

On the 5th the symptoms had improved. The line of anæsthesia was a little lower and the movements of the left arm were more coördinated but still very clumsy. On the 8th the plantar reflex could be obtained on the right side but there was no alteration of the other reflexes. There was also some increase of power in the lower extremities. On the 9th both plantar reflexes could be obtained and there was also a very slight return of knee-jerk on both sides. On the 16th power over the sphincters had returned. The patient from this time continued to improve very rapidly and when seen some weeks afterwards he was quite well, his gait was normal, he had perfect control over the sphincters, and the knee-jerks were both present.

The symptoms in this case make it quite clear that the ataxy depended on an organic lesion, and its mode of onset points to the nature of the lesion being an inflammatory one and of a disseminated type. It is especially interesting to note that there was no anæsthesia of the arm or loss of sensibility to weights but with regard to the latter symptom it must be stated that it was not tested until after the ataxy had begun to improve so that possibly there may have been some sensory alteration when the disease was at its worst. Another important feature of the case was the very rapid recovery which took place, especially with regard to the ataxic symptoms which passed off in a very few days.

CASE 2.—The second case was that of a woman, aged fifty-eight years, who complained of inability to use the left arm. She stated that she was in her usual health until the evening of Sept. 4th when she noticed a tingling in the left arm and hand and she also thought that her left leg dragged a little. She took very little notice of these symptoms until the next day when she found she had lost control over the movements of the left arm. This annoyed her especially at meals, for she was quite unable to guide a fork to her mouth with the left hand and she was afraid to try much lest she should hurt herself. She also found that she dropped things if she held them in the left hand. I saw her first on the 6th, two days after the onset of the symptoms, and there was then still very marked incoördination of the left arm. On attempting to touch any point the fingers went very wide of the mark, so much so that on trying to put her finger to her mouth she missed her face altogether. There was no anæsthesia either over the arm or elsewhere, weights could be well distinguished, and she could also tell what position the limb was put into. There appeared to be some slight weakness of the limb. No definite symptoms could be found in the left leg either motor or sensory. I did not see her again until a week had passed, and by that time the incoördination had almost entirely passed away. She still complained of sensations of numbness, tingling, and coldness all down the left side of the body but no anæsthesia or other objective symptoms could be found. At the end of another week the patient was again seen and the ataxy had then quite disappeared. The coldness of the left side had improved but some tingling and numbness, especially of the left arm, still remained. Otherwise she expressed herself as perfectly well.

With regard to the cause in Case 2 the patient put it down to the fact that she had lately been obliged to carry heavy weights. For three weeks before the attack she had carried a large bucketful of water from the top to the bottom of a house and *vice versa* and the journey was made altogether about four times a day. She stated that she always used the left hand and that she felt a great strain on coming down stairs as she always kept the arm stiff and held the pail well away from the body in order not to spill the water. There were no signs whatever of any organic lesion in this case. On the whole it seemed probable that fatigue was the cause of a temporary functional derangement of the movements of the limb which caused a loss of harmony between the actions of the different muscles and so produced the clumsy movements.

Queen Anne-street, W.

WEST OF ENGLAND EYE INFIRMARY, EXETER.—The committee of the West of England Eye Infirmary, Exeter, which receives patients from all parts of Devon and Somerset, is anxious to erect a new building on the present site. To carry out their full plans £30,000 would be required, but in order to meet present exigencies £10,000 is asked for. As has been already stated in THE LANCET an anonymous donor has recently given £2000 and on Dec. 10th two anonymous gifts of £1000 and £105 respectively were received.

## Clinical Notes : MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

### A CASE OF OTITIS MEDIA ACUTA HEMORRHAGICA.

BY J. T. C. NASH, M.B., C.M. EDIN.

A WOMAN, aged forty-seven years, whose powers had been overtaxed by long and incessant nursing and anxiety, was suddenly seized about 2 o'clock one morning with severe pain in both ears. She stated that the pain was very acute for about an hour when the ears went "pop" and blood began to stream from them. When I saw the patient, about 8 A.M., I was shown several pellets of blood-saturated wool while from both ears there still issued a copious sero-sanguineous discharge. Hearing was markedly deficient on both sides. Each drumhead showed a recent tear. There was a history of some ear trouble when a child but of none in the meanwhile. Under careful treatment the discharge ceased after passing through serous and purulent stages. There was at no time any odour. In the course of the affection the mastoid cells on both sides became involved but the inflammation quickly resolved. The patient made a thorough recovery with normal hearing power. The tympana were left only slightly opaque but the tears had healed.

No doubt the early and free hæmorrhage was of benefit. Both ears were simultaneously affected, but the pharynx was not inflamed.

Beckenham.

### A NOTE ON A RARE DEFORMITY.

BY CYRIL H. FLORY, M.R.C.S. ENG., L.R.C.P. LOND.

ON Oct. 3rd last a primipara in the course of a natural labour was delivered of a male infant who is bilaterally "club-handed"—that is to say, the child's hands are situated at the lower end of the ulna but articulate loosely with the inner lateral aspect of the same. Both radii are wanting (this is mentioned in text-books as being a usual concomitant condition) and on neither hand is there a thumb. The ulnæ are unusually stout as if to compensate for the first-mentioned deficiency. At birth and for some days afterwards the thenar border of the hand lay alongside the inner border of its ulna, the fingers pointing towards the elbow; this position is now modified, the hands being at right angles with the forearm. Using a little force the hand can be brought to the extremity of the ulna and in the same straight line, but the original position is assumed immediately on releasing. The child is for the rest beautifully shaped and there is nothing in the parental history which would lead one to anticipate such a misfortune.

Overton, Ellesmere.

### NOTES ON TWO TYPICAL EXAMPLES OF VARIETIES OF OVARIAN TUMOUR.

BY JAMES OLIVER, M.D., F.R.S. EDIN.,

PHYSICIAN TO THE HOSPITAL FOR WOMEN, SOHO-SQUARE.

CASE 1. *Cholesteatoma; operation; recovery.*—A single woman, aged twenty-five years, began to menstruate at the age of sixteen years. Since its appearance the menstrual discharge had reappeared regularly; it had always been scanty and accompanied by pain, seldom severe, in the lower abdomen. Two years ago the patient had detected a small lump in the hypogastric region. For twenty-one months it seemed to have maintained the same size and as it produced practically no discomfort she paid little heed to its existence. Three months ago she was seized suddenly with severe pain in the lower abdomen and as the pain had continued more or less since its onset and the lump had steadily increased in size &c.

was asked to see her. This attack was not connected with menstruation. On examination I found that the hypogastrium was occupied by a small, central and globular swelling which pushed forward markedly the abdominal wall in its immediate locality. The tumour extended three inches to the left and three inches to the right of the linea alba and its summit was felt at a spot four and a half inches above the pubes. It was very tender to the touch and with difficulty fluctuation could be elicited. Per vaginam the cervix uteri was found to be located rather far back. In front and to the right of the cervix the vaginal roof was pushed down by a somewhat globular swelling, which was fixed and was continuous with the abdominal tumour.

At the operation the tumour was found to be extensively adherent to the anterior abdominal wall and to the floor of the pelvis. After separating the adhesions I transfixed and tied the pedicle and removed the tumour intact. It was a cholesteatoma of the right ovary. The inner lining of the cyst glistened like mother-of-pearl and the fluid teemed with cholesteroline and fat.

*Remarks.*—The cholesteatoma is according to my experience most probably a congenital tumour. It may display no activity until the occurrence of menstruation or the observance of marriage.

CASE 2. *Chondrocystoma; operation; recovery.*—The patient was a woman, aged forty-two years. She had been married twelve years, had had two children and no miscarriage; the last child was born nine years previously. During the last nine months the menstrual discharge which hitherto had recurred regularly had been delayed seven or fourteen days, and had been accompanied with severe pain in the lower abdomen. For six years the patient had complained off and on of pain in the lower abdomen and back. On abdominal examination nothing of note was found, but on vaginal examination the cervix uteri was found to be located well forwards and towards the right wall of the pelvis and the fundus was felt posteriorly in Douglas's pouch; the uterus as a whole was retroverted. To the left of the uterus and in close apposition with it was felt a small movable swelling of about the size of a hen's egg. This swelling was extremely nodular and very hard.

The patient was operated upon, and the tumour when removed proved to be the left ovary slightly enlarged. Its surface was much corrugated. When cut into it was found to be composed of two loculi, one of which contained clear fluid whilst the other was occupied by two softish bodies of the size of beans floating in a little clear fluid. These bodies were unattached. The wall of the cyst was cartilaginous and was nearly a quarter of an inch thick. The free bodies contained in the tumour appeared to be macerated ovarian stroma.

*Remarks.*—"Gyroma" is the name given to this variety of tumour by some authorities, but in my opinion it is not so appropriate as "chondrocystoma." It is a benign growth and is in no way related to the endothelioma. The cartilage of which it is composed is fibrous. The loose bodies found in the interior of this tumour appear to be pieces of ovarian stroma macerated and slightly altered.

Gordon-square, W.C.

WITHINGTON FEVER HOSPITAL SCHEME.—A meeting of ratepayers and property owners in Burnage was held on the 4th inst. "to protest against the proposed erection in Burnage of a hospital for infectious diseases by the Withington Urban District Council." The hospital has to be built somewhere and no one objects to it if it is not near them, but only near their friends somewhere else. The common pleas were raised that it would lower the value of property and was unpleasant in a residential district, but the chairman acknowledged that the objections to it "were largely sentimental." He thought the neighbourhood of the Withington workhouse would be a suitable site as there was an isolated area where there were already a workhouse, a crematorium, a destructor, and a cemetery. But this site would no doubt be objected to by the people of Whalley Range, Chorlton-cum-Hardy and West Didsbury, all residential suburbs. Many speeches were made, all more or less in the same strain, though one of the speakers pointed out "that at present there was not a building within a quarter of a mile of the proposed site." It seems doubtful if this protest will be successful, for an "infectious hospital" as it is often called is never welcome and has to be placed where there is least resistance.

## 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. Proœmium.

### LEEDS GENERAL INFIRMARY.

A CASE OF ANEURYSM OF THE LEFT POPLITEAL ARTERY  
TREATED BY REMOVAL OF THE ANEURYSMAL  
PORTION OF THE VESSEL.

(Under the care of Mr. H. LITTLEWOOD.)

EXTIRPATION of the sac of an aneurysm, when possible, is probably the most satisfactory method of treatment of this serious disease of an artery and the results are superior to those following any other method of treatment. P. Delbet<sup>1</sup> collected statistics on the subject and showed that extirpation gave a mortality of 11.32 per cent., while the death-rate from ligature was 18.95 per cent., though it must be remembered that in most of the cases in which extirpation has been applied the aneurysm has been traumatic. It might have been thought that gangrene would have been a more frequent result of this method than of ligature, but it is decidedly less common after extirpation, and the probable explanation is that in ligature the artery is occluded at two points—namely, at the aneurysm and at the point at which the vessel is tied, while in extirpation the continuity of the artery is destroyed only at one spot—namely, where the aneurysm is situated. Of course the method of extirpation has its limits, but at present it is hardly possible to define them as it has not been applied in a very large number of idiopathic aneurysms. For the notes of this case we are indebted to Mr. F. E. Taylor, house surgeon.

A married man, aged twenty-five years, was admitted to the Leeds General Infirmary under the care of Mr. Littlewood on June 9th, 1897, on account of pain and a pulsating tumour in the left popliteal space. He stated that he was engaged as a tailor's presser and stood all day at a table and used with his right hand an iron weighing 24 lb.; whilst doing so he had the left leg constantly extended and in advance of the right. He was engaged to do "piece-work" and when in regular employment worked about twelve hours a day. For two months previous to the onset he had been working for fourteen or fifteen hours a day through overtime. The symptoms commenced six weeks before admission. On returning home from his day's work he began at that time to have shooting pains at the back of the left knee and down the leg. The pain was at first slight and appeared in the evenings only. Little notice was then taken of the pain as it was thought to be due to rheumatism and the leg was daily rubbed with some embrocation. The pain gradually increased in severity so that at the end of a week he consulted Dr. Gordon Sharp to whom Mr. Littlewood is indebted for the notes of the case until the time of the patient's admission to the infirmary. When first seen by Dr. Sharp the patient complained of pain in the left popliteal space. He was treated as a case of rheumatism as nothing could be found on examining this region. He was seen a week later when a faint but distinct pulsation could be made out. He was advised to stay in bed, but this he refused to do—in fact he kept to his work (not working overtime) until June 3rd, but he then consented to stay in bed. A few days before this a pulsating swelling could be made out and over this was heard a harsh continuous murmur. From the 3rd until the time of his admission to the infirmary on the 9th he remained in bed. During this time he suffered greatly from pain and the swelling increased in size.

On examining the left lower extremity a pulsating tumour was visible at the back of the knee distending the popliteal space. The circumference of the limb round the middle of the patella measured 16 in., the similar measurement of the other limb being 14 in. The pulsation in the tumour was

<sup>1</sup> Traitement des Anévrysmes externes en général et en particulier. 1839.