

in the present case was derived from that which had been swallowed for the relief of the gastric distress. Owing to the dilated condition of the stomach we must conclude that its contents were unduly retained, so that the salts were absorbed into the blood instead of passing on into the intestines and thence escaped through the kidneys.

I have examined the urine in several instances in which magnesia was being taken, some being cases of moderate dilatation of the stomach, but have failed to find any deposit of the kind I have described; I have also analysed several phosphatic calculi in the museum of University College, Liverpool, but have not succeeded in finding any of the monohydric magnesium phosphate as a constituent.

Apart from the interest attaching to all abnormal states of the urine I think that the present communication is not without its bearings on practical medicine. In the first place, unless the nature and mode of origin of these crystals¹ were understood their discovery in the urine might give rise to misapprehension and perhaps to groundless alarm in the mind of the physician; and, secondly, their presence seems to indicate that the stomach meets with difficulty in emptying itself and so might suggest the existence of serious organic disease.

Finally, we have to ask ourselves, in the light of the present case, whether these crystals may not sometimes coalesce so as to form massive concretions; whether, in fact, the free administration of magnesia may not be an occasional factor in the production of phosphatic urinary calculi.

Liverpool.

A CASE OF OVARIAN TUMOUR WITH SPONTANEOUS RUPTURE AND ŒDEMA OF THE LEGS SIMULATING MALIGNANCY.

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A PATIENT, single, aged 61 years, was sent to me in January, 1902, by Mr. F. J. Hart of Much Wenlock complaining of an abdominal swelling and œdema of the legs. She stated that she had had the change of life eight years previously when she was 53 years of age, that five months previously she had noticed a stiffness and for two months a swelling in the abdomen which had latterly increased very considerably in size. During this same period both legs had become very œdematous which had rendered locomotion difficult and in consequence had confined her to bed. There was no history of any injury or fall but in November pain was complained of in the region of the umbilicus with difficulty in the opening of the bowels. For many years weakness of the bladder had given trouble, producing at times retention of urine with incontinence. On examination the patient, who was naturally spare, was seen to have a large abdominal tumour rising from out of the pelvis and on palpation it was felt to reach to one inch above the umbilicus; it was hard, tense, and fluctuating in places. Above the tumour and in the right hypochondrium and loin fluctuation was obtained as of free fluid in the peritoneal cavity. By vaginal examination the tumour was felt in front and was found to be displacing the uterus backwards. Both legs were markedly œdematous, especially the right. There were no enlarged glands to be felt or prominent veins on the abdomen to be seen, nor was the abdominal wall œdematous. The urine was pale, neutral, and contained no albumin or sugar. The diagnosis made was one of malignant ovarian tumour with free fluid in the peritoneal cavity and pressure on the iliac veins. At the operation on Jan. 17th, on opening the abdomen, colloid material of gelatinous consistency and amounting to about one pint was found free in the peritoneal cavity. A large trocar was inserted into the tumour but owing to the fluid being too viscid it would not run, so that it had to be removed by ladling it out with the hand. The tumour was a left-sided multilocular ovarian cyst and its

pedicle was ligatured in the usual way; the pedicle was not in any way twisted. The peritoneal cavity had to be flushed in order to bring up to the surface the remnants of the sticky lumps of colloid. The peritoneum was everywhere injected, covered with lymph, and showing the results of slight peritonitis. The right ovary was small and atrophic and was not removed. The patient made a satisfactory recovery from the operation, only during convalescence catheterism had to be resorted to on account of the weak and atrophic condition of the bladder. Pathologically the tumour was a glandular multilocular cyst of the left ovary; the contents consisted of a thick tenacious colloid and amounted to about half a bucketful; on most careful examination no point of rupture of the cyst wall could be detected.

The case is interesting and worthy of record on account of (1) the spontaneous rupture of the cyst, allowing of the escape of some of its contents into the peritoneal cavity; (2) œdema of both legs as a pressure symptom; and (3) the difficulty in diagnosis.

1. Rupture of an ovarian cyst is not often met with in a simple tumour, owing to the fact that all such cases are recognised and are dealt with early and before the tension of the fluid within the cysts has reached the point of rupture. In this case the cyst wall was found to have been distended and thinned out in several places. In the absence of any history of injury or fall, this complication must be called "spontaneous" as opposed to "traumatic," and may be accounted for by the rapidity of growth of the tumour with increased tension of its contents. It seems probable that the colloid had been free in the peritoneal cavity for two months, for at this time complaint was made of pain in the umbilical region together with great difficulty in obtaining an action of the bowels, and this was further borne out at the time of the operation when a peritonitis of some weeks' duration was observed, the presence of simple colloid in the abdomen in the absence of any bacterial infection having produced a simple inflammation of the peritoneum with no constitutional poisoning effects. This fact is of particular interest to the abdominal surgeon and it demonstrates that cyst contents and the like of a simple nature are perfectly harmless provided that germs have not been introduced from without.

2. Œdema of both legs as a pressure symptom is not often seen nowadays for the same reason as that before mentioned. The cause of the œdema was on account of the heavy weight of the tumours pressing on the iliac veins, the contents being large in amount and thick, if not semi-solid, in consistency, and this explanation seemed satisfactory when on removal of the tumour the œdema soon disappeared.

3. With regard to the third point the diagnosis made of this case was one of malignant disease of the ovary which rested on (a) the rapidity of growth, for according to the history a swelling of the abdomen had been noticed for two months only although a "stiffness" had been felt somewhat longer; (b) the hard firm character of parts of the tumour suggestive of solidity of growth; (c) fluctuation above the tumour, as of free fluid in the peritoneal cavity, a condition which of itself is highly suggestive of malignancy although met with in some simple enlargements of the ovary; and (d) œdema of the legs, a symptom more often met with in malignant ovarian than in simple tumours although not pathognomonic of malignancy.

Birmingham.

"IDIOPATHIC," OR CONGENITAL, HEREDITARY AND FAMILY HÆMATURIA.¹

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IDIOPATHIC hæmaturia is not mentioned in text-books nor have I found any reference to it in medical literature. Dr. W. H. W. Attlee, however, has recorded "three cases of recurrent hæmaturia occurring in one family"² which I believe to be of the same nature as those which form the subject of this paper. The "essential renal hæmaturia" of

¹ These crystals were demonstrated and described before the Royal Medical and Chirurgical Society of London on Nov. 27th, 1900.

² A paper read before the Harveian Society of London on April 24th, 1902.

² St. Bartholomew's Hospital Journal, December, 1901.