the former operation was performed in this country by Mr Mitchell Henry many years ago, and which resulted in a rapidly fatal issue, I was led to try the milder measures I hav described; and as an alternative of the more severe operations for the relief of this troublesome affection the plan is one which is, I think, deserving of a more extended trial. I would only further suggest that it should be practised cautiously.

Hanley, Staffordshire.

CASES OF SUDDEN OBSTRUCTION OF THE ŒSOPHAGUS.

BY PUGIN THORNTON,
SURGEON TO THE ST. MARYLEBONE GENERAL DISPENSARY.

LAST year two cases of stricture of the œsophagus came under my notice, in both of which a sudden obstruction to the passage of food was the first symptom of disease. In the first case the affection proved to be of a benign nature, in the second malignant. I venture to bring these cases forward because sudden and extreme dysphagia, attacking a person apparently in good health, is a rare condition, and one which must affect a surgeon's ability to determine upon the nature of an œsophageal stricture. Sir James Paget, who saw the second case, tells me that he has never before known sudden obstruction to the passage of food to be the first symptom in cancerous stricture of the gullet. The first case is also of much interest, because in most respects it resembled one of malignant disease.

CASE 1.—Mrs. ——, over sixty years of age, was sent to to me by Mr. W. H. Evans, of the Finchley-road. Mrs. —— informed me that four days previously, during dinner, a piece of meat had stuck in her throat, and that it was with great difficulty she had managed to pass it down, that for some hours after the accident she had been unable to swallow anything, and then, and till the time she saw me, she had only been able to take liquids drop by drop. The patient was in good health at the time of the accident and had never before found difficulty in taking food. She had been apt, she acknowledged, to hurry through her meals, although unable to masticate her food properly, her teeth not being in good order. Since the accident Mrs. —— had felt continuous pain in the right ear, and had been troubled with a constant collection of frothy phlegm. In swallowing she also felt pain between the cricoid and sternal cartilages. Her expression was anxious. She was very thin, but was not aware that she was thinner than she had been for years. The larynx and surrounding parts were normal in appearance. Mr. Evans had written to say that he had been unable to pass an instrument through the stricture, and I also met with the same difficulty, the constriction being opposite the cricoid cartilage. At first beginning with a large-sized bougie, I made steady and protracted pressure on the stricture, and I then tried quickly through some of the smaller instruments. On March 13th I could pass a bougie down the left side of the gullet, but on the right side the œsophageal canal was still firmly closed. Mrs. —— had been able to take small pieces of dry bread, and could now drink without stopping. The pain in the right ear continued, but was not so severe, and the anxious expression in her face had disappeared. This patient made a complete recovery, and has remained free up to the present time from any relapse, although she has since, I have heard, been through a severe attack of pneumonia.

CASE 2.—Major ——, aged sixty-two, consulted me on March 23rd, 1880, on account of dysphagia which had troubled him for three weeks. When he came to see me he was unable to take solid food, and liquids only with difficulty. He said that the stoppage had come on suddenly during a meal, when he was apparently quite well. Finding himself unable to take anything he became very nervous, and for some hours would not make any further attempt to swallow, and when he tried he could only manage a teaspoonful of fluid at the time. On examination I found a stricture at the upper part of the lower third of the œsophagus, through which I could not pass the smallest-sized bougie. The patient was well nourished in body, nor had he noticed that he had lost flesh. His face was anxious, but presented no appearance of a cancerous cachexia. There was a murmur to be heard in the cardiac region, which, on consultation with Dr. Ringer, this physician pronounced to be aortic, and not aneurismal. For diagnostic purposes I asked this gentleman to pay me a second visit in a fortnight's time. I afterwards learnt that he was taken to Sir James Paget. He died a few weeks later.

At the post-mortem examination Dr. Hodson, of Bishop's Stortford, has informed me that he found a cancerous stricture, annular, but not complete, about one inch and a half above the cardiac orifice.

What the condition of the œsophagus was in the first case it is hard to say. It could scarcely be that the cricoid cartilage was diseased, or the patient would have felt pain on external pressure, and most probably some mischief would have been detected in the laryngeal examination. If we say that it was a case of spasmodic stricture it is difficult to account for the fact that on passing a bougie at the patient's second visit an obstruction was met with on the right side of the gullet, and not on the left. One would think that the closure of the œsophageal walls in the case of a spasmodic stricture would either give way all at once or equally from the centre of the canal, unless, indeed, in this instance a very slight and old-standing constriction of the mucous wall on the right side of the œsophagus was present at the time of the accident. Undoubtedly the circumstance of finding a complete stricture, apparently organic, in an old woman, attended with the symptom of constant pain in the right ear (the side, let it be noted, the stricture lasted the longest), and with the presence of a quantity of frothy phlegm, pointed in a great measure to the affection being of a cancerous nature.

Mr. Power, in 1866, related in THE LANCET (vol. i., p. 252) a case of stricture in which the patient died of inanition, but that on a post-mortem examination he found a perfectly natural condition of the œsophageal walls. In this case the difficulty of swallowing came on gradually, and a large-sized bougie was on one occasion passed by force through the stricture. By both patients I was asked to give a decided diagnosis. In both instances I was unable to do this. With regard to the case of Mrs ——, I explained that the nature of the illness could not at once be determined upon, but could only be cleared up by time; that although the condition of the patient was undoubtedly very serious, yet, at the same time, from the abnormality of the symptoms, there was reason for saying that the case should not be considered as hopeless. In the second instance, although one had the experience of the case of Mrs. ——, there was more reason to suspect that the stricture was of a cancerous nature on account of its position, but here again it was difficult to account for the suddenness of the attack, coupled with the absence of other signs, and the previous good health of the patient. Perhaps the proper course for clearing up the diagnosis in each case would have been to attempt to pass a bougie whilst the patient was under chloroform.

Devonshire-street, Portland-place.

PHANTOM TUMOUR.

BY P. D. MALLIK, M.B.

ON Dec. 3rd, 1880, I was called to see a case of spurious pregnancy. The patient's history was as follows:—

M——, aged seventeen, married. No children, no miscarriages. Menses arrested since July, 1879. General health good. No family history of hysteria. A month after the cessation of her menses she had nausea and the usual sympathetic disturbances of pregnancy. About the second month the breasts became increased in size and tender, and afterwards became much larger and firmer; blue veins were seen crossing them. The nipples became turgid, and the changes in the areolæ were marked, and exactly resembled those seen in a case of true pregnancy. About the fifth month the abdomen was found to be prominent and enlarged. Quickening was perceived by the patient, and, what is more strange, apparent fœtal motions were observed. The patient was pronounced pregnant, and although she was suffering at the time from irregular attacks of intermittent fever, yet, according to the prejudices still unfortunately prevalent among a large section of the native community, she was not placed under

medical treatment — the very fact of pregnancy being, in their opinion, a sufficient reason against the administration of any medicine. The size of the abdomen increased progressively until it resembled the gravid uterus at full term. Exactly at the end of nine months all the phenomena of labour supervened. Regular pains came on and continued to increase in force and frequency, but no progress was observed. The pains lasted about twenty-four hours, after which period the patient had an attack of intermittent fever. Days and months elapsed, but the labour pains never returned. The parents of the girl became anxious, and thought she had an abdominal tumour. Accordingly they sought medical assistance, and Babu Hara Lal Dutt, of Chandernagore, who was sent for, requested me to see the case in consultation with him. On inspection, the tumour was situated exactly in the centre of the abdomen, and extended from the pubes below to the ensiform cartilage above. The umbilicus was not protruded. There were no striæ over the abdomen. On palpation the tumour was found to be elastic; it had not the hard feel of a solid tumour. Its boundaries were not distinctly circumscribed. Firm, even, continued pressure perceptibly diminished the size of the tumour. The tumour had no connexion with the liver, spleen, ovaries, or uterus. On auscultation, neither the fœtal heart sound nor the uterine souffle could be heard. Rumbling noises were audible all over the tumour. On inquiring whether the patient ever had "fits," a negative answer was received, but we were told that she now and then complained of "globus hystericus." Taking all these facts into consideration, we diagnosed phantom tumour. To confirm our diagnosis, we placed the girl under chloroform. When complete anæsthesia was produced, the tumour entirely vanished from sight; but on withholding the administration of chloroform for a few minutes, it reappeared and assumed its former size and shape. Thus the fact of spurious pregnancy was established beyond doubt. We ordered ten-grain doses of bromide of potassium three times a day. Whether this medicine will do her any good time will show.

Hooghly.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Procemium.

GUY'S HOSPITAL.

COMPOUND FRACTURE OF LOWER END OF FEMUR ; ACUTE GANGRENE ; FATTY EMBOLISM ; DEATH.

(Under the care of Mr. BRYANT.)

FOR the following notes we are indebted to Mr. Dalton.

Chas. B——, aged thirty-two, was admitted into Accident ward on July 18th. At 11 P.M. on the 17th, while alighting from a waggonette at New-cross, he slipped, and the wheel after pushing him a little way, passed over his left thigh. He was taken to Guy's at 1 A.M. in a condition of marked collapse. He had fracture of the lower end of the femur. The arteries were pulsating. Ice was applied. In the afternoon of the same day the thigh swelled and became cold. The temperature rose to 102°. Mr. Lucas was called as gangrene had set in, but did not consider it expedient to amputate. By 11 P.M. the pulse was imperceptible, the face became cold, the leg swelled and became emphysematous. Incisions were made, but the gangrene extended to the abdomen, and the patient died at 7.20 A.M. on July 19th, thirty-two hours after the accident.

Post-mortem Report by DR. FAGGE.—Face bloated and emphysematous, so also all parts of the body. The whole of the injured extremity was exceedingly tense from the distension of the tissues with gas. The scrotum also was blown up to a large size, and large bullæ of dirty fluid were spread about the buttocks and hams. Both lungs stained from blood soaking, though they were quite *warm*. On section of the lungs the exuding fluids were thickly covered with small droplets of oil of various sizes. I have frequently seen such a state in fat bodies previously; but as it was suspected the case might be one of fat embolism, I examined the parts very carefully, and I soon noticed that the oil had a peculiar glutinous appearance, and that it came in large quantities from the moderate-sized branches of the pulmonary artery. I could take them from the vessels on to my knife and show them to the class in quantity. The lung was otherwise perfectly healthy. — Heart: Healthy. A moderate amount of clot in each side. Muscle distended with gas from decomposition.—Liver: Healthy; distended with gas.—Spleen weighed six ounces and a half.—Lower limbs: Healthy. Knee-joint free from blood, and not implicated in any way by the fracture, which was a comminuted one in the lower third, running from in front and above downwards and backwards. It appeared to be an ordinary form of fracture. The vessels were in no way lacerated or even bruised, so far as we could see. The vein was examined in its whole length down to beyond the fracture, and the artery also. They were free from clot, though both were much stained with blood. This early decomposition is worth noting, as the blood was still quite warm when the inspection was made (eight hours after death). The man was a big muscular fellow, with a fair amount of fat on him.

COMPOUND COMMINUTED FRACTURE OF LEG ; ATTEMPTED PRESERVATION ; SECOND AMPUTATION ; FATTY ORGANS ; DEATH.

Edmund E——, aged forty-seven, was admitted into the accident ward on July 20th, 1880. He was a fly-driver at Chiselhurst, and was thrown from his fly and run over, at 10.30 P.M., on the 19th. A local surgeon bound up his leg and sent him to Guy's. On removing the bandage, a piece of bone was found to have come away. The wound was about two inches long. There was fracture of the lower third of tibia. There was also a graze over the inner side of right patella, about the size of half-a-crown. The right metatarsal phalangeal joint was also a good deal bruised. The left shoulder was tender, but no bruising was to be seen. The tendo Achillis was divided. There was a little crackling up the tubercle of the tibia (emphysematous). Two interrupted side and one back splint were put on, and ice was applied to the seat of injury.

On July 26th the patient complained of heat in the injured limb and a good deal of pain, and he had been delirious during the night. On examining the leg there was a little extravasated blood on the front as high as the knee in the cellular tissue. The wound was on the inner side. There was extensive extravasation of blood in the calf. It was chiefly under the soleus, reaching nearly down to the knee, and lying in a plane superficial to the deep fascia. The tibialis anticus was slightly lacerated. The fracture was of both bones, three and a half inches from the anterior border of the tibia; there was a gap in the under surface of tibia from which the pieces were removed; there was a loose fragment of the fibula attached by muscle only. The posterior muscles were chiefly lacerated. The anterior arteries were not wounded. The internal saphena vein was free, but a good deal of coagulum surrounded it. Around the end of the bones was some granular tissue springing from the muscles. The periosteum reached nearly to the end. Nowhere amongst the muscles or cellular tissue was there any suppuration. There were some fine adhesions between the muscles around the clot. No suppuration round the end of the bones. All the clot looked firm except at one point, where it was grumous near the fracture. End of tendo Achillis was torn; the upper part looked a little swollen. The gap between was not filled up, though within the sheath there was a little new lymph. The ankle-joint was sound. Coagulum in medullary cavity. No pus beyond the clot. There was everywhere much yellow serous fluid. Stokes's supra-condyloid amputation was performed. Next day the patient was partly delirious, and very thirsty. The pupils were contracted, and there was a spasmodic twitching of the muscles. He was perspiring freely. Urine clear, pale, slightly ammoniacal, with no trace of bile or albumen. On the 28th he was quieter. There was a little yellowness of conjunctiva. There was no œdema or redness above the amputation. On the 29th he was restless. Tongue brown and dry; sordes on lower lip. Perspired freely. Passed excretions in bed. He had a peculiar smile playing over face. Urine was brown, with a greenish colour floating on top; there was some sediment; albumen was