

increased to orthopnoea. On examination it was then found that the percussion note was resonant all over the left side of the chest back and front, the cardiac dulness was obliterated, and the heart's impulse could not be felt at all to the left of the sternum. The bell sound was easily obtained. The patient died on April 13th from syncope. The skiagram was taken shortly after death; an exposure of three minutes was given, the tube being at a distance of two feet above the chest.

At the necropsy on puncturing the chest-wall over the left pleural cavity gas escaped under pressure. On opening the chest the cavity of the left pleura was found to contain a large quantity of gas, the lung being collapsed and compressed and the heart being displaced so as to be almost in the middle line. The pneumothorax extended throughout the pleural cavity; there were a few recent adhesions at the apex. No fluid or pus was present. The perforation had taken place posteriorly and above the root, there being a small slit-like opening leading into the lower part of an apical cavity. The lungs showed caseous tubercle throughout. There was no recent pleurisy.

Remarks.—In a case such as the above there is of course no difficulty in making a diagnosis of the condition present and the chief interest of the skiagram, apart from what may be learned from it by the practical x-ray worker, lies in the very clear demonstration of the position of the displaced viscera in a case where the lung is not firmly bound by adhesions and where there is a positive pressure within the pleural cavity. The flattening and downward displacement of the diaphragm could hardly be made out by physical signs; the position taken up by the lung and the complete displacement of the heart from the left side of the chest are all clearly shown in the skiagram. Another point well brought out is the broadening of the intercostal spaces on the side of the pneumothorax. In addition the skiagram shows the shadows thrown by caseous tubercles, the portion of lung immediately above the right arch of the diaphragm being the only clear piece of lung shown.

For permission to publish these notes I am indebted to Dr. Clifford Beale, under whose care the case was.

P.S.—Since sending this case to THE LANCET I have shown in the museum of the British Congress on Tuberculosis five cases of a similar condition; and I believe other cases are on record, one being shown by Professor Bécélère of Paris.

Victoria Park, E.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF EXTRA-UTERINE GESTATION; RUPTURE INTO THE GENERAL PERITONEAL CAVITY; OPERATION; RECOVERY.

BY D. LLOYD CLAY, M.R.C.S. ENG., L.R.C.P. LOND.

ON April 19th, at 5 A.M., I was called to see a woman, aged 31 years, who presented all the signs of internal hæmorrhage. Her face was deadly pale and her pulse was very quick and almost imperceptible. She was bathed in cold perspiration and she complained of agonising pain in the lower part of the abdomen, chiefly on the right side, and also about the right shoulder. On examination slight distension of the lower part of the abdomen could be made out and there was great tenderness in the right iliac region, the slightest touch causing the patient to call out. The breathing was very shallow and purely thoracic. Per vaginam I was able to make out a little fulness on the right side and behind the uterus. The history of the case was as follows. For six weeks she had suffered from irregular hæmorrhages accompanied by shooting pains; the discharge would sometimes last two or three days. At times she passed some solid material. Previously to the appearance of these hæmorrhagic discharges she had not "seen anything" for six weeks. From the above symptoms and the history I diagnosed extra-uterine gestation (three months) with rupture into the peritoneal cavity, and I called in Dr. W. Fell who confirmed the diagnosis and advised immediate operation.

At 7 A.M., after the patient had rallied slightly, I accordingly opened the abdomen midway between the pubes and the umbilicus, the incision being three inches long. On reaching the peritoneum that membrane bulged into the wound and on being opened a quantity of blood escaped. I then easily reached the gestation sac, transfixed the base with an aneurysm needle threaded with stout silk, and tied it in two places. One ligature was cut short, while the other was thrown round the whole pedicle and tied again and the sac was removed. All clots were removed, Douglas's pouch was well sponged out, and the abdominal cavity was washed out with large quantities of boric lotion, saline solution being used at the finish. The abdominal wound was now stitched in the usual way and the patient was put back to bed, having stood the operation, which lasted 35 minutes, very well. Vomiting was very troublesome for the first 24 hours, and the patient was given ice to suck and small doses of morphia hypodermically. The patient did very well up to the nineteenth day, when I was again sent for. On examination some fulness and tenderness could be made out in the lower part of the abdomen. The temperature was 102.6° F. I now felt sure that there was some collection of pus somewhere in the pelvis. On the twenty-first day there was great abdominal distension, together with retention of urine. The temperature was 101°, the pulse was quick, and great pain was complained of. Per vaginam a fluctuating swelling could be made out in Douglas's pouch, pushing the uterus upwards and forwards, the cervix being felt right above the pubes. The posterior vaginal wall was very tense and bulged externally. Pelvic abscess was diagnosed, and I decided to make an opening as soon as possible per vaginam. On examination per rectum, however, the abscess was found pointing and on the verge of bursting about three inches above the anus. Slight pressure by the finger was sufficient to open the abscess and a large quantity of pus mixed with blood escaped. There was immediate relief; the temperature dropped and the patient recovered without a bad symptom.

I report the case on account of its successful result and because it was so very heavily handicapped. The operation had to be done in a great hurry and in a private house—where, of course, strict antiseptic principles could not be carried out. The patient was so blanched that not a single vessel had to be seized on cutting through the abdominal wall.

Wellington, New Zealand.

A CASE OF PAGET'S DISEASE OF THE NIPPLE OCCURRING IN A YOUNG SUBJECT.

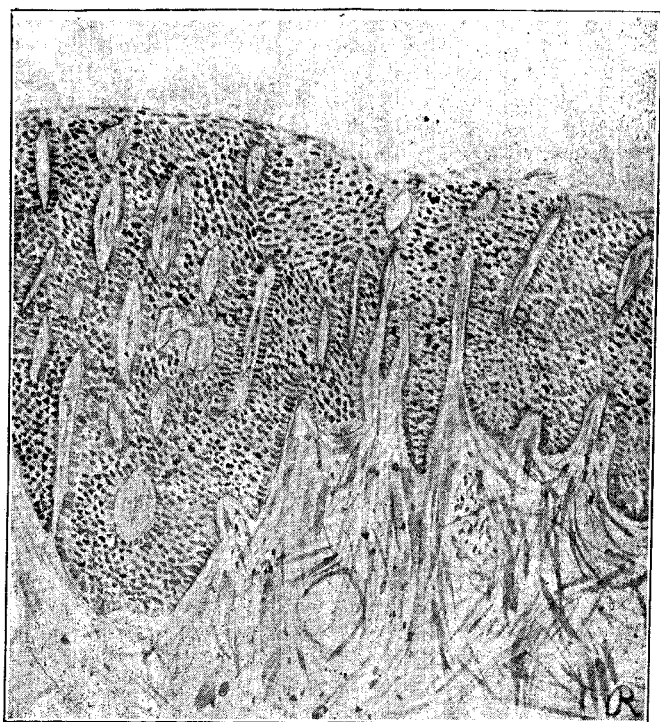
BY RICHARD ALCOCK, M.D. VICT.

SOME time in 1892 I was consulted by a woman on account of an eczematous condition of the right nipple and areola. She was 28 years old, was married, and had borne children. She came to me from time to time afterwards, but no treatment had any effect. In 1893 I advised her to have the entire breast removed. The condition at that time was as follows. Occupying the situation of the areola was a slightly raised eczematous surface, moist, red, and exuding a discharge clear, yellow, and viscid. There was no ulcer, strictly speaking, the surface of the sore retaining a cutaneous appearance. The nipple itself was non-existent; as the patient expressed it, "it had scaled away," probably a literal statement of actual fact. The condition was sharply limited to the region of what was formerly the areola. I advised complete removal on account of the known tendency to carcinoma in these cases and also because a nippleless mamma would be a useless appendage.

In November, 1893, the patient was removed to the Goole Cottage Hospital and the operation was performed by my friend Dr. Macdonald Brown, surgeon to that institution. The after-history was uneventful. Up to the present time (1901) there has been no recurrence and she has enjoyed good health since and given birth to further children.

I prepared sections for the microscope, from one of which a drawing was made under a low power (vide illustration). It will be seen that there is a considerable proliferation of the epithelium downwards into the subcutaneous tissues in the form of branching and anastomosing columns of cells. The vascular papillæ reach up as far as the free surface and no doubt account for the exudation. On the surface there are abundant evidences of loss of substance by shedding of

the superficial epithelial cells. The morbid conditions were limited to the cutaneous tissues. The condition is clearly a neoplasm, simulating epithelioma to a certain extent, but differing from it in many respects, notably in the entire absence of "nests." I have thought it worth while to place



a, Epidermis. b, Papilla. c, Dermis.

the case on record on account of the youth of the patient and also on account of the microscopical characters which I have not seen described as here presented in any text-book to which I have immediate access.

Goole.

HÆMORRHAGE DUE TO INCOMPLETE ABORTION.

BY F. W. ERNEST HUTCHISON, M.B., C.M. GLASG.

A WOMAN, aged 36 years, who had been married 10 years and was the mother of four children, consulted me in January last, complaining of losing blood at different times, first dating the symptom from a miscarriage which she had had six months before. She was two and a half months pregnant, she said, when the miscarriage took place. Just before consulting me she was losing a much greater amount of blood than previously. She was extremely anæmic and weak. On examination blood could be seen escaping from the os uteri. The sound passed three inches and the uterus was slightly enlarged. The patient losing so much blood and being so weak I decided at once to explore the interior of the uterus. This I did in the usual way by Hegar's dilators, and passing the finger inside I at once detected a number of small lumps studded over the surface. These were removed by the finger-nail chiefly and also by Récamier's curette. Afterwards I applied pure carbolic acid to the endometrium. Subsequently the patient menstruated normally in every respect.

Kelvedon, Essex.

LONDON TEMPERANCE HOSPITAL.—A stained-glass window has been recently unveiled at the London Temperance Hospital by Mr. Alderman Strong, chairman of the board of management. The window is the gift of the brother of a patient, is the personal work of the donor, and was given as a token of appreciation of kindness and benefits bestowed by the hospital staff. The window is pictorial in design, the central figure being that of Christ, surrounded by those in fetters, the suffering, and the young; underneath is inscribed the text, "Come unto Me, all ye that labour and are heavy laden." On either side are angels praying and shields bearing the words, "Amor," "Pietas," "Patientia," and "Fortitudo," surmounted by angels in glory; the canopy is white and gold. Among those present were the Rev. Dawson Burns, D.D., Colonel Sheffield, L.C.C., and the members of the board of management.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas e morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

UNIVERSITY COLLEGE HOSPITAL.

A CASE OF TUMOR CEREBRI IN WHICH ROTATION OF THE TONGUE WAS PRESENT.

(Under the care of Dr. J. ROSE BRADFORD.)

THE abnormal movement of the tongue described in the case recorded below is remarkable and difficult to account for by the light of our present knowledge. In cases of lingual paralysis it is very desirable to determine, when possible, which individual tongue muscles are paralysed, both intrinsic and extrinsic. For the notes of the case we are indebted to Mr. A. Ernest Jones, late house physician.

A woman, aged 37 years, was admitted into University College Hospital on Jan. 5th, 1901, with the following history. She had suffered from headache, which was not localised, for two years. Attacks of vomiting had occurred every month for the past five months, lasting for three days. These attacks had no relation to food. There was no nausea. She had had fits for three years. The convulsions started in the right arm or leg and never became general. They were accompanied by no loss of consciousness and could be stopped by sitting on the twitching hand. She had had two "strokes." The first "stroke" occurred on August 21st, 1899, when she became unconscious after several fits and was comatose for six weeks. There was no vomiting. The right arm, leg, and face were found to be paralysed on the tenth day. The second "stroke" occurred on Dec. 26th, 1900, and left her weak in the left side of the face. Her memory had been failing for 18 months.

On admission there were slightly marked cerebral hemiplegia on the right side, involving the face, and fine occasional tremor in the right hand, which was increased by exertion. Sensation was unaffected. The movements of the eye and the pupils were natural. The palate moved well. On opening the mouth the lower jaw distinctly went over to the left, and the left masseter was weak. The tongue, when protruded, went to the left, but not more than would be accounted for by the jaw movement. It, however, rotated in such a manner that the dorsum looked upwards and to the left. It was horizontal when at rest and showed no atrophy or trophic changes. Well-marked optic papillitis with commencing atrophy was present, the inflammation being more marked on the left side than on the right. The sight was unaffected. There was no other evidence of involvement of the cranial nerves. The sphincters were unaffected. The intelligence was dulled.

The patient died seven weeks after admission. During that time she had 50 or 60 fits, no aura occurring. The only changes in the physical signs were that the rotation of the tongue became less marked in the last two weeks of life and rigidity of the left limbs supervened a few hours before death. Twitching of the right face also frequently occurred.

Necropsy.—At the post-mortem examination a subcortical tumour was found on the left side of the cerebrum. It was five or six centimetres high; it had its centre opposite the arm area, involved the corpus callosum, and was evidently pressing on the opposite hemisphere. Microscopically it was a round-celled sarcoma.

Remarks by Mr. JONES.—I have been unable to find a case of rotation of the tongue occurring clinically anywhere recorded. Beevor and Horsley¹ state that on stimulation of a localised area of the cortex in the lower part of the ascending frontal convolution opposite the upper end of the inferior transverse frontal sulcus of Eberstaller the tongue rotates in such a manner that its dorsal surface becomes applied to the cheek of the same side. This movement

¹ Philosophical Transactions of the Royal Society, vol. 185B., Part i., 1894, pp. 54-58.