

half filled with tepid water (82° F.) are rubbed for five minutes in the water, then dried, and the patient is put to bed. Ambulant cases can rest for an hour and then return home. These baths were repeated three times a week for three to four weeks, the average of baths per patient being eight. The malaria came to an abrupt termination within 10 days. During five weeks only five attacks were noted, my successor at Somvix saw two abortive cases (T. under 101°), and all the 18 cases except one, who had one single slight feverish attack, were free from fever for the year during which they remained under observation. I may add that Dr. Brand⁴ had similar results in typhoid fever.

The following table shows the number of severe malarial attacks per month in 18 cases under different treatments:—

	Attacks per month.
1. In Corsica and France, under quinine treatment (140 days)	107
2. In Somvix (alt. 1300 m.), under quinine treatment (60 days)	65
3. In Somvix, with tepid-bath treatment and without quinine (35 days)	5

The general health of all the patients rapidly improved, while the anæmia disappeared. If this treatment does not appear too simple for my English colleagues to try, I should be glad to hear if any of the 14,000 (or more) patients still suffering from malaria in England profit thereby.

A LARGE URETERAL CALCULUS ASSOCIATED WITH PYONEPHROSIS.

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THE patient, a married woman, was admitted into Great Yarmouth Hospital on Feb. 2nd with a large tumour of the right flank. I saw her on admission, when she gave a history of increasing debility and latterly pain in the right side of the abdomen. Debility had been present for about two months and pain for a fortnight. She had had to get up at night about three times to micturate for a period corresponding roughly with the period of debility. She had hæmaturia about 12 years ago, but no symptoms since then until present illness.

Examination.—On examination she had a large fluctuant tumour reaching from the right loin to well below the anterior superior spine. The tumour had the shape of the kidney, moved on respiration, and was not tender. No pus or blood in urine. Pulse-rate 118. Temperature normal in morning, up to 99·6° to 101° F. at night. I took a radiogram next day and found a large stone at level of sacro-iliac synchondrosis. Diagnosis, large ureteral calculus with hydronephrosis.

Operation (Feb. 7th).—Patient was put in the usual position for nephrectomy and an incision made from angle of twelfth rib and spine down to a point 1 in. internal to anterior superior spine, and thence parallel to Poupart's ligament and 1½ in. above it to just beyond point where the deep epigastric (which was cut) passed upwards. The kidney was first exposed and separated back and front, starting from above and working downwards; it was fairly adherent and below the peritoneum was freely opened, and at the same moment as this was recognised the tumour burst and much pus escaped. The patient was at once turned over on her back, packs inserted, and the pus mopped clear. The stone could now be felt, and I cleared it and the ureter as rapidly as possible from the underlying iliac vessels, until I had got sufficient ureter free below to clamp it. The ureter was then caught in ovariectomy clamps and divided; this left the kidney attached only on its inner surface

by a broad narrow pedicle. This was rapidly divided by scissors and swab pressure until the renal vessels were reached; these were found near the top of the tumour, and were clamped and divided. The peritoneum was swabbed out and carefully sutured, a long tube put in retroperitoneally down to the ureteric stump, which was ligatured, and the wound closed in layers; the tube was brought out near the top of the wound. The kidney must have contained about two pints of pus.

On examining the specimen the stone was found tightly gripped by the much thickened ureter, which was removed with difficulty. The lower part was dry, dark, and shiny, and the upper part covered with a cap of phosphates, soft and mushy on top, so that quite a lot of sand was left behind when the stone was finally shelled out. The stone was 3 in. in length and 4 in. in girth. It weighed 2 oz. 2 drs.

The patient left the hospital in much improved health, with the wound completely healed, on March 15th.

RUPTURE OF AN AORTIC ANEURYSM INTO THE PULMONARY ARTERY.

BY W. E. PEACOCK, M.D. DURH.

THOUGH many cases die from the exhaustion caused by the pressure and erosion before the sac ruptures, and not a few from some other disease, it is agreed that death from aneurysms of the thoracic aorta is generally sudden and caused by rupture of the sac. Rupture of the ascending aorta commonly takes place either externally, into the pericardial cavity, into the right pleural sac, into the right bronchus, or, more rarely, into the superior vena cava or pulmonary artery.

The post-mortem examination of the following case showed rupture into the pulmonary artery.

I was first called in to see the patient a few minutes before death occurred and found a well-nourished woman, aged 67. She was livid in appearance and obviously seriously ill; her pulse was small, intermittent, but not quickened. Ten minutes after my arrival she died. It appeared she had been suffering from a cough and pains in the chest for six months previously, during which time she had been carrying on her ordinary housework. She was the mother of several children and before her cough commenced had been doing hard manual work, pushing a milk wagon from house to house. Only an hour previous to my being sent for she had been out shopping when she began to "feel ill" and unable to proceed alone, so that she was assisted to her home.

An autopsy was obtained and an aneurysm of the ascending aorta, about the size of a Tangerine orange, discovered communicating with the pulmonary artery about an inch above its origin. The communication would admit a large quill and its margins were formed of organised blood-clot. There was no blood in the pericardium, the lungs were deeply congested and the aorta showed marked patchy atheroma. The brain was deeply congested, and one kidney somewhat granular and contracted; all other organs normal.

Up to the present there are about 50 recorded cases of rupture into the great veins of aneurysms of the ascending aorta, or of the aortic arch, and J. B. Herrick has recently described a case in which the sac communicated with the left innominate vein. It is surprising that many of these cases have not ended in sudden death. Herrick's case lived for six weeks, while Strickland Goodall and Kingsbury have recorded a case of rupture into the left pleural cavity in which death did not occur until over five weeks afterwards, when the patient suddenly fell back dead.

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⁴ Deutsche Medizinische Wochenschrift, 1887.