

at which time, in addition to the other facts related, it was found that the cerebral motor nerves, the spinal nerves on the left side, and the sphincters were in normal condition; the special senses were intact, with the exception of a burning sensation on the left side of the tongue, and both ears seemed hard of hearing. The headache, which was tolerably constant, increased gradually when the patient lay on his left side, and diminished on turning to the right. Sight was good on both sides, but no ophthalmoscopic examination was made."

The following is a condensed account of the progress of the case as shown by notes taken from time to time:—During the period intervening between the patient's admission till his death, on Sept. 27th, he remained in much the same condition as regards the hemiplegia; sometimes exhibiting a considerable degree of improvement, but again relapsing. A month after admission he had entirely lost the power of speech, and communicated his wishes by gestures. No convulsions or attacks of vomiting occurred during the whole period he remained in the hospital. Towards the end of the period a marked change for the worse was observed. He complained of excessive headache, refused food, and lay in a state of semi-stupor, disturbed by occasional fits of wild delirium. He died in a state of great emaciation and prostration on Sept. 27th, two months after admission.

Post-mortem examination.—On opening the head the dura mater was found adherent over the left parietal region at its upper part. Growing from the dura mater, on the left side of the falx cerebri, was a fibro-sarcomatous tumour, partially ossified, of the size of a goose's egg, which rested chiefly on the postero-parietal lobule of the left hemisphere. This part of the left hemisphere was scooped out and atrophied to an extent corresponding to the convexity of the tumour; while the hemisphere itself was pressed laterally outwards from the middle line as well as downwards and forwards, so as to cause considerable flattening of the convolutions in the frontal and lateral aspects of the hemisphere. The rest of the brain was normal.

Remarks by Dr. FERRIER.—The symptoms led me to diagnose a tumour of the left hemisphere, and also to determine its probable position. I found that a similar diagnosis of a tumour had been made by Dr. Moritz, from a paper which had been handed to the house-surgeon, on which were written the following words: "Tumor cerebri in parte superficiali sinistra pontis Varolii. Hyperæmiæ periodicæ. Diagnosis non omnino certo, sed valde verisimilis. Therapie: Kali sodat et bromat. Derivantia." Without desiring to call in question the reasonableness of Dr. Moritz's conclusion from the facts he had before him, I formed the opinion that the symptoms pointed rather to a tumour situated on the left hemisphere, and also indicated its special seat. The absence of any signs of interference with the function of the nerves arising from the left side of the pons Varolii, the nature of the paralysis, and the partial and recurrent aphasia, indicated a higher situation of the tumour, the convulsive phenomena receiving an explanation otherwise than from direct irritation of motor strands. From the fact that the voluntary movements of the leg were most affected, I pointed to the upper parietal region as the probable seat of the growth, but reserved an opinion as to how far other centres were involved in structural change. The post-mortem examination justified the correctness of the diagnosis. The cortical region specially involved (the postero-parietal lobule) corresponds to the region in the brain of the monkey concerned in movements of the leg and foot. Hence the marked loss of voluntary control over these movements observed in the patient during life. The paresis of the hand and arm, and also the partial aphasia, receive their explanation by functional interference with the arm and speech centres, caused by the pressure exerted by the tumour, as indicated by the flattening of the convolutions. The arm centres, situated in the convolutions bounding the fissure of Rolando, and the speech centre, known as Broca's convolution, were involved in the flattening, as well as the mid-frontal convolutions which govern the facial muscles. In this condition we have an explanation of the partial affection of movement and function of articulate speech. The functions of the brain centres are specially dependent on the integrity of their circulation and nutrition. The effect of such an increase in the intracranial pressure, as caused by a tumour of such size, was to cause considerable

impairment in the circulation. Hence, in addition to the special symptoms recorded, the apathetic condition and continual tendency to sleep were caused, essentially from the anæmic state of the hemisphere. The stage of irritation, as indicated by the unilateral convulsive seizures, had been passed before the patient's admission to the hospital, and the gradual tendency was to induce more extended and complete paralysis as the tumour increased in size. The case from the first was seen to be hopeless, and the treatment was directed to relieve symptoms and keep up nutrition.

MIDDLESEX HOSPITAL.

MENORRHAGIA; GRANULAR OS AND CERVIX; UTERO-GESTATION.

(Under the care of Dr. ARTHUR EDIS.)

M. M.—, aged thirty-two, married fourteen years, with four children, the youngest three years old. When first seen in September, 1873, she stated that the catamenia had been quite regular until the middle of July, and there had been a slight show and much bearing down in August. On Sept. 13th she experienced severe crampy pain in the left lower abdomen, and profuse flooding commenced; retching and pain in the lower part of the back and abdomen set in, and she had all the symptoms of a threatened miscarriage.

On examination a few days afterwards the uterus was found to be enlarged, the cervix soft, spongy, and intensely granular. Nitrate of silver was applied, and rest enjoined, and, as the patient was very nervous and restless at night, chloral hydrate with bromide of potassium was prescribed. On driving home the same day the cab ran against another vehicle, and was nearly upset. The patient was carried upstairs in a fainting condition, her clothes saturated with blood, and the hæmorrhage continuous. She was seen immediately afterwards, and was found to be in a very prostrate condition. As she was still losing blood, and it seemed more than probable that the ovum had been expelled (nothing definite being ascertainable by a local examination), large doses of ergot were given, and endeavours were made to rally her by stimulants. The hæmorrhage ceased in a few hours, and, after remaining in bed for a week or ten days, she resumed her ordinary avocations, bark and acid being prescribed as a light tonic.

In the middle of October, whilst sitting quietly in the Polytechnic, she felt a sudden gush of blood and watery discharge. She was driven home, and when seen was in a very exhausted condition, faint and sick. On examination, the uterus was found to have increased in size; in fact, there seemed little doubt that utero-gestation was still going on. The cervix being still very granular, a strong solution of nitrate of silver was applied, and absolute rest was enjoined. After a few days quinine-and-iron was given, the cervix being touched with the nitrate of silver about once a week until the granular condition was relieved.

After this she improved in health, and went her full time, being delivered at the end of March last of a fine girl.

The points worthy of note in this case are—the recurrence of severe flooding on three or four occasions, the presence of granular disease of the cervix, the free application of nitrate of silver, and the employment of ergot in large and continuous doses on one occasion (about the second month), without interfering with the progress of utero-gestation. The employment of the nitrate of silver and of ergot was not undertaken unadvisedly or in ignorance, but with full knowledge of the condition and its contingencies. If carefully employed, there is everything to gain and nothing to lose; for if abortion result, it would have been more likely to occur had no treatment been resorted to; and when it does take place it is in spite, and not in consequence, of the treatment.

NORTH LONSDALE HOSPITAL, BARROW-IN-FURNESS.

SEVERE COMPOUND COMMINUTED FRACTURE OF RADIUS AND ULNA; SIMPLE FRACTURE OF HUMERUS; AMPUTATION OF FOREARM; RECOVERY.

(Under the care of Dr. SINCLAIR.)

THE occurrence of cases like the subjoined raises a question which has not hitherto been answered as positively and definitely as may be wished—namely, at what point

amputation should be performed when there is severe laceration or a compound fracture in the distal portion of a limb, with a simple fracture in the proximal portion of the limb? Should amputation be performed at or just above the seat of the laceration or compound fracture, or should it be done high up at the seat of simple fracture? There are some who recommend the adoption of the latter course, on the supposition that there is not, as a rule, sufficient reparative activity to heal the stump and repair the fracture; while others advise amputation only at the seat of compound fracture, leaving the simple fracture to be dealt with in the ordinary manner. Mr. Erichsen says that "the proper course to adopt in such a case as this would mainly depend on the conditions of the intervening soft parts. If these be sound, free from extravasation, not contused or lacerated, the limb may with safety be removed just above the lower fracture, the upper fracture being treated on ordinary principles. But if there is extensive bruising of the limb, with ecchymosis or deep extravasation between the fractures, then it would clearly be useless to amputate low down, as not only would the stump have to be formed of tissues in a state of disorganisation, but the inflammation set up at the seat of operation would speedily spread into the structures filled by extravasation, and, setting up unhealthy suppuration in these, would spread upwards to the higher fracture, converting it into a compound one of the worst kind." This is, undoubtedly, the best practice, the soundness of which is well illustrated in the following case, for the notes of which we are indebted to Mr. H. B. Vincent, house-surgeon.

William P.—, a shipwright, aged thirty-six, married, was admitted on October 7th, suffering from a very severe compound comminuted fracture of the left radius and ulna, extending into and freely exposing the wrist-joint, together with severe contusion and laceration of the entire palm and of all the soft parts on both aspects of the forearm in the immediate vicinity of the fracture; also a simple transverse fracture in the middle third of the humerus of the same arm. Very severe hæmorrhage was going on when he was admitted. The accident was caused by the hand being drawn in by some very powerful and rapidly-revolving machinery, by which the patient sustained the injuries about his hand and forearm, whilst the suddenness and the violence with which he was snatched from the ground caused the fracture of the humerus.

Primary amputation of the forearm was performed in the ordinary way, about three inches below the elbow-joint. Esmarch's apparatus was not used, in consequence of the fracture above. Petit's tourniquet was used on the brachial artery. The fracture was put up in four softly-padded splints.

The man did very well, notwithstanding that he always took a desponding view of his state. His temperature was never higher than 101.2°, nor was his pulse more than 96. His bowels were not open until the seventh day. He took the ordinary diet of the hospital at the end of a week. On the ninth day all the ligatures and sutures had come away. With regard to the fracture, on the day after the operation the splints had to be removed, in consequence of the pressure on the flaps, and his arm was laid upon a pillow; and from the fact that at every dressing of the stump, notwithstanding that every care was used, some movement took place in the fracture, so that on the thirteenth day after the operation there was no sign of union. On that day (Oct. 20th) the fracture was then securely put up in splints. On Nov. 4th, twenty-eight days after the operation, the case was as follows:—Fracture firmly united, the cicatrix on the stump nearly healed up, and there was slight passive motion in the elbow-joint. The patient was up and about.

SALFORD ROYAL HOSPITAL.

ANEURISM OF THE FEMORAL ARTERY; LIGATURE OF EXTERNAL ILIAC.

(Under the care of Mr. WALMSLEY.)

S. T.—, operative baker, aged forty, married, was admitted June 25th. He was of spare habit; height 5 ft. 5 in.; weight 8 st. 10 lb.; very little fat on the body; muscles thin and flabby; aspect pale, sallow, and unhealthy; face much marked with acne; temporal arteries prominent and tortuous; no arcus senilis; pulse feeble and frequent; heart

sounds natural; urine normal; family history imperfect. Fourteen years ago the patient had a chancre, and also a suppurating bubo in left groin, but he never had any secondaries. In March last, when lifting a sack of flour, he gave himself a "kench," and felt as if he had strained something in his left groin. Four days after he perceived a small lump in this region, which slowly increased in size. A fortnight later he became conscious of pulsation in the tumour, accompanied by pain, especially when in bed. About a fortnight before admission the swelling had increased greatly, and the pain was very severe. He could scarcely walk to his work, which, however, he continued to attend to till June 21st.

When examined on day of admission the tumour was very large, the pulsating area being $7\frac{1}{2}$ in. by $5\frac{1}{2}$ in.; it overlapped Poupart's ligament, filled entirely Scarpa's triangle, and extended into middle third of thigh. Pulsation, purring thrill, expansion, and bruit were all well marked. The entire extremity was cedematous and the superficial veins enlarged and varicose. He felt the limb to be weak, cold, and numb.

June 29th.—During the last four days the tumour had increased rapidly. Owing to its great size, and considering the condition of the limb, an attempt at cure by compression was deemed inadvisable. At 4 P.M., the patient being under chloroform, the external iliac was tied. The operation was the ordinary one, with incisions transverse to the artery, and was free from any special difficulty. The superficial epigastric vein bled freely, and had to be tied. The superficial epigastric artery was not met with. The genito-crural nerve was well seen after the internal oblique and transversalis muscles had been separated from Poupart's ligament. A carbolised catgut ligature was used, the wound closed with two wire sutures, and dressed with carbolic oil.

In the first four days after operation the wound seemed to be healing by primary adhesion. On the fifth day (July 4th) a sharp attack of erysipelas set in, which yielded in a few days to tincture of perchloride of iron and port wine. From this period the recovery was steady and continuous.

At his own urgent request the man was made out-patient on August 8th, having recovered perfectly the use of his limb, which had assumed a natural appearance, and the tumour being reduced to one-third its original dimensions, and quite free from pulsation. He has not, as desired, presented himself at the out-patient room since leaving the hospital. Had any untoward symptom occurred, it is fair to infer he would have done so.

Medical Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

At the meeting of this Society on the 24th inst., Dr. C. J. B. Williams in the chair, a very interesting paper by Geo. G. GASCOYEN, F.R.C.S., entitled "Cases of Syphilitic Reinfection, with Remarks," was read, and provoked an animated discussion. The author commenced by giving the details of eleven cases of syphilitic reinfection which had passed under his observation, and seven of which he had himself treated for both diseases. Ten of them had previously had general syphilis, and in six of these constitutional symptoms again manifested themselves; while in the other four an indurated chancre only was the evidence of a second contamination. The remaining case was one of well-marked indurated chancre with inguinal adenopathy for the first disease; but the reinfection showed itself as an indurated chancre followed by tertiary lesions, without the intervention of any of the secondary affections. The importance of these cases was dwelt upon as evidence that the diathesis created by syphilis may completely wear out and leave the individual free from all trace of his former attack, so that he may become the parent of healthy offspring, and be liable to contract again the disease if exposed to contagion. That examples of syphilitic reinfection cannot be