

pital for a week or two longer, the onychia meanwhile slowly improving, and then he was lost sight of. After the lapse of four months he was met walking briskly along the street, following his ordinary occupation. He said that the nitrate had "effected a perfect cure." He had used nothing else, except "a lotion of herbs," and he had got speedily well.

The second case was that of a pale, flabby little boy, aged three years and a half, who was brought on Jan. 20th, 1874, with malignant onychia of the right thumb. The disease began a month before he came to the hospital, and took its origin from jamming the thumb in a cab door. The thumb had a very characteristic appearance, being enlarged through its whole extent, and clubbed at the point. The nail was ragged and misshapen, and the ulcerated surface around it bled freely. The patient was ordered steel wine, and nitrate of lead was dusted upon the sore night and morning. It was said at first that the application gave great pain, so that the child screamed violently; and probably it was not applied regularly. Still the ulceration improved. At a subsequent visit the mother said that the application was less painful, and she asserted that it was regularly used. The case was steadily improving during the three or four weeks that he attended, but afterwards the child was attacked by the measles, and did not visit the hospital. The nitrate was, however, beneficial in this case, and would doubtless have effected a cure if it had had a fair chance.

The third case was that of a married woman, aged thirty-seven, who applied at the hospital on Feb. 3rd, 1874. She was suckling at the time, and was rather weak. The malignant onychia had originated in the prick of a hair-pin two months before. When first seen the right thumb was red, swollen, and clubbed. There was a large, ragged ulceration; the nail had perished; and the last phalanx was necrosed, and was separating. She was ordered to take quinine mixture, and to apply the nitrate of lead twice a day. It gave her very trifling pain, and seemed to produce an immediate amendment. In a few days the last phalanx came away. As there was a good deal of pain in the thumb, poultices were applied over the nitrate. She went on steadily improving, without a drawback, and in six weeks the disease was cured, the thumb remaining of course somewhat misshapen in consequence of the loss of the last phalanx.

On the whole, having regard to the severity of onychia maligna, and the great difficulty of treating it successfully by the ordinary lotions or ointments, Mr. Fairlie Clarke is inclined to think that the remedy to which Mr. MacCormac has drawn attention is a very valuable one.

THE HOSPITAL FOR WOMEN, SOHO SQUARE. CASES OF OVARIOTOMY.

THE following is a continuation of the report of the ovariectomy cases performed at the above-mentioned hospital during the past year:—

CASE 4. *Multilocular cyst; recovery.*—Harriet A——, aged twenty-six, married six years, was admitted April 18th, under the care of Dr. Meadows. Has had three children (last child seven months ago) and one miscarriage. Catamenia have not appeared since confinement; previously regular. Menstruation painful and scanty. First noticed the abdomen large after last confinement, when there was a swelling on the right side, which has gradually increased since.

On admission, the abdomen was found enlarged, the girth at the umbilicus being thirty-four inches. There was a globular swelling reaching to the ensiform cartilage, dull all over, and fluctuation very distinctly felt; flanks resonant. In the left iliac fossa, and extending into the left loin, was felt a hard mass, which moved on moving the rest of the tumour. Per vaginam: uterus normal; uterine sound in normal direction three inches. No tumour felt in pelvis.

On the 26th April Dr. Meadows performed ovariectomy. The cyst was found to be connected with the right ovary, and contained five pints of green gelatinous fluid; walls very thin. There were no adhesions, except a band from the omentum. The pedicle was of fair length, and about the size of two fingers. It was clamped, and divided with the cautery, as also the band of adhesions from omentum, and both dropped in. The abdomen was then well mopped out,

the wound brought together with deep silk sutures, dressed with lint dipped in carbolic oil, covered with oil-silk, and supported with broad strips of plaster, an abdominal belt being placed over all.

The patient made a good recovery, and was discharged cured on the twenty-fourth day.

CASE 5. *Multilocular cyst; peritonitis; death on the seventh day.*—Mary L——, aged forty, married twenty-one years, was admitted April 28th, under Dr. Meadows. Has had four children (last fifteen years ago) and two miscarriages. Catamenia regular up till eighteen months ago; since irregular and painful. First noticed abdomen swollen eighteen months ago; since then has gradually increased.

On admission, abdomen enlarged, dull all over except in flanks; distinctly fluctuating, and measuring at umbilicus 37 in. in girth. Per vaginam, uterus somewhat drawn up; uterine sound passes 2½ in. On deep pressure to the left of the uterus the tumour can be distinctly felt, and fluctuation can be made out by external palpation.

On the 3rd of May Dr. Meadows performed ovariectomy. The cyst was found to be connected with left ovary; contained thirteen pints of brownish-green fluid, and was free from adhesions. The pedicle, however, was very thick and short. It was securely tied with strong whipcord, the cyst cut away, and the pedicle dropped into the abdomen. The abdominal cavity was then well sponged out, the wound brought together with deep silk sutures, dressed with lint soaked in carbolic oil, supported with broad strips of plaster, and an abdominal bandage placed over all.

Patient did well for the first four days, when the abdomen became distended and painful; sickness came on, and she died on the evening of the seventh day.

At the post-mortem examination the intestines were found matted together, and there was general peritonitis. The pedicle and its vicinity were specially the seats of inflammatory action.

CASE 6. *Multilocular ovarian cyst; recovery.*—Alice C——, aged thirty-nine, married eight months, was admitted under the care of Dr. Heywood Smith on May 6th. The patient was never pregnant, catamenia always regular, menstruation at times painful. First noticed the abdomen to be enlarged ten months ago, and since then it had gradually increased.

On admission, the abdomen was occupied by a soft, elastic, indistinctly fluctuating swelling, reaching about three inches above umbilicus, and dull on percussion. The flanks were resonant on percussion, as well as the upper fourth of the abdomen per vaginam. The uterus was found pushed backwards, and to the right, by a soft elastic swelling situated in front of it. On palpation externally fluctuation was felt. Uterine sound measured three inches and a half.

On May 10th Dr. Heywood Smith performed ovariectomy. The cyst was found to be connected with the left ovary, was multilocular, and contained six pints of thick, gelatinous fluid, and was free from adhesions. The pedicle, of fair length and rather small, was clamped, and divided with the cautery. The abdomen was then mopped out, the wound brought together with deep carbolised silk sutures, dressed with Lister's oil silk and lac plaster, and supported with broad strips of plaster, with an abdominal belt placed over all.

The patient made an excellent recovery, and was discharged cured on the twentieth day after the operation.

ROYAL FREE HOSPITAL.

CANCER OF THE DESCENDING COLON; INTESTINAL
OCCLUSION; PERITONITIS; DEATH.

(Under the care of Dr. COCKLE.)

THE following case, for the notes of which we are indebted to Mr. H. W. Saunders, M.B., F.R.C.S., resident medical officer, presents some points of practical interest. The symptoms were those of chronic obstruction in some part of the large intestine, and the indication was, if possible, to make a regional diagnosis of the obstruction, in order to decide on the advisability of operative interference. The question of operation turned entirely on the determination of the seat of the stricture in the bowel. Unaided by the light of the post-mortem examination, it must be

confessed that there were few localising signs. Could the exact site of the tumour have been diagnosed, it is evident that, *quoad hoc*, colotomy would have offered a prospect of at least temporary relief. An operation was, however, decided against by those who examined the case before death.

Sarah B—, aged sixty-nine, admitted March 10th, suffering from obstruction of the bowels. On admission the patient was a very thin but healthy-looking woman, the mother of eight children, the youngest of whom is aged thirty-eight. After the last confinement there was illness, with fever and pains in the abdomen, lasting six weeks. From this she recovered perfectly, and had not suffered since from any notable abdominal symptoms. Before her present illness there had never been any difficulty in defecation or any discharge from the anus. She states that the motions had never been decreased in calibre. There was no history of cancer in the family.

The history of her present illness can only be very imperfectly obtained, the statements of the patient and her friends being at variance on some points, and not very intelligible. She appears to have been in her usual health until a fortnight before admission, when the bowels became confined, and shortly afterwards a swelling in the abdomen was noticed, which she stated was localised a little to the left of the umbilicus. Vomiting soon set in. The patient had no medical attendance until a week had elapsed, and then it appears enemata and purgatives, followed by opium, were administered. Her friends stated that there had not been at any time any faecal vomiting. She had not emaciated very markedly, but was always very thin.

On admission, she was suffering acute pain; the expression was anxious, and the manner very querulous; the pulse feeble and intermittent; tongue coated in the centre with thick yellow fur. The abdomen was very much and uniformly swollen and tender; hyper-resonant all over, except in the left iliac region, where the tone was flatter. The patient fixed the site of obstruction "close to the bladder." There was slight glandular swelling in the left groin; great meteorism; no flatus passed by the anus. On inspection, the greatly distended bowel could be seen often twisting and writhing and changing position. There was not much borborygmus. On exploration, the rectum was found empty, and apparently free from obstruction; but a long tube could be passed only about four inches. No blood or mucus had passed per rectum. Vomiting was infrequent, and consisted of mucous matters and food only. Some food was retained. There was dysuria and scanty high-coloured urine.

On the 11th a diagnosis was made of obstruction in the large intestine; but there was nothing to point to the nature and exact site of obstruction, except, as to the latter, the patient's own sensations, which proved to be well founded at the autopsy.

From this date until the death of the patient on the 16th March there was little variation in the symptoms. Vomiting was slight and infrequent, and never stercoraceous. Fluid food was taken fairly well. The abdomen became still more tense and tender; the distress was not extreme until a day or two before death. The highest temperature recorded was 99° F.

The treatment consisted in the exhibition of belladonna, and two days later of the aqueous extract of aloes in half-grain doses every hour. Subcutaneous injections of morphia were administered at night. On the 13th, galvanism to the abdomen was ordered twice daily. Eggs, milk, and brandy were given in small quantities frequently, and on the 15th enemata of the same, which were not, however, retained.

The question of operative interference was decided against for the following reasons: the extreme probability of existing peritonitis at the time of admission, the long preceding duration of the obstruction, the age of the patient, and the difficulty of diagnosing the site of the disease.

The much-distended bowel was punctured on three occasions at several spots with a fine trocar and canula, a good deal of faecal-smelling flatus escaping, followed by temporary relief.

Post-mortem examination.—Body greatly emaciated. (At the request of the friends the abdominal organs only were examined.) On opening the abdomen recent lymph was seen to be thrown out in great quantity, matting together the small intestines. The large gut was free from recent adhesions, but there were numerous old peritoneal adhesions

binding down especially the caecum and descending colon. There was but little fluid effused. The bowels were enormously distended and packed even up to the duodenum with semi-fluid faeces. There were no traces of the punctures made before death. At the sigmoid flexure was a sudden narrowing of the gut to about half its calibre, with some evident thickening. On opening the bowel there was seen, exactly at the sigmoid bend of the colon, a cauliflower-like mass springing from the wall of the bowel and completely occluding it. The mass measured about one inch and a half in each direction, was tolerably firm, and of villous, flocculent appearance. There was no trace of ulceration either in it or in the neighbouring part of the gut. Below it the rectum was empty and somewhat narrowed. The walls of the bowel above and below the growth appeared quite healthy and without evident thickening. The other abdominal viscera were healthy.

Microscopical examination.—The great bulk of the growth was seen in sections to be made up of enlargement and proliferation of the tubular glands, which grew outwards on the free surface in the form of branched villous-like processes; the glands maintained their calibre, and many of them contained transparent and granular material, probably mucus; the lining columnar cells were very large. The interstitial connective tissue was strewn in many places with small round lymphoid cells, like those normally found in this situation. The growth, therefore, belonged to the class of gland or "adenoid cancers," and probably in reality was a variety of epithelioma.

ROYAL UNITED HOSPITAL, BATH.

SUDDEN CESSATION OF CHOREA AFTER TREATMENT BY CHLORAL HYDRATE.

(Under the care of Dr. COLE.)

THE nature of the essential cause of chorea and the most effectual mode of treatment are yet vexed questions in medical pathology and therapeutics. Its frequent association with heart disease, its common occurrence after rheumatism, its mode of onset, and the evidence that has been afforded by some post-mortem examinations, have favoured the so-called embolic theory of the cause of chorea. It must not, however, be forgotten that this explanation entirely fails in a large number of cases. One of the main difficulties in determining the anatomical cause of chorea is, of course, the rare occurrence of death in this disease. Even when the opportunity of making post-mortem investigations arises, it not unfrequently happens that the chief and the most imposing lesions are those due to the super-vention of intercurrent disease. In the estimation of the effects of remedies in this affection it is, moreover, of great importance to avoid the logical fallacy of *post hoc ergo propter hoc*. Many drugs of directly opposite action have been vaunted as specifics in the treatment of this disease. But, whatever may be the immediate beneficial effect of the administration of a remedy, the natural tendency towards spontaneous cure should not be overlooked. This, however, should be no argument for the adoption of the *laissez faire* mode of procedure. The action of remedies should always be noted, and, when satisfactory, persevered in, and duly accredited.

For the notes of the following case we are indebted to Mr. Walter A. E. Waller, house-physician.

A. L—, aged seventeen, single, servant, was admitted December 29th, 1873. This patient had been attending at the hospital for about a month previous to admission, on account of anæmia and irregular menstruation.

For about fourteen days previous to admission, she had noticed slight movement in the left side of face, which, in the last week, had become much worse, and extended to whole of left side of body. She had not had chorea before. There was no history of rheumatism, and the present attack is attributed to a fright occasioned by someone entering her room after she had gone to bed.

On admission she was well nourished. The whole face, with the exception of a bilateral malar flush, was anæmic, and the gums were blanched. The left arm and leg were in a state of constant and considerable movement; so much so that the clothes required frequent readjustment. The left eyebrow was corrugated; the tongue, which was thickly coated