

form gauze, sterilized gauze, cotton, and a binder applied. Drachm doses of hot water were given during the first twenty-four hours, with one-eighth grain of morphia for pain.

March 5th. Calomel, a saline and an enema caused a free evacuation from the bowels.

March 9th. Wound dressed and a small amount of pus was found in the lower angle of the wound.

March 10th. Superficial stitches removed.

April 24th. Lower part of wound healed by granulation.

April 27th. Discharged. No evidence of reappearance of hernia.

November 29, 1898. Examination shows no evidence of return of the hernia.

CASE VII. Female, age forty-nine years, entered St. Joseph's Hospital October 2, 1898. She has borne four children and had one miscarriage at three months. About fifteen years ago she noticed a small swelling at the navel, which has never wholly disappeared. The swelling has gradually increased in size until now it is as large as a child's head. Examination reveals a large umbilical hernia whose contents are irreducible. The skin covering the mass is ulcerated and has the appearance of an epithelioma. At frequent intervals during the past year she had had vomiting spells lasting from a day to ten days. Lately they are scarcely two weeks apart. The abdomen is very large, the wall containing a thick layer of fat. Rest in bed, benzo-beta-naphthol, calomel, salines, enemas and easily digested nourishment constituted the preparatory treatment. After a bath and thorough scrubbing with soap and water a bichloride poultice was worn during the night previous to the operation.

October 5, 1898. Operation under ether. The abdomen was scrubbed with ethereal soap solution, potassium permanganate, oxalic acid, bichloride of mercury, ether and sterilized salt solution. An elliptical incision was made about the hernia, the sac dissected free and opened. A large mass of omentum and several coils of intestine were found adherent to sac, which was trabeculated. The intestine and omentum were carefully dissected free, portions of the omentum being removed after ligating with a chain-catgut suture. The remainder of the contents of the sac were returned to the abdominal cavity and the sac excised. The peritoneum was dissected from the fascia and united with a continuous catgut suture. Several buried silver-wire mattress sutures brought the fascia firmly together. The skin was united with silkworm-gut. Owing to the thick layer of fat three deep silkworm-gut sutures were passed through the skin, fat and fascia at some distance from the wound on either side. An aseptic dressing was applied. The operation was long and tedious, owing to the trabeculated condition of the sac and the firmly adherent intestine and omentum; yet at the conclusion of the operation the patient's pulse was good, no stimulant having been given. Saline enemas given and drachm doses of hot water with coffee during the first twenty-four hours.

October 15th. Ten days after the operation the three tension silkworm-gut sutures removed. Slight amount of pus about one of the stitches.

October 19th. The silkworm-gut suture in the skin was removed. Primary union.

November 3d. Patient sitting up.

November 5th. Discharged well. There is firm union of the wound.

CASE VIII. The following case whose photographs I present with this history illustrates the enormous size an umbilical hernia may attain. One is better able to judge of the size of the hernia by comparing it with other portions of the body than if measurements were taken. At the time of my examination of the hernia I judged that fully three-fourths of the intestine and omentum occupied the hernial sac, rendering operation out of the question, as the present abdominal cavity was not large enough to hold all of the intestine contained in the sac. Another interesting feature of this case is the unusual hypertrophy of the mammary glands, one reaching to the umbilicus, as shown in the photograph. The patient did not consider the large size unusual or of any special importance, having suffered no inconvenience from them. This case emphasizes the value of early operation.

This patient, age sixty-two years, a hardworking woman, mother of five children, noticed twenty-eight years ago, while carrying her fourth child, a small swelling in the umbilicus. During the following ten years the swelling increased in size, but she thinks it has remained stationary during the past eighteen years. When she was married her weight was only one hundred pounds. After reaching her thirtieth year her weight has gradually increased until at present she weighs two hundred and sixty-two pounds. She had the hernia ten years before she wore a support of any kind. Trusses she found of no value, so she contrived an ingenious band to fasten about the body with a bag attached in front to receive and support the hernia. During the past five years she has had almost constant diarrhea. She has had only two attacks that appeared to be due to strangulation of the hernial contents, one two years ago and the other, for which I was consulted, one and one-half years ago. At present she runs a sewing machine and does the greater part of her own housework including washing.

A CASE OF MEDIASTINAL SARCOMA.¹

BY GEORGE G. SEARS, M. D., BOSTON.

JACOB D., a Russian, twenty-five years old, a carpenter by trade, was admitted to my service at the City Hospital in August, 1898. He knew nothing of his family history, and had paid so little attention to his own symptoms that only a very meagre account of them could be obtained. Last December he noticed that he was growing short of breath and that his face and neck became swollen when stooping or working hard. Two months ago he began to cough and occasionally spit up a little dark blood, and three weeks ago he noticed that his chest had enlarged. There has been no pain, but he has had a feeling of soreness across the lower portion of his chest, and has lately lost considerable flesh.

Physical examination showed a fairly nourished but anemic man with cyanotic extremities. The jugulars and the larger veins of the arms and in the axillæ, especially the right, were dilated and prominent, and at the level of the insertion of the diaphragm in front was a zone of dilated capillaries, while the veins of

¹ Read at a meeting of the Clinical Section of the Suffolk District Medical Society, November 16, 1898.

both legs, particularly below the knees, were varicose. The chest was much enlarged, especially on the left side, which moved but little with respiration. His appearance gave the impression that a cord had been drawn tightly around the body at the level of the umbilicus, and that the thorax had been forcibly and greatly distended, the left side yielding more than the right to the pressure. There was dullness at the base of the right chest, while the left was dull throughout, the dullness crossing the median line and extending behind two-thirds of the way to the right posterior axillary line, and in front to the right nipple, from which the upper limit curved inward toward the second cartilage. Full resonance was, however, obtained nowhere in the chest except in the right axilla. Vocal fremitus and resonance were present, although faint, over the upper half of the left front and at the apex of the axilla, but were lost below. In the left back fremitus could be felt only in a small area between the spine and the angle of the scapula. The respiration over the left front, except at the base where it was absent, was faint, bronchial and accompanied by friction sounds. Over the upper portion of the back it was feeble, becoming bronchial and distant below the angle of the scapula. Over the right chest the fremitus, voice and respiration were within normal limits. The cardiac impulse was most marked in the fifth right interspace almost in the nipple line. The sounds were normal. The lower edge of the liver extended fully two fingers' breadth below the costal border. The spleen could not be made out.

Except the inguinal and the left epitrochlear, which were slightly enlarged, the glands were normal in size. The leucocytes numbered 16,600. The pupils and voice were normal.

The following day an aspirating needle was introduced in the seventh interspace in the left posterior axillary line and sixteen ounces of bloody fluid withdrawn, a culture from which was negative. No appreciable relief to the patient followed, although the percussion note, the fremitus and the respiration improved down to the angle of the scapula; below that the respiration remained faint and bronchial. As no material change had occurred in the signs over the lower left front and anterior axillary region, a needle was introduced the next day in the sixth space a little outside the mamillary line, and thirty-eight ounces of bloody serum withdrawn. The fluid flowed out in vigorous spurts synchronous with the heart, and a distinct pulsating movement was imparted to the needle itself, which was increased when the patient held his breath. Very marked pulsation was also visible over the front of the left chest, but as this had not been previously noticed and disappeared soon after, it was probably due to a more vigorous action of the heart under the excitement of the operation. Some relief followed, and at the earnest solicitation of the patient another attempt to introduce the needle was made the next day, the fifth space just outside the nipple line being chosen, but so much resistance was encountered, the needle evidently entering a solid body, that it was withdrawn and again inserted in the interspace below, but the result was negative.

On August 7th fremitus could be felt over the left back nearly to the base, but was lost as the posterior axillary line was approached. The respiration below the angle of the scapula had also become more normal, the bronchial character being less marked. Fremitus

over the right front could be felt faintly down to the third rib, but was lost below. In the right back friction had been noted four days ago over a considerable area between the inner border of the right scapula and the vertebral column, and to-day it is also present near the angle of the scapula. Medium moist râles are heard over the whole right back.

August 15. A capillary pulse has been seen and felt in the fingers during the past two days. Except a gradual loss of strength, there has been no marked change in his general condition, and, apart from the orthopnea, there is no especial suffering. A clinical diagnosis of new growth of the mediastinum and left lung, with secondary deposits in the right, had been made, but as its nature was still doubtful a hollow needle was introduced in the third left interspace anteriorly, where the signs showed the greatest density of the lung, with the hope of obtaining a shred of tissue. The attempt was successful, a small fragment being caught in the needle, which, under the microscope, was pronounced by Dr. Mallory to be a spindle-celled sarcoma.

August 16. He failed very rapidly and died.

Autopsy, August 17th, by Dr. Mallory. The thoracic cavity is occupied by a large tumor mass, which binds together the thoracic viscera, the heart being firmly imbedded in it. The lungs are pushed backward and downward and at their roots are firmly attached to the tumor. Height of diaphragm, seventh interspace on left, eighth rib on the right side. The left pleural cavity is obliterated, the visceral pleura being bound by firm fibrous adhesions to the parietal. Right pleural cavity contains about one litre of blood-stained fluid. On the surface of the parietal pleura are numerous, more or less spherical, soft, whitish tumor masses, varying in size from .5 to 2 centimetres in diameter.

The main tumor mass has evidently arisen from the posterior mediastinal lymph glands. It forms a large mass, measuring 22 x 18 x 14 centimetres, which has shoved the heart forward and to the right. On the left side it projects forward as far as the outer surface of the heart. On the posterior and on the left side the growth is ultimately joined to the muscle substance of the heart wall, from which it cannot be separated.

The pericardial sac is entirely obliterated by old, fibrous adhesions, excepting a few small pockets containing clear fluid. The pericardium can be stripped up only with great difficulty and is found to completely surround the main tumor mass. So far as can be made out, the growth extends between the visceral pericardium and the heart muscle on the left and posterior surfaces. The heart is not hypertrophied and the muscle is of good color, excepting that in the wall of the left ventricle is a small, white, opaque area, apparently fibrous in character. The valves and cavities are normal.

Left lung.—Pleura firmly adherent to the parietal pleura. The cut surface is dry, grayish in color, mottled with dark green and black, and is studded with whitish, soft, projecting, round tumor nodules, varying in size from 1 to 5 centimetres in diameter. One of the larger nodules near the base of the lung shows dark red, hemorrhagic areas.

Right lung.—Pleura smooth and glistening. Surface of a grayish color, mottled with green and black, and studded with tumor nodules of varying size, .5 to

4 centimetres in diameter, which project more or less above the level of the surface, some of them being almost pedunculated. On section these nodules are found to be of the same nature as those in the substance of the left lung. The cut surface of this lung shows the same appearance as that of the left. The bronchial and mesenteric glands are not involved.

The liver extends to the distance of a hand's breadth below the costal border; weight 1,950 grammes, color normal and markings distinct. On its surface and scattered through its substance are numerous tumor masses, similar to those in the lungs, and giving the same appearance on cross section.

Examination of fresh tissue from the tumor showed spindle cells and small round cells. The other organs were of no special interest.

Anatomical Diagnosis. — Sarcoma of posterior mediastinum, lungs and liver; old myocarditis; old pleuritis.

In reporting the physical signs I have only attempted to indicate the daily variation which resulted from the rapid absorption of what remained of the fluid after aspiration and from the production of adhesions between the two pleural surfaces, which in less than two weeks, through the formation of organized connective tissue, had become so firm that they could only be separated by cutting. We were evidently dealing with two collections of fluid, one of which was located in the left back, the other in front. The latter may have been inside the pericardium, which would more readily account for the spasmodic character of the flow through the needle, but no evidence as to its situation could be obtained at the autopsy, both surfaces of the pericardium and of the pleura being bound firmly together by dense, fibrous adhesions.

The completion of the clinical diagnosis, through obtaining a shred of the sarcomatous tissue, must be ascribed chiefly to good fortune, first, in striking one of the tumor nodules, which were separated by considerable areas of normal lung, and, second, in having it remain in the hollow of the needle by which it had been punched out. It is to be regretted that, owing to a misunderstanding, a bacteriological examination only was made of the pleural exudate, as corroborative evidence as to the character of the tumor might have been obtained by the discovery of characteristic cells.

ANTI-TUBERCULOSIS BILL. — We learn from the *Medical News* that a bill has been introduced in the Senate at Albany requiring all cattle brought into the State to have had a test thirty days previous at the hands of a State official, who is empowered to furnish a written permit to import them. All transportation companies are forbidden to carry cattle without such certificate and permit. Violation of the law is punishable by fines.

THE "KANSAS MEDICAL JOURNAL." — The *Kansas Medical Journal*, which has been published for the last ten years in Topeka, Kan., has been discontinued, and its former editor, Dr. W. E. McVey, will have editorial control of the *Medical Monograph*, a one hundred and fifty page monthly, which will be published in its place.

ANOTHER CENTENARIAN. — It is announced that Miss Mary Spooner, of New Bedford, has passed her one hundred and fifth year.

A POINT ABOUT INCISIONS AND SCARS IN THE HAIRY SCALP.

BY GEORGE H. MONKS, M.D., BOSTON.

I HAVE frequently noticed that scars in the scalp often seem to be unduly broad, — much more so, in fact, than the nature of the injury and the prompt

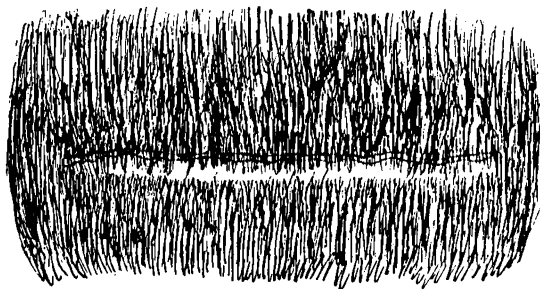


Fig. 1.

healing of the wound would lead one to expect, — and for a long time I was at a loss to know the reason of this.

Some years ago a boy was sent to me in whom there was a long transverse scar directly across the back of the head. This scar had resulted from an incised wound, but after healing, it appeared to be so broad that the parents of the boy desired that some operation be done, with a view to making it smaller and less noticeable. It was while this case was under my care that I think I discovered one of the causes, if not the principal one, of the breadth of certain scars in the scalp. The scar in

this boy's head was carefully dissected out for its entire length, and fine stitches were introduced, which brought the lips of the wound into perfect apposition, after which the wound was sealed up with cotton and collodion. The dressing and the stitches were removed after the usual period. The first result was most satisfactory. The freshly healed wound appeared as a fine line which could hardly be seen, except when the hair was held away from it on all sides. Every one was pleased. Later, however, to our chagrin, when the young man began to brush his hair the scar reappeared, and the condition seemed to be about as bad as it was before the operation, the scar showing up with unpleasant distinctness. At first I was entirely at a loss to account for all this, and was afraid the freshly

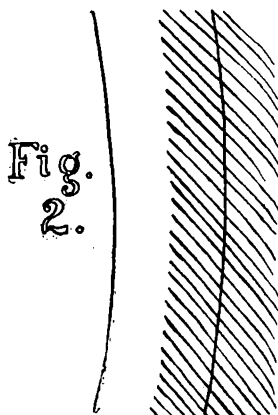


Fig. 2.

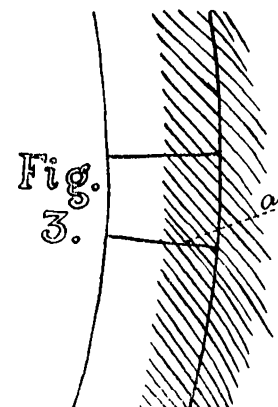


Fig. 3.