case, he submitted, was not explained by the *post-mortem* examination. The blood which was so freely passed could not have come from the kidney which was excised, for the malignant kidney did not bleed till it had fungated and broken through the capsule, which had not happened in the kidney which had been cut out. The blood, he was inclined to think, must have come from the remaining kidney.

MR. BARWELL recommended a lumbar incision for removal, whenever it was practicable, but remarked that the rib was, in many people, too near to the crest of the ilium to allow of this. He agreed with Sir Spencer Wells's suggestions as to sewing up the peritoneal covering of the kidney when an abdominal opening had been made, but wished to take a further step in such cases, and to drain through the loin the cavity behind the peritoneum, where there might be bleeding or suppuration.

MR. LAWSON TAIT took objection to Dr. Dickinson's opinion against excision