upper part of the ascending parietal convolution, the visceral and parietal layers of the arachnoid were strongly adherent; there was a small patch of freshly effused lymph on the pia mater, and flat osteophyte (made up of two pieces closely bound together side by side) of the size of the thumb-nail, one-seventh of an inch thick, growing from the arachnoid and pressing upon the brain, its under surface being very rough and having several spiculæ. An inch and a half in front of this growth was another three-quarters of an inch long, one-tenth of an inch thick, and one-fifth of an inch broad, with sharp needle-like extremities, curved downwards; this was situated at right angles to the falx cerebri. Between the two growths the membranes were much thickened and there were signs of old inflammation. A similar set of growths (three in number), in the same position as the first one described, were found growing in the arachnoid over the right hemisphere, but extending over about twice the surface occupied by those on the left hemisphere, and having several very sharp and needle-like spiculæ, all curved down on to the pia mater. The visceral and parietal layers of the arachnoid were adherent in the situation of the growths, as on the left side, but there was no sign of recent or active inflammation on this side of the brain. The upper surface of the dura mater was normal. There was no fluid in the subarachnoid space or ventricles of the brain, and no other signs of inflammation of the membranes or of the brain. The superficial veins of the right side of the brain were somewhat congested, and the right lateral, superior and inferior petrosal sinuses were full of dark tarry blood. Thoracic cavity: The right lung was firmly bound everywhere to the chest walls by old adhesions. There were some old tubercular deposit in the upper part of the pleura. The lung itself was œdematous, but otherwise healthy. The left lung was œdematous, and some old tubercular deposit existed in the upper part of the pleura; otherwise healthy. Heart normal. Abdominal cavity: Gall-bladder full of thick reddish bile. Spleen enlarged and soft. Pancreas normal. The stomach contained some ounces of thick bile, and the mucous membrane was covered with thick, stringy, sticky mucus. Duodenum full of thick bile. Jejunum normal. The ileum contained much bilious fæcal matter. Colon and rectum normal. Kidneys normal.

Remarks.—The growth of osteophytes from the arachnoid is a sufficiently rare pathological condition to justify the publication of the above case. There was no history of syphilis; there were no symptoms by which cerebral disease could be diagnosed till the fatal attack, when the symptoms of pressure on, and irritation of, the cortex of the left hemisphere of the brain were well marked. In my opinion the fever suffered from was malarial, and merely caused an exacerbation of the chronic disease, and determined the fatal irritation and inflammation.

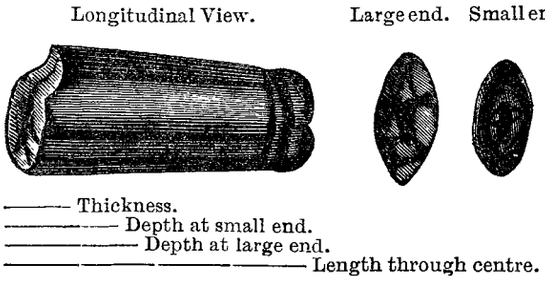
Bhamo, Burmah,

FOREIGN BODY IN THE AIR PASSAGES.

BY CHARLES BOYCE, M.B., C.M. EDIN.

THE following case is interesting as showing the length of time which a foreign body of the size shown by the accompanying diagrams may remain in the air passages without producing any untoward symptoms.

On October 20th last P. C ——, aged twenty, whilst driving home on a very dark night through a narrow lane smoking a briar pipe with a vulcanite mouthpiece was thrown out of his degcart and rendered insensible, the pipe he was smoking being lost. For some time he lay insensible, and became cold and wet from the restoratives used by the surgeon who saw him at the time. When he recovered consciousness he was carried home and seen on the following day by my assistant, Mr. Macartney, and myself. His condition was as follows: There was considerable ecchymosis of the face and eyes, slight nasal catarrh, but no difficulty of breathing or impairment of expansion, resonance, or respiratory sounds, vesicular breathing being apparently equal over both lungs at repeated examinations. Examination of his throat showed nothing beyond relaxation of the fauces and elongation of the uvula. No laryngoscopic examination was made. There was no cough or shortness of breath; no pain or uneasiness, except on lying down in bed at night, when the breathing became whistling. This was the reason of my careful examination of the lungs, as I feared the development of some inflammatory trouble. As no improvement occurred in his condition, I advised him to go to Brighton for a change of air, cautioning him against going out at night or exposing himself to cold. When he had been some time there, one morning (Dec. 13th), whilst eating his breakfast, he swallowed a small fishbone, which caused a violent fit of coughing, during which he brought up part of the vulcanite mouthpiece of the pipe he was smoking at the time of the accident, the shape and exact size of which are figured in the diagrams. At the time of the convulsive cough a deep-seated pain at the sternal end of the right clavicle was experienced.



——— Thickness.
——————— Depth at small end.
——————— Depth at large end.
——————————————— Length through centre.

Remarks.—The most notable feature in this case was the absence of any serious symptoms; in fact, it was only whilst in the recumbent posture that any symptoms occurred pointing to the presence of a foreign body, and as the patient was quite unaware of what had happened to the mouthpiece of his pipe, the real condition was never suspected. I should be inclined to say that the foreign body lay crosswise in the trachea at its bifurcation, and that whenever he assumed the horizontal posture its position became slightly altered, so as to project more or less into the bronchi, causing the whistling breathing, and the pain at the right sterno-clavicular articulation which was felt at the time of its expulsion. Had it been in one of the bronchi, we should have expected far more serious symptoms from the size of the body, and the dyspnœa which was observed only on lying down would have been difficult to explain. The termination of the case was most fortunate for the patient, especially when we consider the size of the body expelled. Mr. Durham in Holmes' "System of Surgery" (3rd edition) gives the results of a number of cases of foreign bodies in the air passages, from which it appears that of those in which no operation was performed death resulted in about 40·94 per cent.

Maidstone.

OVARIAN TUMOUR FOLLOWING INJURY; OPERATION; RECOVERY.

BY JAMES WILSON, M.D., F.R.C.S. ENG.

MISS L——, aged eighteen, gives the following history:—About three years ago she struck her left side against a door, felt faint, had severe and continuous pain for two years, and thought she could feel a lump at the seat of injury. About a year ago the swelling began to increase, with complete cessation of the pain. Bowels costive; menstruation irregular, periods varying from a fortnight to two months. She consulted a medical man, who treated her for indigestion and flatulence.

On examination the chest was found to be normal. Urine free from albumen. Slight œdema of feet and ankles. Family history of phthisis. Temperature normal; pulse 130 per minute. On examining the abdomen, it was found exceedingly enlarged, with distinct fulness on left side. On percussion, dulness extended from the pubes to the sternum. Resonance in flanks, but more marked on right side. Distinct wave of fluctuation in every direction. Per vaginam the uterus was normal, save that it was markedly depressed.

On March 3rd, under the A.C.E. mixture, ovariotomy was performed. The abdominal walls were thin, tense, and free from adipose tissue; hæmorrhage slight. On opening the abdomen the tumour was found to be non-adherent. It was tapped and about two gallons of fluid withdrawn, when a dense fibro-muscular tumour, weighing about 2¾ lb., was removed with the cyst wall. The pedicle was tied with China silk. The other ovary was found enlarged and cystic, and was also removed. The abdomen was cleared of a little ascetic fluid with sponges. The abdominal wound was