with a certain amount of inflammation surrounding it. The wounds were thoroughly cleaned up and the damaged tissue removed, irrigated, and dressed with fomentations. For the next few days the large wound was treated with iodine irrigations and boracic fomentations, the latter four-hourly, and the patient was apparently doing well.

On Nov. 1st, at 9.30 A.M., the patient complained of slight stiffness in the jaws and the muscles at the back of the neck, also that the wound in the thigh was "burning" very much. Temperature 99°F. Tetanus was at once suspected, and on inquiry it was ascertained that he had received no injection at the clearing hospital. The wounds did not appear worse; they were cleaning up fairly well. He was given a mixture containing the three bromides, iodide, and nepenthe, four-hourly, and an injection of morphia $\frac{1}{6}$ gr. was administered. In the afternoon he received an injection of 1500 units of antitetanic serum subcutaneously. In the evening the wound in the thigh was causing intense pain and "burning very much"; temperature 100°. He received an injection of morphia gr. $\frac{1}{6}$, and calomel was administered. On the 2nd the morning temperature was 100°. Trismus was very marked, risus sardonicus was obvious, and there were jerking movements all over the body. He received a further injection of 1500 units of antitetanic serum subcutaneously. On the 3rd the temperature was 100°. The patient was removed to a small darkened ward by himself. He now had very marked and violent jerking movements, and arching of the back. The abdomen was retracted and very hard and board-like. He was unable to be fed by the mouth and rectal alimentation was resorted to. On the 4th the patient's condition was about the same. He was given an injection of antitetanic serum intrathecally of 3000 units; chloral hydrate gr. xx. was given four-hourly, and the bromide mixture was discontinued. The injections were administered by Major (temporary) B. Hudson. The wounds were progressing satisfactorily, but were still very painful. Temperature 100°. On the 5th the wounds were less painful and the patient felt better. The jerking movements, especially of the legs, were still marked and the trismus, &c., were still present. On the 6th the temperature was 100°; stiffness of the jaws was relaxing and the jerking movements were less violent. The bromide mixture was resumed. On the 8th the trismus was less marked and the temperature was normal. On the 12th the patient was very cheerful. The jerking movements and the trismus were very slight and the wounds were clean. On the 18th all signs of tetanus had quite disappeared and the patient felt well. On the 22nd he was discharged to hospital ship.

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ST. MARK'S HOSPITAL FOR CANCER, FISTULA, AND OTHER DISEASES OF THE RECTUM.—On Feb. 11th Sir Richard Biddulph Martin presided at the annual general meeting of this hospital, and in moving the adoption of the report referred to the improvements which had been made in the nurses' quarters and in the operating theatre. The finance and general work of the hospital were satisfactory. The War Office, he said, had accepted the hospital's offer of 12 beds for the wounded and three of the hospital's five surgeons had volunteered for active service. The seventy-ninth annual report, which was adopted, showed that during 1914 the total number of new out-patients was 1966, as compared with 1854 in 1913, and that the number of in-patients admitted last year was 732, as compared with 641 in the previous year. The number of operations was 686.

# Medical Societies.

## ROYAL SOCIETY OF MEDICINE.

### SECTION OF OBSTETRICS AND GYNÆCOLOGY.

*Ruptured Unilateral Solid Cancer of Ovary Removed.—Squamous-celled Carcinoma.—Inversion of Uterus.—Exhibition of Specimens.*

A MEETING of this section was held on Feb. 4th, Dr. W. S. A. GRIFFITH, the President, being in the chair.

Dr. HERBERT SPENCER read notes of the case of a patient, aged 27, who had a Ruptured Soft, Solid Growth of the Left Ovary, measuring 5¾ by 3½ inches, with about a gallon of free blood-stained fluid in the peritoneum. The tumour was removed; the other ovary, appearing healthy, was left behind. The patient subsequently had two children and remained well seven years after the operation. Similar cases were recorded by Hofmeier and von Velits. The tumour had the microscopic characters of a medullary carcinoma. Dr. Spencer did not agree with Pfannenstiel's opinion that in all cases of unilateral papillary tumours, cancer and endothelioma of the ovary, the other ovary should be removed, for he had seen examples of all those conditions remain well seven years after unilateral ovariotomy. He suggested, however, that, notwithstanding its microscopic characters, it was possible that the specimen shown was not malignant.—Dr. CUTHBERT LOCKYER said that he was not convinced from a casual examination of the microscopic section of Dr. Spencer's specimen that it was a carcinoma; he thought it would very likely prove to be an endothelioma, and if that were so the long immunity from recurrence would be more easy to understand, as endothelioma of the ovary was far less malignant than solid carcinoma of that organ.—Dr. HENRY BRIGGS remarked that the tumour shown and admirably described by Dr. Spencer stirred the unsettled problem as to what these tumours really are. As solid adenomata, in the Departmental Museum of the University of Liverpool, Dr. Briggs said he had had them illustrated and catalogued for over 15 years; repeated and recent revisions of the catalogue had left them as they were, awaiting any more acceptable advance in histology.—Dr. AMAND ROUTH asked how Dr. Spencer proposed to decide whether the removed tumour was malignant or benign at the time of operation, and what course he would now pursue as regards the second ovary if he decided that the one removed was carcinomatous?—In reply Dr. SPENCER said he saw no evidence that the tumour was an endothelioma; structurally it was a typical medullary carcinoma, and it did not resemble microscopically the endothelioma he had met with in a dermoid. In reply to Dr. Routh's question, he thought in the case of such a soft tumour as the one shown (which in the fresh state resembled a spleen), it would be difficult to cut satisfactory rapid sections at the time of operation. He had not yet decided whether the tumour was malignant or benign, but had made a suggestion on that point in his paper. A similar case he would treat similarly. If the ovary, apparently normal at the time of operation, grew subsequently, he would remove it, but with very little hope that malignant disease affecting both ovaries would not recur.

Mr. GORDON LEY (for Dr. RUSSELL ANDREWS) read a short communication on Squamous-celled Carcinoma occurring in a Cystic Teratoma of the Ovary.

Dr. R D. MAXWELL read a short communication on Inversion of the Uterus, (1) Acute, (2) Chronic.—The subject was discussed by the PRESIDENT, Dr. J. P. HEDLEY, Dr. ROUTH, Dr. BRIGGS, Dr. SPENCER, Dr. E. L. HOLLAND, Dr. COMYNS BERKELEY, Dr. T. G. STEVENS, and Dr. G. F. BLACKER.

Mr. GORDON LEY demonstrated a Fibroid of the Uterus, showing Invasion by Tubercle.—The specimen was remarked upon by the PRESIDENT, Dr. STEVENS, and Dr. LOCKYER.

The PRESIDENT showed an example of the "Bowel Pack," suggested by Mr. J. L. Aymard, of Johannesburg, in THE LANCET of Jan. 16th, p. 150, which he had made, and found that it answered the purpose well. It is made by coiling fine wire on to a pad of "cellular" cloth, the wire being sewn by a running stitch along its whole length. The wire he used was No. 22 gauge pure tin fuse wire, and was covered in by a single layer of lint sewn on to the pad.

When one of appropriate size is placed in position it keeps the bowels out of the way of the area of operation, and is a valuable improvement on the ordinary pad. It could be bent into any shape without injury.—Remarks followed by Dr. COMYNS BERKELEY, Dr. J. S. FAIRBAIRN, Dr. MAXWELL, and Dr. SPENCER.

## CLINICAL SECTION.

*Exhibition of Clinical Cases.—So-called Frost-bite.*

A MEETING of this section was held on Feb. 12th, Mr. J. CHARTERS SYMONDS, the President, being in the chair.

Dr. JAMES GALLOWAY showed a case of Splenomegalic Anæmia. The patient, a boy aged 8½, had been observed by his mother to have a slight swelling of the abdomen 18 months ago. This enlargement had increased. He was said to have had an attack of jaundice about 15 months ago; his complexion was said to have become paler, and a year ago a severe epistaxis occurred. There had been an eruption of small purpuric spots and an attack of hæmatemesis a few days before he was admitted to hospital in November, 1914. Since that date he had been under constant observation. At first his condition became worse and another attack of hæmatemesis with copious melæna occurred. The lad was pallid and had a slight degree of protrusion of the abdomen; the spleen was markedly enlarged, reaching the level of the umbilicus; the lower edge of the liver could be felt below the costal margin, and this organ apparently extended higher in the abdomen than normal; probably it was enlarged. The blood had been frequently examined and the following report was characteristic. Red blood, fragility normal. Wassermann negative. Rouleaux and fibrin formation fair. Red blood corpuscles, 2,900,000 per c.mm.; hæmoglobin, 30 per cent.; colour index, 0·5; white blood cells, 840 per c.mm.; polymorphonuclear leucocytes, 57·5 per cent.; small lymphocytes, 35·0 per cent.; large lymphocytes, 1·5 per cent.; eosinophiles, 1·5 per cent.; basophiles, 1·0 per cent.; large hyaline, 3·5 per cent. There was no history indicative of syphilis. The father and mother appeared to be healthy. There were three sisters and one brother who were in good health. An uncle on the father's side had hæmatemesis associated with a swollen abdomen, but had recovered his health. An uncle on the mother's side had been treated for hæmatemesis and ascites. The question of removal of the spleen arose.

Mr. H. MORRISTON DAVIES showed the following cases: 1. A case of Mediastinal Teratoma. The patient, a man aged 21, was admitted to hospital in March, 1913. Six weeks previously he had noticed a swelling over the upper part of the left chest, which increased rapidly in size and became red and painful. He was admitted to an infirmary with a temperature of 104·8° F. The swelling was incised through the third space and pus escaped. It was noticed that the pus was of a peculiar consistency. A few days later, as there was no improvement in the patient's condition, another opening was made in the anterior axillary line, portions of the fourth rib being excised. The general condition became worse, and there was expectoration of large quantities of offensive sputum. Some hairs were found in the discharge from the wound, and the condition was recognised as an infected dermoid. He was then transferred to Mr. Davies's care, extremely emaciated, and in a condition of profound toxæmia. His temperature fluctuated between 102° and 104°. The skin around the opening was excoriated, and there was slight bulging of the surrounding chest wall. There was a copious discharge of pus, sebaceous material, and occasionally hairs. The heart was displaced to the right, and cough was accompanied by offensive expectoration. Under local anæsthesia the third left costal cartilage was removed, and the finger-like processes of the teratoma could be seen. A cavity was found extending inwards to the right of the sternum, outwards to the anterior axillary line, downwards to the fourth space, and upwards to under the first cartilages on both sides. A week later, as drainage was inadequate, portions of the third and fourth left ribs were removed under open ether anæsthesia. The patient suffered very greatly from shock, but improved slightly during the succeeding weeks. After two months the left second costal cartilage was removed, the second and third right costal cartilages were divided, and the upper part of the body of the sternum was excised. After another month the teratoma was partially separated from the pericardium. Two months later further attachments were divided so as to give better drainage. These operations were done under chloroform anæsthesia, and were followed by great shock. The patient improved, and cough and expectoration ceased. Subsequently the projecting portions of the teratoma were on five occasions excised under anæsthesia by gas and oxygen. In June, 1914, Mr. Davies began to separate the main mass of the teratoma from its attachments to the pericardium, aorta, and surrounding structures; it required five operations before the mass was excised. This part of the growth, half of which was exhibited, measured 13 cm. by 8 cm. by 7·2 cm. It contained, in addition to stratified epithelium, hairs, sebaceous matter, mucous follicles, cartilage and bone, cysts containing mucus, and lined by ciliated columnar epithelium. A further portion was treated in the same way and excised in November, 1914; this measured 7 cm. by 5 cm. by 4 cm. Very little of the teratoma remained. The granulations over the pericardium and other structures were becoming rapidly covered with epithelium, and the cavity from which the teratoma was removed had become obliterated to a great extent, partly by the mediastinum and partly by the expansion of the lung. 2. A case of Bronchiectasis treated by Ligature of Branch of Pulmonary Artery. The patient, a youth aged 17, was admitted to hospital in May, 1913. Seven years ago he had a severe attack of bronchitis, from which he never "properly recovered." During the previous year his cough was much worse and he expectorated large quantities of offensive sputum. Physical signs consisted of dulness, weak breath sounds, and coarse râles over the right base. The sputum contained many different forms of organisms, including streptothrices. Early in June the lung was completely displaced by nitrogen, and four days later the right side of the chest was opened through the fourth intercostal space and portions of the fourth and fifth ribs removed. The branch of the pulmonary artery going to the lower lobe was then tied at the root of the lobe. The patient was anæsthetised by infusion of ether and the lung was kept partially expanded by Mr. Davies's hyperatmospheric apparatus. As soon as the chest was opened the vagus was injected immediately above the hilum of the lung with 2 per cent. of novocaine. The patient experienced practically no shock after the operation. The temperature rose on the third day and 24 oz. of clear fluid were aspirated from the right side of the chest. A week later the temperature was still up, and turbid fluid, which contained streptococci, was found in the pleural cavity. This was drained through an opening in the incision. After three days, as the discharge and sputum were now offensive, a counter-opening was made behind through the ninth rib under local anæsthesia. From this time recovery was uneventful. By August the sputum was reduced to about ½ dr. only per diem and a small sinus was present; he was discharged to a home. The patient had since been working for many months. He said that he felt perfectly well and only occasionally coughed (two or three times a week). A skiagram taken at the beginning of last year showed a shadow at the base of the lung, but in one taken this year the shadow had greatly diminished, and the diaphragm was visible for the first time since he came under Mr. Davies's care. 3. A case of Bronchiectasis treated by Rib Mobilisation (Wilm's operation). The patient, a girl aged 15, deaf and dumb, was admitted to hospital in September, 1913, with extensive bronchiectasis involving the whole of the right side. Over the left base the percussion note was impaired; the breath sounds were harsh; expiration was prolonged and there were moist sounds. Nitrogen displacement was tried, but failed, owing to adhesions. Portions of the first nine ribs were removed through a posterior incision. Ten days later the second stage of the operation was done, the first to the seventh costal cartilages, including the costal margin, being cut away. There was slight shock after each operation. The patient's general condition had much improved. The cough and sputum were greatly diminished, and the latter was no longer offensive. The patient, who previously was often drowsy and apathetic, had become a bright girl and able to go out to work for the whole of each day. 4. A case of Osteitis Fibrosa Cystica. The patient, a girl aged 14, fell on her left hip 18 months ago. Pain was slight and passed off in the course of the day. In March, 1914, she again fell on her hip, and since then she had had occasional slight pain and had limped continuously. She

was seen in April, and a skiagram then taken showed a condition of affairs very similar to that which could be seen in one taken this month. There were very slight limitation of flexion, more of extension, some limitation of abduction and adduction, marked limitation of internal rotation, but none of external rotation. The range of movement in this direction was, however, not increased. There was shortening of the limb, and the great trochanter was raised to above Nélaton's line to an extent practically corresponding with the shortening. Thickening at the upper end of the shaft and of the neck of the femur could be felt. The skiagram showed curvature and enlargement of the upper end of the shaft and of the neck of the femur; the bone was expanded and the cystic condition and septa were easily seen. The epiphysis of the great trochanter was unaffected. The only alteration since April was a slight increase in expansion of the outer aspect of the bone.

Mr. STANLEY BOYD exhibited a case, similar to that last shown by Mr. Davies, in a girl aged 12. There was expansion of the upper end of the left femur, and a skiagram showed a central translucent area and also a fissure. There had been pain in the upper part of the femur for which the child had been kept in bed. After going out she had been knocked down by a boy while at play, when the fissure had been produced. At an operation, tissue was removed from within the swelling, which looked like the growing edge of sarcomatous growth, but which microscopically proved to be connective tissue undergoing ossification. Since then the translucency had become almost normal, and the child ran about free from pain or discomfort.

Mr. R. H. JOCELYN SWAN read a short paper on So-called Frost-bite, based on 100 cases among soldiers returned from the front, 80 of whom had been under his care at the Royal Herbert Hospital, Woolwich. The only causal condition common to all was continuous standing with wet feet. There were two distinct groups of cases: (1) Those in which there was little destructive change, but marked subjective symptoms were present; and (2) those in which there was gangrene of various amounts from a superficial skin lesion to that in which one or more toes were destroyed. In the first group there were cutaneous anæsthesia and analgesia. Joint sense and vibration sense might be lost. Patchy hyperæsthesia was sometimes present, and there was pain on movement or pressure. He regarded the condition as resulting from nutritional change and not as a neurosis, which had been suggested by some. With respect to the second group the gangrene was often greatest in the great toe, and the majority were examples of dry gangrene. It was more usual for one foot to be affected, but there was no ready explanation as to why this should be so. The gangrene had no relation to points of pressure. He thought that the condition was attributable to the dependent position of the feet, to wet, and to want of exercise, and not to cold. Canadian officers had told him that the condition was quite unlike that of true frost-bite with which they were familiar. As preventive measures he suggested the wearing of a thin mackintosh covering outside the sock, but inside the puttee, and the free use of vaseline or whale oil to protect against the wet, and that the boots should be large enough to allow of free movement of the toes. The men should be instructed to carry out this movement.—Dr. GALLOWAY likened this condition to thrombotic phlebo-arteritis obliterans.—Dr. E. G. FEARNSIDES said that the cases could be classified into three groups: (1) Those with objective signs with perhaps some sensory loss, but without subjective symptoms; (2) an intermediate group with slight alteration of sensation, showing blunting of sensation, but without anæsthesia, and a band of hyperæsthesia at the upper border of the affected area; and (3) those in which sensation was lost over an area of the stocking type, which in ordinary civil practice would be ascribed to neurosis. In the Balkan War it had been agreed that the objective changes were vascular in origin.

## LARYNGOLOGICAL SECTION.

*After-treatment of Submucous Resection of the Nasal Septum without Splints.—Exhibition of Cases and Specimens.*

A MEETING of this section was held on Feb. 5th, Dr. WILLIAM HILL, the President, being in the chair.

Sir WILLIAM MILLIGAN read a note on the After-treatment of Submucous Resection of the Nasal Septum without Splints. Having used Whitehead's varnish for painting between the perichondrial flaps and stitches and varnish for the line of incision for several years, he concludes that there is less discomfort and better drainage than after packing the nose. The after-results have been good, and there has been no hæmorrhage or hæmatoma of the septum.—Dr. P. WATSON-WILLIAMS said that packing the nose might cause serious disadvantages, as in cases of sinusitis.—Sir STCLAIR THOMSON agreed, but stated that in simple cases his practice had been to replace the whole of the septum in small pieces and to pack the nose with sponge tissues so that the parts remained in position.

The following cases and specimens were shown:—

Sir WILLIAM MILLIGAN: A woman, aged 30, with Chronic Lymphangitis of the Nose commencing three years earlier.—Dr. WATSON-WILLIAMS had seen similar cases with latent sinusitis.—Mr. H. TILLEY suggested a blood culture for vaccine treatment.—Dr. BROECKART had obtained excellent results by excision of the hypertrophied tissues.

Mr. E. D. D. DAVIS: 1. A boy, aged 14, from whom he had completely enucleated a large Nasopharyngeal Fibroma with a strong dissector and the finger without splitting the palate under intratracheal ether. 2. Three post-mortem specimens illustrating Diseases of the Pituitary Body treated by Killian-Hirsch operations.—The PRESIDENT referred to the dangers of these operations.—Mr. W. G. HOWARTH said that it was important to distinguish the cases in which the disease was below the sella turcica from interpeduncular and pontine tumours. The latter were generally fatal.

Dr. W. H. KELSON: A man suffering from Laryngeal Obstruction following acquired specific disease. The larynx showed fleshy masses resembling pachydermia.

Mr. W. M. MOLLISON: A patient with Traumatic Fixation of the Right Vocal Cord and Displacement of the Right Arytenoid Cartilage. He had been operated on ten years back for goitre. Such a condition was common after goitre operations; sometimes the lesion was caused by pressure of the thyroid gland and antedated the operation.

Mr. W. STUART-LOW: 1. A man with Dyspnœa caused by Tracheal Compression. Skiagrams of the chest (exhibited) showed a definite shadow, but there was doubt whether this was caused by aneurysm or mediastinal tumour.—Dr. KELSON suggested the possibility of a syphilitic mass. 2. A patient with Epithelioma of the Pharynx and Tongue treated by Diathermy. The glands of the neck had also been punctured with the cautery with marked improvement.

Mr. C. I. GRAHAM: A similar case to the foregoing after operation and dissection of the neck.

Dr. JOBSON HORNE: An Epithelioma of the Tonsil in a woman aged 43.

Mr. H. L. WHALE: A circular piece of tin $1\frac{5}{8}$ inches in diameter, bent and jagged, removed from the gullet of a soldier by œsophagotomy. Recovery was uneventful.

Mr. C. W. M. HOPE, Mr. H. BUCKLAND JONES, and Dr. JOBSON HORNE: Soldiers who had had Gunshot Wounds of the Larynx or Pharynx.

Dr. DAN MCKENZIE: A patient with Synechiæ of the Nose treated by Diathermy with excellent result.

Mr. TILLEY: Three children of the ages of 7, 8, and 10 years, who had had Acute Suppuration of the Nasal Accessory Sinuses. Complete recovery followed operation in all cases.

Mr. GRAHAM: A patient with Tuberculosis of the Nasal Fossæ, and sections of the tissue containing tubercle bacilli stained *in situ*.

Sir STCLAIR THOMSON produced a report by Professor Shattock on his specimen of Laryngeal Growth, exhibited in December, 1914, stating that the disease was early squamous-cell carcinoma.

Dr. JOBSON HORNE demonstrated microscopical sections of Pachydermia of the Larynx.

## MEDICAL SOCIETY OF LONDON.

*Discussion on Gunshot Wounds of the Head.*

A MEETING of this society was held on Feb. 8th, Sir JOHN BLAND-SUTTON, the President, being in the chair.

Sir VICTOR HORSLEY opened a discussion on Gunshot Wounds of the Head. His paper is published on page 359 of this issue.

Sir DAVID FERRIER said that were it not for the President's express invitation he would not have ventured to take part in the discussion, for he had little or no experience of