

combined with the manipulation of the uterus through the abdominal wall were contributing factors in the change of position. Children V₁ and B₂ had a conjoined placenta. The change in position of the third child was most probably the reason why this large placenta came away last of all.

The puerperium was uneventful. The uterus involuted quite normally. The lax condition of the abdominal walls after delivery was very remarkable. Puerperal complications are said to occur more commonly in the case of triplets. This is probably because of the unusual strain on the mother and the liability to complications during the labour. No collapse occurred after labour, although such an enormous reduction in the intra-abdominal tension had taken place so comparatively suddenly. I believe that it is in these cases that the application of a firm binder is more especially useful in averting collapse.

In cases of triplets the children are often very premature and many are stillborn. The foetal mortality (according to Edgar) is about 31 per cent. The children delivered at this labour were certainly slightly premature but they all thrived very well after birth. However, I have recent information that one child died when two months old from broncho-pneumonia. The other two are in splendid condition.

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NOTE ON AN ABNORMALITY OF THE LIVER SIMULATING A THORACIC TUMOUR.

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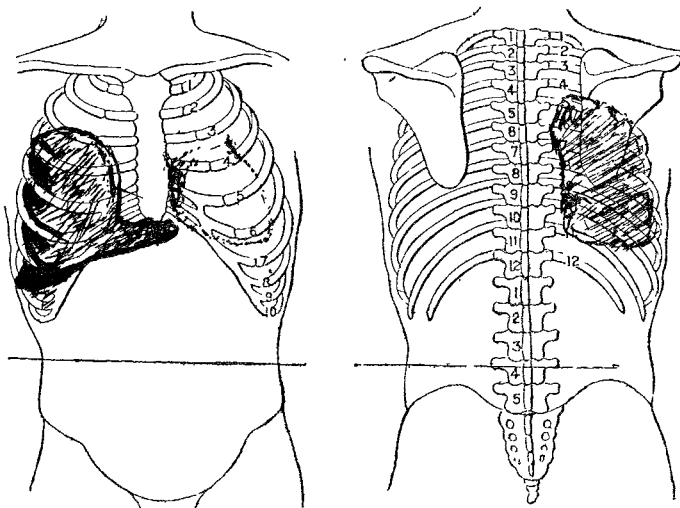
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THE patient, a man, aged 57 years, was admitted to the Blackburn and East Lancashire Infirmary on the evening of Dec. 16th, 1907, partially unconscious and suffering from dyspnoea. He had been working up to three days previously. The history of the illness was that on Dec. 13th while stretching up to the mantelpiece he was seized with sudden pain in the chest and with shortness of breath.

On admission he was suffering from severe dyspnoea and had a pulse rate of 106, his temperature being 101.6° F. The lungs produced a highly resonant note on percussion, except on the right side, where an area of dulness extended from the second interspace to the costal margin in front and going as high as the spine of the scapula behind. Over the dull area was an absence of breath sounds, of vocal



Rough diagram to illustrate area of absolute dulness on the right side of chest. The shading should have extended up to the lower border of the second rib in front.

resonance, and vocal fremitus, but harsh vesicular breathing, accompanied by numerous crepitations and a few sibilant rhonchi, could be heard over the rest of the lungs. The heart appeared to be enlarged; the apex beat was at the level of the sixth rib, half an inch outside the nipple line. The heart sounds were muffled and considerably masked by respiratory sounds. The legs were cedematous up to the knees.

There was no albumin in the urine. The patient was restless and irritable and apparently unable to answer questions. He gradually lost consciousness and died on Dec. 18th.

A post-mortem examination was made. On opening the right thoracic cavity a large, smooth, rounded tumour was seen projecting up through the right side of the diaphragm into the thoracic cavity and displacing the lower and middle lobes of the right lung, which were collapsed and shrunken into a very small size. The lower and middle lobes were pushed up by the tumour into the upper and back part of the right thorax against the upper lobe which was emphysematous. The upper convex surface of the tumour was covered by the diaphragmatic pleura and reached to the level of the second rib. The inferior surface forming the base was slightly concave and rested upon what was apparently the liver beneath it but at the same time was attached all round to the remainder of the diaphragm. On opening the abdomen the liver was seen in its usual position but seemed to be of unusual shape and to be minus the gall-bladder. It extended from the right hypochondrium almost to the left but no division into the right and left lobe could be discerned. After removing the organ from the abdominal cavity the gall-bladder was observed lying behind it and connected with the thoracic tumour which on section was found to consist of liver substance. These two liver masses were connected by a duct from each, which joined to form a common duct leading to the duodenum. A third small lobe of liver substance was found situated above on the left extremity of the lower lobe, being connected to it by a very narrow neck of liver tissue and surrounded by a fold of peritoneum. The weight of the tumour was 38 ounces, the smaller mass 23 ounces, and the smallest three ounces. The heart: the pericardium was adherent and very much thickened. The right auricle and ventricle were filled with ante- and post-mortem clots. The tricuspid valve admitted four fingers to the middle joint; there were old vegetations on the valve. The left ventricle was hypertrophied. The aortic valves were apparently normal. The lungs: on the right side the pleura was slightly adherent to the chest wall. The lower and middle lobes were collapsed, the upper being emphysematous. On the left side the pleura was extensively adherent to the chest wall. The lung was emphysematous, the lower lobe being cedematous. The spleen was very small; it measured three inches by one inch.

We are indebted to Dr. M. Bannister for his kind permission to publish this case.

Blackburn.

THE CELL AS A FACTOR IN PHAGOCYTOSIS.

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IN the paper on Phagocytosis read before the Medical Section of the Royal Society of Medicine on March 25th¹ Mr. S. G. Shattock and Mr. L. S. Dudgeon emphasised the importance of the rôle of the cell and demonstrated that it, as well as the serum, played a part of some importance. In July, 1907, with the view of endeavouring to ascertain whether fatigue lowered the power of resistance to infection by acting on the cell or the serum, I made 88 determinations of the tuberculo-opsonic index of 44 women in labour in Queen Charlotte's Lying-in Hospital, Marylebone-road, N.W. As the observation seems to suggest that the lowered resistance to infection in women during and immediately after labour may be due at least in part to want of avidity of the cell, I have thought that it might be of some interest to those who heard, or have since read, the interesting paper mentioned above.

With each patient's serum I made two determinations of the tuberculo-opsonic index, in the one case using the patient's own cells and in the other using my cells. I found, using my own cells, that in 39 cases the index was between 0.8 and 1.2. Of the remaining five cases three were above 1.2 and only two below 0.8, thus confirming Dr. G. T. Western's conclusion that fatigue does not lower the opsonic

¹ THE LANCET, March 28th, 1908, p. 933.