

PART IV.
MEDICAL MISCELLANY.

Reports, Transactions, and Scientific Intelligence.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

President—SAMUEL GORDON, M.D., F.K.Q.C.P.I.
General Secretary—W. THOMSON, M.D.

SECTION OF PATHOLOGY.

President—J. MAGEE FINNY, M.D.
Sectional Secretary—J. B. STORY, F.R.C.S.I.

Friday, November 2, 1888.

The PRESIDENT in the Chair.

Opening Address.

THE PRESIDENT delivered his opening address. [It will be found at p. 14.]

Case of (a) Popliteal Aneurysm, cured ; (b) Thoracic Aneurysm, fatal.

DR. WALTER SMITH exhibited the viscera of a man, aged fifty-four years, admitted into Sir P. Dun's Hospital, May 18, 1888. He was a porter by occupation, and enjoyed good health although not temperate. Thirty-four years ago he had a venereal sore on penis, and a suppurating bubo.

About eight years ago he was in Jervis-street Hospital for a tumour in left popliteal space, which was treated by "pressure," and cured. April 10th, 1888, he suddenly became faint and greatly distressed in his breathing, and after five months' suffering died.

The prominent symptoms were—pain across upper part of chest, over left side and down the arm, also over the upper dorsal spines, which were tender. He was much troubled with dyspnoea, but laryngeal symptoms were never marked, and he could swallow without difficulty.

A considerable bulging of the three upper ribs on the left side existed, dull on percussion, and exhibiting pulsation synchronous with that of

the heart. There was neither cardiac nor aneurysmal murmur. The pulse in left arm could scarcely be felt, and was delayed.

A few days before his death he was seized with rigors, retching, and intense pain in back and left side. The temperature rose to 103·4°. He gradually became cyanotic, and died on September 25th.

Post mortem examination:—Left pleura adherent; right pleura almost completely free. Numerous sub-pleural hæmorrhages over base of right lung. Occupying upper part of thorax was a large ovoid tumour, about five by four inches. This proved to be an aneurysmal sac, arising about one inch above semilunar valves of aorta, and almost completely filled with a firm laminated clot. The bodies of 2nd, 3rd, 4th, and 5th dorsal vertebræ were eroded, and the posterior wall of sac of aneurysm being deficient, the blood clot lay in contact with the vertebræ. The innominate and left carotid arteries were not involved; the left sub-clavian artery was flattened by the tumour. The œsophagus was incorporated with the wall of the aneurysm, and the left vagus nerve was flattened into a tape-like band.

The aorta was slightly atheromatous above and below the aneurysm.

An old infarction was found in right lung. The left popliteal artery and vein were fused together into a firm mass, and the lumen of the artery was completely occluded by a dense organised thrombus.

The PRESIDENT said—The late Dr. Stokes directed particular attention to this tendency to change of form as a valuable sign in the diagnosis of thoracic aneurysm as distinguished from other tumours.

DR. M'KEE remarked that no very advanced degree of atheromatous or sclerotic change was necessarily associated with aneurysm; and this was supported by the fact that aneurysm was not a disease of late, but rather of middle life. A point in this case which struck him as rather anomalous was the smallness of the heart. An interesting question was whether aneurysms occurring in persons with a syphilitic history were attributable to immediate syphilitic change or to the effects of the syphilis on the constitution generally. The latter hypothesis was, he thought, sufficient to explain the occurrence of the aneurysm.

DR. FOOT said this case bore out three important points laid down by the late Dr. Stokes. One was the non-increase of the tumour, by which it was distinguished from other tumours which were of a rapidly growing nature. The second point to which Dr. Smith had drawn attention was the absence of murmur. The third point, to which Dr. M'Kee had drawn attention, was that in thoracic aneurysm the heart was not necessarily hypertrophied unless the aneurysm was sufficiently near to the region of the aorta to make the valves incompetent. The case reminded him (Dr. Foot) of one which he had at the Meath Hospital many years ago.

DR. BIGGAR remarked that, a great many years ago, when Spurzheim was in this city, he said that he had found the arteries of Irishmen to be

much thinner than those of persons of any other nation that he had an opportunity of examining.

DR. SMITH, in reply, said that if Hibernian arteries were thin, they were evidently elastic, and able to stand a sudden shock. An important clinical point was the variability of the signs and symptoms of aneurysm, and another feature was the curious relief that was sometimes temporarily given by a local abstraction of blood in the case of aneurysmal tumours, and which would not have the same effect at all in an organic tumour. The infrequency of murmur was one of the points of difference between thoracic and abdominal aneurysms.

Case of Ectopia Ventriculi.

DR. C. B. BALL communicated a case of ectopia ventriculi. A tumour the size of a pea was removed from the navel of a child, aged two months. The surface was red and moist, and microscopical examination showed that their surface consisted of glands identical with the pyloric glands of the stomach. The centre of the tumour was composed of blood vessels and muscular tissue. Only six of the recorded cases exhibited gastric glands, most of the others having a mucous membrane similar to that of the intestines.

DR. M'KEE asked could any explanation be offered of the fact that the tumours were different on the several recorded cases.

Case of Cystitis.

SIR WILLIAM STOKES communicated a case of cystitis after the removal of papillomatous tumours from the female bladder. The tumours had been removed some three years before the death of the patient, by Dr. Greig Smith, and the *post-mortem* appearances were those of cancer of the bladder.

DR. M'KEE had examined a portion of the bladder in this case, and found clusters of epithelial cells in the muscular layers, which could not have existed there if the tumour had been simply a benign one.

MR. WHEELER said he had had four cases of papillomatous growths under his care from time to time.

PROFESSOR BENNETT said the question here was the same as that raised in the case of the late Emperor of Germany—namely, whether it was possible that a papillomatous tumour, which was proved by microscopic examination to be benign, could pass into an epithelioma. They did not usually find cases of papilloma of the anus and other localities turning into carcinoma.

DR. FOOT observed that the kidneys of the patient, which had been sent round, appeared to him to be quite sufficient to account for her death, when taken together with the prolonged irritation, pain, and loss of rest that accompanied the cystitis.

MR. STORY said he had no difficulty in believing in the development of a benign tumour into a malignant one.

SIR WILLIAM STOKES, in reply, said that Professor Bennett would find it to be laid down by several authorities that papillomatous disease of the bladder had a special tendency to run into carcinoma, and he thought, from what had been laid down by Hutchinson and Sir James Paget, that there was a pre-cancerous stage in a vast number of cases of cancer.

On the motion of DR. FOOT, seconded by DR. MACSWINEY, it was ordered that the specimen should be sent to the Reference Committee.

The Section then adjourned.

Friday, November 30, 1888.

The PRESIDENT in the Chair.

Fracture followed by Gangrene.

MR. W. I. WHEELER communicated a case of fracture followed by gangrene.

Epithelioma in the Horse.

DR. R. GLASGOW PATTESON said :—Epithelioma is an excessively rare disease among the domesticated animals, while among wild animals, living either in confinement or in their natural state, it is almost unknown. Mr. Bland Sutton has met with only two examples. One was in a Japanese wolf; the growth occupied the mucous membrane between the gums and the tongue, and presented the appearance of a leathery patch, resembling the chronic superficial glossitis—the so-called “*ichthyosis linguæ*,” which occurs in man. The second growth occurred in the anus of a dog. Mr. M'Fadyean, Demonstrator of Pathology in the R. V. College, Edinburgh, has not met a case; and both he and Mr. Sutton agree in the observation that tumours from the penis of the horse are generally fibromatous or papillomatous.

The specimens were obtained from a horse ten years old, from which two previous growths had been removed. The tumour was situated on the inferior aspect of the penis, involving also the sides and part of the upper surface of the organ. It was about $2\frac{3}{4}$ inches in length by about $1\frac{1}{2}$ inches in width, the longest axis lying transversely. Its edges were raised, nodular, and everted; the surface irregular, with commencing ulceration. Microscopically it proved to be a typical epithelioma, the “cell nests” being specially well marked.

Another point of interest in the tumour is that, although originating in a part the epithelium of which normally contains pigment, yet in no portion of the neoplasm could pigmented cells be found.

In the available records of veterinary literature I have been unable to meet with a case of epithelioma of the penis.

PROFESSOR BENNETT said that the case just submitted distinctly proved the occurrence of epithelioma in one of the lower animals. It had been long familiar to pathologists that carcinoma, in the form of scirrhus, occurred in the lower animals. These cases were important as tending to disprove an absurd theory that cancer in man was a descendant of syphilis. Now it was certain that neither the horse nor the dog at least could be ever infected with syphilis.

Tubercular Ulceration of the Intestine.

DR. BEWLEY exhibited, for DR. JAMES LITTLE, a case of tubercular ulceration of the intestine. The patient from whom the intestine had been removed suffered for two years from phthisis, and for the last three months of his life from uncontrollable diarrhoea. The small intestine contained 79 large typical tubercular ulcers, and the large intestine about 30. The lungs showed the ordinary phthisical changes. Dr. Little called attention to the fact that the man, in spite of such lesions, was very considerably fat.

Diseased Heart.

DR. MACSWINEY exhibited and gave an account of the following case of a diseased heart :—

A woman, aged seventy years, was brought dead to Jervis-street Hospital. At the autopsy, nothing abnormal to account for death was found in the head or abdomen. The lungs were also healthy. Upon opening the pericardium, which was healthy, the heart was found large, very hard, and having some adipose tissue deposited upon its right upper surface. All its cavities were quite empty; both ventricles were contracted. The right auricle and ventricle were, in all particulars, normal. The left auricle was of normal size, but its walls were hypertrophied. The auriculo-ventricular ring was hard, corrugated, greatly narrowed, admitting the tip of one finger. The left ventricle was greatly hypertrophied, and of small dimension in the cavity. The aortic valves were entirely consolidated and converted into a dense, hard, calcified mass. A small aperture existed in their centre, admitting barely a goose-quill; this hole allowed the passage of water from the aorta into the ventricle. No medical history could be obtained, so that one could only speculate as to the physical signs and symptoms during life. The woman's daughter, however, positively assured Dr. MacSwiney that her mother "never lay a day," never consulted a doctor, and made no particular complaint of ill health. It is noteworthy that there were no external appearances on the body, which was wasted, pointing to the cause of death—neither œdema, nor dropsy, nor cutaneous venous congestion. Also, that there was absence of any atheromatous patches upon the thoracic aorta.

Congenital Malformation in a Mummy.

PROFESSOR BENNETT submitted a case of congenital malformation in a mummy. The bones were those of an Egyptian mummy that was many years ago placed in Marsh's Library. There was an extraordinary contrast between the two humeri. The left was perfectly normal, and was apparently that of a full-sized man. The other humerus was very small and stunted, and had at the elbow end this remarkable peculiarity, that it was wider from condyle to condyle than the bone on the sound side, while the distance between the margins of the articular surfaces was a trifle less. The upper extremity of the stunted humerus articulated with a joint which showed traces of chronic rheumatic arthritis. The joint was evidently one in which motion had taken place. He called this a congenital malformation, because he did not know any other explanation of the conditions. The bones of the forearms corresponded in length, but the right were a trifle slighter and a little atrophic; there was no sign of arrested development, nor was the clavicle different from that at the other side. He came across an exactly similar specimen many years ago while dissecting, which was also exhibited.

MR. FRAZER said there were also found a few pieces of the original mummy case, with the gilding, ornaments, and bandaging, sufficient to show what it was. He was particularly struck by the peculiar perforation at the lower end of the mummy humerus. He found the same thing in the bones disinterred some years ago at Donnybrook, in connection with a Danish massacre that was known to have occurred there.

MR. LENTAIGNE said it seemed to him that the deformity might have resulted from epiphysary fracture, which often arrested the development of the bone. In both the mummy and the modern bone it was not at all improbable that there might have been a fracture; and if that occurred near the epiphysis in early life it would have caused an arrest of development. If the malformation of the upper arm were congenital he could not see why it should be accompanied with a perfectly natural forearm.

PROFESSOR BENNETT, in reply, said that Jonathan Hutchinson was the leading authority for arrest of development after epiphysary fracture. He did not know a single recorded case of arrested development following epiphysary separation. Epiphysary separations always united with great accompanying deformity, but there was not a single trace of any such deformity on either of the bones now before them.

Case of Rare form of Typhoid Ulceration of Ileum.

DR. BEWLEY showed the ileum of a patient who had died of hæmorrhage in typhoid fever. The case had been a long one, consisting of a primary attack and two relapses. The ulcers were few in number, eight or ten, and (with the exception of two or three in the cæcum) were con-

fined to the lowest 3 feet of the ileum. Their surface was smooth, and appeared to be in process of healing, but in the centre of several of them was a fresh ulcer surrounded by thickened and overhanging edges.

SECTION OF OBSTETRICS.

President—W. J. SMYLY, M.D., F.K.Q.C.P.

Sectional Secretary—ANDREW J. HORNE, F.K.Q.C.P.

Friday, November 23, 1888.

The PRESIDENT in the Chair.

Exhibitions.

DR. MASON exhibited two ovarian cysts. One was almost unilocular, and had a solid mass on one side. It was not adherent to any of the structures, and was removed without difficulty, and the woman made an uninterrupted recovery. The other cyst was removed from a woman, forty-seven years of age, and was very much larger. There was a large amount of ascitic fluid, and the tumour was practically solid. No fluid came from it when it was tapped, and it had to be broken down and removed almost piecemeal. The case went on very well for eight days after the operation. On the night of the tenth day, however, she got bronchitis; her lungs seemed to fill up, and she died in twelve hours after being attacked. On *post mortem* examination the abdomen was found to be healthy, but there were signs of gradually organising lymph in it.

DR. MASON also exhibited an anencephalic foetus. The upper part of the skull was totally deficient. The child presented by the lower extremities, and was delivered without difficulty. After its birth the heart pulsated for a few minutes, but no respiration was established.

Opening Address.

The PRESIDENT delivered his address. [It will be found at page 28.]

Sloughing Fibrous Polypus of the Uterus.

DR. LANE read notes of a case on the above subject. The patient, aged thirty-two, married three and a half years, never pregnant; had had menorrhagia since January, lasting three weeks at a time, and accompanied by great fœtor. Slight difficulty in passing urine was experienced on June 10th, followed by complete retention next morning. On vaginal examination the tumour was found projecting through os. Torsion was first tried, but the tumour breaking down, a wire ecraseur was then applied and the pedicle cut through; a short straight midwifery forceps was then put on and the polypus delivered without the slightest injury to perinæum.

DR. MACAN said he saw the case. Notwithstanding the washing out, the smell was most horrid, and was calculated, in these antiseptic days, to make one disinclined to have anything to do with the case. The case was very œdematous, and the bottom of the tumour was like a huge carcinoma. Where there was sepsis before an operation of the kind, he believed the best way was to remove the original source of danger.

DR. NIXON observed that the odour was a point of importance in the case.

DR. LANE replied.

Mammary Inflammation and its Treatment by Elastic Pressure.

MR. ANDREW HORNE read a paper on the above subject. He believed the methods usually recommended and taught were gravely defective. Suppuration ought to be a very rare occurrence. Inflammation of the breast was almost always the result of infectious material gaining entrance through fissures and cracks of the nipple, and too much attention could not be paid by the attending physician when such a condition exists in the nursing mother.

The method of treatment advocated was to envelop the breast in a layer of absorbent cotton. Having first painted the breast with a five per cent. solution of oleate of mercury and morphin, then having procured an elastic web bandage, five yards long by three inches wide, he makes equable and gradual pressure over the inflamed gland, thereby securing the most perfect rest possible.

DR. MACAN said he had long used compression of the breast in certain cases, although he did not regard it as suitable where there was suppuration; but he felt that he could recommend Mr. Horne's plan, even where there was suppuration, as strongly as in other cases. It gave great relief to the patient, and was, he thought, a great step forward. One of the advantages was that in certain cases it would permit the woman to go on nursing, which, in the case of the poor, was a great advantage. One class of cases to which it seemed specially applicable was the troublesome form of affection in which, although the breast was enormously distended, and the skin quite tight, not a drop of milk would flow. Formerly he used to apply India-rubber plasters cut into strips.

DR. MASON said the plan recommended would greatly extend the treatment of sore breasts by pressure. Pressure was a very old mode of treatment; but the graduated mode of applying it which Mr. Horne put forward was comparatively recent, and seemed to have had most successful results. Varieties of plasters had for long been before them. Belladonna plaster he believed to be one of the best. In this kind of treatment it was most important to give the breast perfect rest. It was remarkable that women who did not attempt to nurse their children did not suffer from sore breasts.

The PRESIDENT said this method of treatment was suggested to him some years ago by Mr. Horne, and he had since employed it. He used to employ Martin's bandages, but he believed Mr. Horne's arrangement to be much better. One of its best features was the covering up of the breast which it involved, by which external infection was prevented. One of the causes of inflammation of the breasts he believed to be—that when a patient felt her breasts growing swollen and tender she would ask some assistance from the midwife, who would handle a cracked nipple with fingers covered with putrid lochia, and in that way infect the breast and cause inflammation.

MR. HORNE, in reply, said the bandage he used was an ordinary web elastic. One of the reasons why he had adopted this bandage instead of elastic plasters, was that it was most difficult to put on elastic plasters in such a way as to get even pressure. Another reason was that elastic plasters were apt to produce an eczematous eruption on sensitive skins. That would never happen with his bandages. The belladonna and cere-cloth plasters, which for a long time used to be applied in the Rotunda, no doubt, used to give a great deal of relief; one reason for that being that they prevented the breast from being rubbed or used, or anything from happening to it which would lead to suppuration. As to Martin's bandage, patients to whom he had applied it complained that it caused uncomfortable heat; whereas his bandage being more porous, allowed a freer circulation of air.

SECTION OF SURGERY.

President—HENRY FITZGIBBON, Pres. R.C.S.I.

Sectional Secretary—MR. W. THORNLEY STOKER.

EDWARD HAMILTON, F.R.C.S.I., in the Chair.

Friday, December 7, 1888.

Notes on a Peculiar Dislocation of the Thumb.

MR. J. DALLAS PRATT read a paper on lateral luxation of the ungual phalanx of the thumb, the dislocation being complete and the direction of it inwards. He stated he believed that the case was so rare as to be almost unique. The patient, a man about forty years of age, had slipped in the street, and putting out his hand to save himself, came down on the point of his thumb. The injury, a cast of which was exhibited, was very difficult to reduce, the ordinary methods—Clove pitch, Hay's knot, Levi's apparatus, &c., &c.—having failed. Finally, by bending the joint, so as to increase the deformity and bring the phalanx at right angles to the proximal one, and then making traction in the axis of the thumb,

the bone went back into its normal position. There was no fracture, and the dislocation had not recurred a year after reduction.

The CHAIRMAN said the case was one of extreme rarity, and the force producing the dislocation must have been such as would be likely to produce a similar result higher up, and even fracture of the bones.

MR. WHEELER corroborated Mr. Pratt's description of the case from personal observation. The two bones were lying side by side, showing complete dislocation, and the joint was reduced with perfect apposition. The man had come under his own notice on two previous occasions for dislocation of the shoulder and radius. Whether the ligaments were peculiarly lax or not he was unable to say.

MR. THOMSON asked whether Mr. Pratt regarded the case as one of complete or partial lateral dislocation. The cast did not seem to represent a complete lateral dislocation.

MR. PRATT replied that when he first saw the man the dislocation did not seem to him to be complete, the appearance of the thumb being exactly that represented by the cast now. But when he had manipulated the thumb, he satisfied himself that the dislocation was complete. The phalanges were particularly short—half an inch difference as compared with the normal length—while the skin was hard and thick. Hence the difficulty of reduction, which was only accomplished by increasing the deformity—i.e., bending the thumb at a right angle with the other joint, and putting his finger, as it were, in the axis of the thumb.

Exostoses of the External Auditory Meatus.

MR. ARTHUR BENSON read a paper on three cases of exostosis (or hyperostosis) in which he had operated successfully.

CASE I. was only alluded to, as its details had been previously reported. Ivory exostosis of external auditory meatus of gentleman, aged thirty-three, growing from anterior wall, sessile; skin covering it not ulcerated; middle ear not implicated; no otorrhœa. Operation done with dental engine, and completed with chisel and hammer, January, 1884. *Result:* No return whatever. Hearing now perfect.

CASE II.—Patk. D., aged forty-eight. Otorrhœa, with perforation of drum and stinking discharge for twelve months. Exostosis growing from anterior wall, completely filling the meatus, and latterly preventing escape of cheesy discharge; rather narrow bony pedicle. Operation done October, 1887, with chisel and hammer (dental tools). Bony growth removed; was egg-shaped; measured 14 mm. × 10 mm., and weighed, when dried, 10 grains. *Result:* Hearing much improved; otorrhœa nearly ceased; no return. Perforation still present. Returned home within a week.

CASE III.—John K., aged thirty-eight. Otorrhœa for nine months. Deafness almost total. Granulations covering meatus over exostoses.

Bony growth. Sessile from posterior wall very deep in meatus, and blocking it almost totally. Membrana tympani (probably) not perforated. Operation, October, 1888, begun with chisel and hammer, completed, one week later, with gouge and hammer. *Result*: Hearing perfectly restored; otorrhœa ceased. Returned home on third day.

In no case did any secondary inflammation or ill consequences follow the operation.

Mr. Benson considered that no one method of operating could be considered best, but that each case required a method adapted for its special requirements as to size, position, shape, character and complications. Those who advocated only one method of operating were probably those who had but limited experience of the others.

MR. W. THORNLEY STOKER did not see why a dental engine could not be used to destroy the exostoses in the three cases, as it appeared to be a perfectly manageable tool in skilled hands.

MR. BAKER said certain difficulties arose in the way of using a dental engine. In the first case the drill was not sufficiently long to reach in, and the operation was conducted with a speculum, which was blocked up by the hand-piece, so that it was extremely difficult to see. Since then he had, in another case, advised getting a long drill made. It would be easy to cut across the mass of a large exostosis if a spear-pointed drill were used, and two or three holes bored, making a fissure burrow to connect the holes.

MR. BENSON replied that, even in this particular case, if they had a long drill it would be almost impossible to work it. The meatus was so extremely narrowed from chronic and recent inflammation, it was impossible to see anything at all. The operation had to be done by feeling, and it would have been extremely difficult to work the dental engine, especially as the situation was close to the membrana tympani. In this particular case the dental engine would not have been as easy to work as a gouge.

A Case of Cholecystotomy.

MR. KENDAL FRANKS read a paper on the above subject. [It will be found at page 7.]

MR. BARTON had had a similar case a year before that of Mr. Franks. The patient was an elderly woman, who had suffered from symptoms of gall-stone for many years. She was a good deal emaciated, and her nutrition had suffered from long-continued disease. She was heavily jaundiced, and the abdomen, on palpation, showed a well-marked tumour in the region of the gall-bladder. The tumour gave little difficulty in diagnosis. The condition of her muscles, and the pyriform shape in the position of the gall-bladder, left no doubt that it was the gall-bladder that was distended, indicating a tumour about the size of a pear. Progressive

emaciation threatened life. He accordingly operated. The operation was perpendicular to the costal cartilages, about four inches in length, and the peritoneum was readily reached and opened. He passed his finger into the gall-bladder, and felt through the walls a number of hard gall-stones, some being impacted in the common duct. The proceeding was adopted of sewing the anterior wall of the bladder to the edge of the incision. The lower part close to the gall-bladder having been opened, a large gush of greenish-yellow bile followed, and he removed with his finger three large stones. But the real difficulty was to reach the stone or stones impacted in the duct, and which constituted the cause of the obstruction. Squeezing or pressing was out of the question, and the only course was to reach the stone or stones with the finger or the forceps. Once the stone had passed through the duct it was exceedingly difficult to reach or press it in any way so as to make it slip backwards. After manipulation he extracted another stone, and concluded that his operation had been successful; but it was not, although the wound was antiseptically dressed, and there was an excellent recovery. There was no peritonitis except on glueing the edges together, and there was no bad result. At the same time there was no relief to the jaundice, and the obstruction remained. The dressings were saturated with bile, and one immediate result was that she felt better. She expressed herself greatly relieved, and her appetite increased; but being an elderly woman, she never fully regained strength from the low state of nutrition into which she had fallen; and in the course of three months she died apparently from want of nutrition. In the last month her appetite failed without further sign of disease that he could make out, while there could be no doubt that the operation relieved her distressing symptoms.

Mr. O'CALLAGHAN detailed his experience of four operations in which he assisted Mr. Lawson Tait. The difficulty in removing the stones was surmounted by plunging a scoop into the duct and manipulating with the finger outside, so as to work out the stone gradually. He did not stitch the gall-bladder to the opening until after removing the stones. Since then he had had two cases himself—one being successful and the other not; the latter, a woman, however, dying of malignant disease. While the operation was one of the most justifiable, as it was also one of the most brilliant, in surgery, the great difficulty was in the diagnosis; and from the results of abdominal surgery he would, where the diagnosis was in doubt, feel justified in making an exploratory incision. Of course, the drainage-tube was not removed until the bile was flowing freely and the temperature became normal.

MR. CROLY thought that the course of closing the gall-bladder and peritoneal surfaces left a space too limited to take out the gall-stones, and there was also the disadvantage of shutting out the surgeon from following the duct, and doing satisfactorily the most intricate part of the operation.

MR. THOMSON did not think there was much difficulty in cutting down on a gall-bladder and removing stones, if stones were there; but the great difficulty was to determine whether or not the surgeon had to deal with a distended gall-bladder. Mr. Lawson Tait, who had had the largest experience of any single person in abdominal surgery, had laid down the rule that when he was in doubt as to what was inside, he cut down upon it, and put in his finger and felt it. He had had a case in point in which all the symptoms indicated a distended gall-bladder; but on cutting down it was found to be a large perinephritic abscess, which extended forwards, pressed on the under-surface of the liver, on the gall-bladder, and on the duct, and had, from mere pressure, brought on attacks of jaundice, from which the lady suffered. Of course there were certain cases easy of diagnosis; he had himself removed over 2,000 gall-stones in a case—*post-mortem!* The tumour had been diagnosed as malignant, and the lady, whom he saw only after death, suffered considerable pain. When she died, however, there was no difficulty of diagnosis. There was an enormous number of little stones, which could be felt, and even heard, when crushed between finger and thumb. The escape of bile through the abdominal wall had been noted in many cases—especially where the gall-bladder had been extirpated altogether, and suggesting the inquiry as to the precise use of that organ.

MR. FRANKS replied.—In one or two cases, where the structure had been found, and the bile flowed externally through the fistula, there was no injurious effect on the general health of the patient. Indeed, he had in his paper endeavoured to emphasise the proposition that the bile did not seem to be necessary to the economy of the human body at all; in fact, the gall-bladder did not secrete bile. The bile was secreted by the liver, and would flow into the intestine, even if the gall-bladder were extirpated. Mr. Lawson Tait showed that excision of the gall-bladder was as sensible and justifiable an operation to prevent the formation of gall-stone, as to excise the urinary bladder to prevent the formation of stone. There were, he pointed out, two distinct classes of cases—one of large numbers, and the other, more serious, of solitary gall-stones. The large gall-stones became impacted in the duct, and, if left alone long enough, would lead to suppuration. As regards Mr. Croly's justifiable criticism, in his case, before opening or suturing the gall-bladder he felt carefully the surface of the liver, and satisfied himself that there was no obstruction in the nature of stone or tumour upon either of the ducts, and there was no necessity to explore the gall-ducts from inside. The real disease was not gall-stone, or stricture of the cystic duct, but was a stricture of the common bile duct. As regards diagnosis, a gall-bladder distended with bile, not gall-stone, made the diagnosis a question of extreme difficulty. He agreed that in cases of doubt an exploratory incision was justifiable.

The Section adjourned.