

mosis, a temporary paralysis in the lower limbs—a so-called reflex paraplegia. In the Planaria the primordial liver consists of nothing more than a few cells scattered along a tract of the intestinal surface, which secrete efficiently for the requirements of the organism. As we ascend the scale of animal life, however, we find these cells by agglomeration and multiplication forming a distinctly projecting nodule from the perivisceral wall of the bowel into the perivisceral cavity, and eventually culminating in the production of that large and apparently independent organ—the liver. It is therefore a gland which, secreting into the intestinal canal, is developed from the coats of the gut. The existence here of a free nerve inter-communication is evidenced by the fact that the passage of a slightly acid fluid into the duodenum determines forthwith a copious secretion of bile, whilst that of an alkaline fluid produces little or no effect. Menorrhagia is a symptom frequently associated with pyonephrosis in the early days, and more especially when this disease appears on the left side of the body. It is the manifestation of a mere augmented and prolonged functional activity of the uterus and Fallopian tube, determined in some occult manner by the condition of the renal organ, whilst the periodicity of the flow itself is undisturbed. In such cases I have failed during life to detect any evidence of disease in the generative tract, and have twice verified this fact by a careful examination of the body after death, the uterus, Fallopian tubes, and ovaries being perfectly healthy.

Montague-street, Russell-square, W.C.

PREGNANCY COMPLICATED WITH OVARIAN TUMOURS; TAPPING, DELIVERY, AND SUBSEQUENT REMOVAL OF CYSTS.

By H. F. BAILEY, M.R.C.S., L.S.A.

ON June 5th last I was called to a lady, aged twenty-nine, whom I was to attend in her first confinement. This was about a fortnight before term. I found the abdomen excessively large, and both legs oedematous, blue, and mottled. Palpation revealed fluctuation with distinct thrill, and percussion resonant flanks, with dulness over the rest of the abdomen.

The diagnosis was left ovarian cyst, and, as the tumour was very tense and the patient evidently in imminent danger from rupture of cyst, I tapped about two inches above the umbilicus and removed two gallons of ovarian fluid. Five days later labour came on, and with forceps a healthy female child was born. Lactation was permitted for three months, but the tumour again filling rapidly, the child was weaned.

On Sept. 14th I operated, aided by my partner, Dr. J. N. Miller, Mr. Cooper giving methylene. On opening the abdomen by a four-inch incision, not only was there the left cyst as diagnosed, but the right ovary was the seat of a second tumour, a very dense-walled dermoid cyst weighing 2 lb. I removed the left cyst in the usual way, tying the pedicle by transfixion with Chinese twist and returning it. The tumour of the right ovary was next removed in like manner, and its pedicle also returned. Only one adhesion of omentum required ligature and division. After thorough sponging of the cavity, the incision was closed with silk sutures passing through the whole thickness of the abdominal wall, a Keith's tube inserted, and the wound dusted with iodoform and dressed with Gamgee pads and strapping. The tube was emptied of coloured serum every six or eight hours for a couple of days, and then removed. The dermoid cyst contained epithelial matter and much hair, the whole mass having the appearance and consistence of mortar; the cysts and contents weighed over 26 lb. Recovery was uninterrupted; the evening temperature on the day of operation was 100°; pulse 88. The next day the pulse and temperature were normal, and remained so.

Dr. Fenwick begs for information as to the relation of pulmonary phthisis to ovarian disease. In this case careful inquiry failed to elicit any family history of phthisis, but the patient's parents were first cousins. I suppose the right cyst had remained nearly stationary in size for years, and that gestation determined the rapid growth of the left.

Blackheath.

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.

ST. GEORGE'S HOSPITAL.

COMPOUND DEPRESSED FRACTURE OF THE VAULT OF THE
SKULL; PARALYSIS OF THE RIGHT ARM;
TREPHINING; RECOVERY.

(Under the care of Mr. PICK.)

THE following belongs to the class of head injuries about which the rule as to operating is simple. The exact locality of the cerebral hemisphere on which there was pressure was doubtful, owing to the large area of bone depressed; but the centre of this area was easily ascertained by reference to Reid's base line. For the notes we are indebted to Mr. Bull, surgical registrar.

G. W—, aged sixteen, a milk-carrier, while delivering milk at some area steps was struck on the head by a falling ladder. He was picked up insensible. On admission (April 7th, 1886) he was unconscious, and bleeding from the nose and mouth. There was a semicircular scalp wound about two inches long over the left parietal bone, and at the bottom of this there was a ridge of bone and a depression about a quarter of an inch in depth. The extent of this depression could not be ascertained, as it passed beyond the full length of the scalp wound. There was slight twitching of the right arm. He vomited some blood, and became conscious four hours after admission. Next day he was restless and irritable. He answered questions, but was drowsy at times. There was slight paresis of the right arm, but no marked paralysis. He was able to move his legs, and had entire control over his sphincters. The bleeding from the nose and mouth had ceased. The wound was dressed and was looking quiet. Next day, forty-eight hours after the accident, the lad was more drowsy, and unless roused he lay quietly on his back. There was marked paralysis of the arm, and the grasp of the hand was very feeble.

After consultation, Mr. Pick (ether having been administered) made an incision across the wound, and reflected the soft tissues. A piece of bone measuring about 3 in. by 2 in. was depressed and wedged below the non-depressed part. The centre of this area was 2½ in. behind the left external auditory meatus, and 3 in. above Reid's base line. A crown of trephine was removed, and after a ridge of bone had been sawn off by a Hey's saw Mr. Pick was able to prise up the depressed bone to its proper level. There was no injury to the dura mater. No ligature was required. A drainage-tube was inserted, the flaps united with silver sutures, and wet carbolic gauze dressings applied.

The patient passed a good night, and was cheerful and conscious next day. His temperature was irregular for a few days, and the wound was foul for four days. At the end of the first week the paralysis began to diminish, and from this time he slowly improved. The wound did well, and in five weeks the lad was sent to a convalescent hospital, on May 12th. At this time there was slight paresis of the arm and hand. He remained in the country five weeks, and on returning was found to have completely recovered the use of his hand and arm.

GENERAL LYING-IN HOSPITAL.

CASE OF CERVICAL EMPHYSEMA FOLLOWING PARTURITION;
REMARKS.

(Under the care of Dr. R. BOXALL.)

FOR the following notes we are indebted to Dr. W. G. Holloway, house-physician.

Mrs. S—, aged nineteen, a well-developed but somewhat delicate-looking primipara, was admitted towards the end of the first stage of labour on August 26th, 1886. Full dilatation of the cervix was reached at 10.20 A.M., and the head passed slowly through the pelvis in the first cranial position. It remained two hours on the perineum, and was eventually

expelled without artificial aid at 1.50 P.M. The labour pains were very strong, and towards the end became almost continuous. The patient meanwhile screamed violently. The child, when born, weighed 6½ lb. The placenta was expressed a quarter of an hour after the birth of the child. The uterus subsequently contracted well.

About three hours after delivery the patient herself was aware of a soreness in the neck and upper part of the chest. It began about the left sterno-clavicular articulation, and thence spread upwards and to the opposite side of the neck. Next morning (27th) a puffy swelling was observed at the root of the neck over the manubrium sterni; it was a little tender on pressure. The skin retained its natural colour. At the apex of both lungs, and especially the left, the percussion note was hyper-resonant and the breath sounds feeble. The patient had a slight cough, but no disturbance of breathing. The heart sounds were normal, but at the base were masked by crackling.

On Aug. 29th, during the physician's visit, the following notes were made:—Slight fulness is apparent about the lower part of the neck on either side, but especially the left. The respiratory movements are rather less marked at the left than at the right apex. Over the puffy area emphysematous crackling is easily distinguished by the finger. It is most marked over the manubrium sterni, but does not extend below its junction with the body of the sternum. It can be felt on either side immediately below the clavicle, extending as low as the upper border of the second rib and outwards as far as the coracoid process. It is more prominent on the left side, extending backwards as far as the edge of the trapezius (where it appears to end abruptly) and upwards to within an inch of the mastoid process, but is less distinct and only brought out by deep palpation. In the anterior triangle it again becomes distinct, extending upwards quite as far as the ramus of the jaw and across the middle line to the opposite side. On the right side of the neck it is as distinctly felt in the anterior triangle as on the left side, but cannot be felt in the posterior triangle. No crepitation can be felt under the trapezius, over the mammae, or down the front of the sternum below the junction of the manubrium and body. Over both anterior and posterior triangles on the left side, and over the anterior on the right, a high-pitched hyper-resonant note is readily produced. The percussion note below the clavicle on the left is slightly higher pitched than on the opposite side. Over the whole area above described superficial crepitation sounds are audible. These are especially numerous on first applying the stethoscope to the surface, and are readily brought out by shifting its position, and are produced, though to a less degree, by the inspiratory movements. In addition, over the pulmonary cartilage they accompany each systole of the heart. No corresponding sound is heard over the aortic cartilage, though no emphysematous crackling can be felt; nor can any sounds be produced by pressure of the stethoscope below the junction of the manubrium with the body of the sternum; crepitation sounds are audible, synchronous both with each inspiration and with each systole of the heart, and extending as far down as the xiphi-sternal articulation, on the right side to the border of the sternum, and on the left a finger's breadth beyond it. In the neck, over the whole area affected, slight pectoriloquy is audible, and the voice assumes somewhat an ægophonic character. The skin still preserves its natural colour. The soreness is diminishing.

Aug. 31st.—No emphysematous crackling can now be felt below the right clavicle, and only very little above it. Over the manubrium and in the supra-sternal notch it is still distinct, and also in the left supra- and infra-clavicular depressions. It is disappearing from below the ramus of the jaw on the left side.

Sept. 1st.—The fulness about the neck has subsided; the hollows are more apparent. Slight emphysematous crackling is still present on the left side in the posterior triangle, and very little over the situation of the sterno-mastoid, but is still distinct at the sterno-clavicular articulation, in the supra-sternal notch, and immediately below the clavicle. On the right side it has disappeared from below the clavicle and from the anterior triangle of the neck, but can be indistinctly felt over the middle of the sterno-mastoid and along the anterior border of the trapezius.

2nd.—The emphysematous crackling has entirely disappeared from the right side, and on the left is limited to the situation of the sterno-clavicular joint and infra-clavicular

depression. The crackling sounds accompanying the systole of the heart have also disappeared. The soreness has gone.

3rd.—No trace of emphysema can be detected.

8th.—Mother and child discharged well.

No special treatment was adopted. The temperature remained normal throughout; the pulse varied from 72 to 80, and the respirations from 20 to 24 per minute.

Remarks by Dr. R. BOXALL.—Few cases of cervical emphysema, the result of bearing down during labour, though not very rare (about 1 in 2000 deliverances), have been fully reported. Dr. F. H. Champneys, in an elaborate scientific inquiry on this subject,¹ refers to some twenty cases or more reported by various observers. As the result of experiments made on still-born foetuses, the same observer concludes that "the cause of emphysema of the neck during labour is rupture of the lung tissue—the air escaping near the root of the lung, passing beneath the pulmonary pleura into the anterior mediastinum, and so beneath the deep cervical fascia into the neck"; and further, that "the air emerges from the thorax along the great vessels, but may not become superficial till it has travelled higher up." The clinical facts of the case quoted above are entirely in accordance with Dr. Champneys' observations. It seems highly probable that air escaping at the root of the lung found its way into the anterior mediastinum; hence the crepitation sounds, synchronous with both inspiration and with the heart's systole, audible over the front of the sternum, where no air had escaped into the tissues superficial to the bone. The air travelling upwards along the pulmonary artery would give rise to similar sounds, heard over the pulmonary cartilage with each systole of the heart; thence travelling onwards and directed upwards by the deep cervical fascia, the air entered both anterior triangles of the neck, and on the left side (where it commenced, and which throughout was more affected than the right), passing beneath the sterno-mastoid, inflated the posterior triangle, and on either side passed over the clavicle as low as the upper border of the second rib and corresponding part of the sternum. Subsequently a little air appears to have found its way also beneath the right sterno-mastoid into the posterior triangle of the same side. In the primiparity of the patient, the severe expulsive pains, the onset of the emphysema soon after labour (often during the second stage), its proclivity for the region of the supra-sternal notch, the absence of disturbance to the respiratory function and of the other serious symptoms beyond the disfigurement, together with the invariable tendency to absorption of the air by the end of a week or ten days, this case, though much less severe in character than many, agrees with the majority of those previously recorded.

NEWCASTLE-ON-TYNE INFIRMARY.

TWO CASES OF SUPRA-PUBIC LITHOTOMY; REMARKS.

(Under the care of Dr. HUME).

THE following are reported on the ground that the position of the supra-pubic as an alternative to lateral lithotomy, as well as some of the details of procedure in the first operation, being still unsettled, it is desirable that the record of cases should be as full as possible.

CASE 1.—T. M.—, aged thirty, was admitted on Sept. 4th, 1886, suffering from the usual symptoms of stone in the bladder. These symptoms had been present for twelve months; during the last two months the urine had been turbid and micturition very frequent. At the time of admission the urine was alkaline and muco-purulent. The stone was readily detected by the sound, and seemed to give a hard ring. Measured with the lithotrite it was found to be an inch and a quarter in what was thought to be its shorter diameter; but on account of the sensitiveness of the bladder some little difficulty attended this examination. It was determined not to crush but to remove the stone by the supra-pubic method as an alternative to lateral lithotomy. The operation was performed on Sept. 9th. The rectum was first distended by Petersen's bag, into which were thrown twelve ounces of water. A like quantity of corrosive sublimate solution (1 in 2000) was then injected into the bladder, causing it to rise half way to the umbilicus. An incision three inches long was made above and over the margin of the pubic bone and the dissection carried down to the bladder wall. The plexus of veins in the overlying

¹ Med. Chir. Trans., vol. lxvii., 1884.