dense felt work of filaments of streptothrix. 3. Pus from chest. Long filamentous-like chains. Most of the elements resemble small cocci, but on the course of the chains are spheroidal and club-shaped elements. The organism stains well by Gram's method, and very badly, if at all, by Loeffler's. Cultures were all sterile till the seventeenth day, when a streptothrix in pure culture grew. The culture, unfortunately, soon died out.

When seen in June, 1910, the patient looked and felt perfectly well. The clubbing of the fingers had quite cleared up. The wound in the side was quite healed. There was only the very slightest deficiency of movement and air entry on the affected side, and resonance and breath sounds were practically normal.

NOTE ON A RARE FORM OF STRANGULATED INTERNAL HERNIA; OPERATION; RECOVERY.

BY HENRY J. CLARKE, JUN., M.A., M.B., B.C. CANTAB., M.R.C.S. ENG., L.R.C.P. LOND.,
HONORARY SURGEON TO THE DONCASTER ROYAL INFIRMARY.

THE patient, a man, aged 37 years, was admitted to the Doncaster Royal Infirmary on Sept. 11th, 1910, at 8.45 P.M. At 8.30 that morning he had had his breakfast, consisting of eggs, bread, &c., and felt perfectly well. At 11.45 A.M. he felt a griping pain in his abdomen and went down the yard to stool; the pain became worse, but he passed a fair motion. On returning to the house the pain became more intense and doubled him up, and he had to go to bed. During the afternoon he vomited six or seven times and continued in great pain.

On admission the man was in great pain and lay on the couch with his knees doubled up. The abdominal walls did not move on respiration, and were absolutely rigid and board-like; there was considerable tenderness in the epigastric area. His temperature was subnormal and pulse 100. It was recognised that some abdominal catastrophe had occurred, possibly perforation of a duodenal or gastric ulcer, and immediate operation was advised.

Operation was performed the same evening at 10 o'clock. The patient was anæsthetised with chloroform. The operation area was first shaved and then painted with tincture of iodine. An incision was made in the middle line, extending from the ensiform cartilage to just below the umbilicus. After opening the peritoneum a deeply congested loop of small intestine was seen situated between the stomach and the liver. At the first glance it looked like an accessory lobe of the liver. On tracing the limbs of this loop backwards towards the spine for several inches they were found to enter a small aperture, the edges of which were tightly constricting the two limbs of the loop. The aperture itself could not be seen, as it was situated too deeply in the abdomen. After considerable difficulty I managed with my left hand to gradually squeeze the limbs through the aperture back again into the greater sac of the peritoneum amongst its fellow coils of small intestine. I was then able with my right hand to bring the affected loop to the surface for examination. Both of the limbs forming the loop presented a constriction, due to the pressure exerted by the edges of the aperture. The portion of intestine between the two points of constriction was very congested, but this soon recovered after being washed with warm saline solution. The abdomen was then closed and the patient returned to bed. Ten ounces of saline solution were injected per rectum every three hours. Next morning the patient was very comfortable; his temperature was 100° F. and his pulse 92. On Sept. 13th he was given a turpentine enema with a fair result. He was discharged quite recovered on Oct. 7th, and is now doing his ordinary work.

In the opinion of both Dr. A. Christy Wilson, who most kindly assisted me at the operation, and myself this was a case of hernia into the foramen of Winslow which had become strangulated. This, of course, is incapable of absolute proof, as there was no post-mortem examination, the man recovering. The case presents several points of interest in that the condition is very rare and that the patient recovered. If he had been left several hours longer without operation it would have been quite impossible to reduce the hernia, for by that time the loop of intestine would have become distended; as it was it only went back after considerable difficulty. Moynihan[1] states that hernia into the foramen of Winslow has been recognised in eight cases. Finally, this case emphasises the need for early diagnosis and prompt action in cases of sudden abdominal emergency.

Doncaster.

NOTE ON A CASE OF MIXED-CELLED SARCOMA OF THE CLAVICLE IN A CHILD.

BY HAROLD W. WILSON, M.S. LOND., F.R.C.S. ENG.,
ASSISTANT SURGEON TO THE CANCER HOSPITAL; SURGEON TO OUT-PATIENTS TO THE VICTORIA HOSPITAL FOR CHILDREN, CHELSEA; SENIOR DEMONSTRATOR OF ANATOMY, ST. BARTHOLOMEW'S HOSPITAL.

AS the clavicle is so rarely the seat of malignant disease the following case of primary sarcoma of that bone seems worthy of a note to record its occurrence. Bland-Sutton,[2] writing in 1906, and referring to the clavicle, says: "Periosteal sarcomata of this bone are rare, and in nearly all recorded cases have originated near the middle of the bone. ..... Examples reported to be central sarcomata arose mainly in the sternal end, but these were in all probability myelomata."

The patient, a little girl of 11 years, came under my care at the Victoria Hospital for Children in October, 1910. Her mother stated that she had noticed a "painless lump on the inner end of the right collar-bone" for about one week. The swelling did not appear to have inconvenienced the child in any way, except that she had complained of slight tenderness whilst being washed the day before she was brought to the hospital. On examination the sternal end of the right clavicle was found to be represented by a globular swelling measuring about 1½ in. in diameter. The tumour, which had a smooth surface and a fairly abrupt steep edge externally, appeared to involve the whole circumference of the bone, and was thought to be a myeloma. It felt bony hard, except for one small place on its anterior aspect, where it appeared to be somewhat softer, and gave way a little on firm pressure before the examining finger. The overlying superficial tissues were not involved, and there was no enlargement of the cervical or axillary glands of the corresponding side. A not very successful X ray plate showed enlargement and great rarefaction of the sternal end of the bone, but did not afford much help in the diagnosis. It showed no limiting shell of compact bone such as one would have expected to find over an expanding growth, nor could the line of an altered shaft be traced into the swelling.

The swelling was cut down upon, and as it was undoubtedly a new growth of some kind the incision was extended, and rather more than the inner half of the clavicle resected and removed with its periosteum, the bone being divided immediately internal to the attachment of the conoid ligament. Portions of the great pectoral and sterno-mastoid muscles at their clavicular attachments were also taken away as a precautionary measure, although they did not show any evidence of involvement. On opening the sterno-clavicular joint it was noted that the articular cartilage of the sternal end of the bone appeared natural. By the ninth day the stitches were out and the wound healed, and one was rather surprised to find that even at this early date the child appeared to suffer no inconvenience from the operation, and that the movements of the right shoulder-joint were as free and painless as those of the opposite side.

After a careful examination of the specimen it was concluded that it was an ossifying sarcoma, which had originated on the anterior aspect of the bone. The growth was spreading outwards immediately beneath the periosteum and had invaded the cancellous tissue of the sternal end of the bone. In the latter situation it was much softer than elsewhere, and presented a purplish appearance with small pale areas scattered throughout its substance. These spots afterwards proved to be small islets of necrosis. It is just possible that this might have been an example of a sarcoma of central origin, referred to by Bland-Sutton as occurring in this situation; but from the fact that there was a very little, if any, expansion of the bone, and seeing that the growth showed a greater sub-periosteal extent than could be

[1] Moynihan's Abdominal Operations, p. 475.
[2] Tumours — Innocent and Malignant, J. Bland-Sutton, fourth edition.

seen in the medullary canal, I think this unlikely, and believe the former view to be the correct interpretation. Dr. F. W. Andrewes was kind enough to microscope several portions of the tumour for me, and reported that the growth was a typical mixed-celled sarcoma showing a considerable amount of necrosis.

At the present time (seven months after operation) the child appears perfectly well, and there is no dropping or falling forwards of the affected shoulder. Knowing, however, what the after-history of these cases almost invariably is, one fears that the appearance of secondary growths in the lungs or elsewhere can only be a matter of a few months at most.

Wimpole-street, W.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

CLINICAL SECTION.

Exhibition of Cases.

A MEETING of this section was held on May 12th, with Sir ALFRED PEARCE GOULD, the President, in the chair.

Dr. WILFRED HARRIS showed a case of Spondylitis, with Progressive Muscular Contracture. The patient was a man, aged 33, who was invalided from the army three years ago on account of constant pains in the back and shoulders. A year previously he had relapsing fever in West Africa. The pains were severe for two months, during which time he noticed that his back and neck were becoming stiff and stooping. This condition had become progressively worse ever since. He had taken 10 gr. of aspirin daily for the last two years, as he found the pains returned if he left off the drug for two days. He was very weak and unable to dress and undress alone. The spine showed general kyphosis and was quite rigid, the head being held forward, with only very slight lateral and antero-posterior movements possible. The chest was not flattened, but was absolutely rigid, breathing being entirely diaphragmatic. The shoulders were very rigid, owing to muscular spasm and contracture fixing the scapulæ, but the shoulder-joints were normal. Under chloroform anæsthesia the scapulæ could be moved fairly freely, but the arms could not be raised much above the horizontal, owing to contracture of the pectoral muscles. The hip-joints and lower extremities were perfectly normal, and there was no evidence of any rheumatic affection. Skiagrams showed no abnormality of the spine or thorax.

Dr. H. D. ROLLESTON and Mr. G. P. HUMPHRY showed a case of Rigidity of the Spine. The patient was a man, aged 26, whose father (6 ft. 6 in.), mother, brothers, and sisters were all healthy except one sister, who had chorea. He had not had any injury, enteric fever, gonorrhœa, or syphilis, and was healthy until January, 1905, when he had acute rheumatism and was in bed for six months. In December, 1906, he had a similar attack, and was in bed for four months, his heart being affected. In April, 1909, he had another attack, and on that occasion his back and neck began to get stiff. In June, 1909, he was admitted into St. George's Hospital, and had the appearance of ordinary subacute rheumatic fever, and reacted to salicylates. It was not until he began to convalesce that the stiffness of the spine was noticed. He then went to Bath for treatment and was somewhat improved. He noticed that the stiffness of the spine varied considerably from time to time. In March, 1910, he was treated with 'leucodescent' light without benefit. In May, 1910, while at the seaside, the rigidity passed off, but returned after he had been in London three weeks, and had remained since. Since he had had the spinal rigidity he had been subject to sudden shooting pains in the back which spread all over the body. There were marked kyphosis and rigidity of the spine; when placed on the floor the first part of his spine to touch the floor was the tenth dorsal spine; when in this position the external occipital protuberance was 2½ in. from the floor. This was maintained in deep general anæsthesia. There was slight lateral curvature in the dorsal region to the right, and a compensatory lumbar curve to the left. The head could be moved vertically for 1 inch; rotation of the head, measured by the movement of the chin, could be carried to an extent of 1¾ inches to the right of the middle line, and ¾ inch to the left of the middle line. Under an anæsthetic these movements were suddenly stopped as if by a bony obstacle. The right arm was smaller than the left, and movement at the shoulder-joint was restricted, the arm not reaching the right angle with the trunk; this appeared to be due to contraction of the pectoral muscles. The movements of the left arm were practically normal. The thighs could be flexed to the right angle on the hips. The big toes were remarkably long; this the patient stated to be hereditary. The chest was flattened and there was only ¼ inch expansion (30¼ to 30½ inches). Breathing was almost entirely diaphragmatic (expansion of abdomen 2 inches), and the abdominal muscles were constantly rigid. The apex beat was in the fifth space in the nipple line, and there was a mitral systolic murmur. There was no alteration in cutaneous sensation. The knee-jerks were present. Dr. G. Allpress Simmons, who had kindly provided the skiagrams, reported that the repeated radiographic examinations made during the past year did not suggest that there was any bony ankylosis of the vertebræ, but that the appearance of the anterior common spinous ligament in the upper cervical region was compatible with the view that there might be calcification in that ligament.—The two preceding cases were discussed by the PRESIDENT, Dr. F. PARKES WEBER, Dr. F. J. POYNTON, Dr. W. ESSEX WYNTER, and Mr. F. S. KIDD

Dr. J. FAWCETT showed a case of Cystic Disease of the Kidneys. The patient was a woman, aged 43, who was admitted for anæmia and the two tumours described later. The "periods" had been profuse for two years, and more so during the past six months. In October, 1910, there was some swelling of the ankles, and since that time she had been short of breath on exertion; she also complained of aching in the loins. The patient noticed the "lumps" in the abdomen three weeks before admission. She had been in the hospital for four weeks. The menorrhagia had ceased and great improvement had taken place in her general condition of health. The tumours were *in statu quo;* they were situated one in each side of the abdomen, reaching from the costal margin above well down into the iliac fossæ on either side and into the loins. They had a somewhat irregular or sinuous outline, and were of semi-elastic consistence. On the surface of the left tumour several rounded "knobby" projections could be felt.—Mr. TARGETT and Mr. BELLINGHAM SMITH were of opinion that the tumours had no connexion with the pelvic organs.

Mr. HERBERT TILLEY showed specimens illustrating removal of Foreign Bodies from the air-passages and the œsophagus. He demonstrated the following: 1. A portion of a rabbit bone which had been impacted in the right bronchus for more than three years, and had produced symptoms of bronchiectasis; the bone was removed by direct bronchoscopy. 2. A portion of mutton bone removed by direct bronchoscopy from the right bronchus, wherein it had been impacted for ten days. 3. A metal cap of lead pencil removed from the left bronchus by direct bronchoscopy. The skiagram was exhibited. 4. A portion of a hatpin removed by direct bronchoscopy from the left bronchus, wherein it had been impacted for six weeks. Skiagram shown. 5. A teat or "comforter" removed from the œsophagus of a child four days old by direct œsophagoscopy. 6. A penny removed from the œsophagus of a girl aged 13; it had been impacted for 13 days. 7. A farthing removed from the œsophagus of a boy aged 5; it had been impacted for five hours.—In the discussion that followed Mr. A. CARLESS, Dr. C. W. CHAPMAN, Mr. KIDD, and Mr. LAWRIE H. MCGAVIN took part.

Dr. ESSEX WYNTER showed a case of Graves's Disease in a boy, commencing at the age of ten. The patient, aged 11, exhibited undue prominence of the eyes at the age of ten, nearly a year ago. When admitted to Middlesex Hospital on March 16th, 1911, there was obvious proptosis, with all the usual signs. The thyroid gland was enlarged, both isthmus and lobes; the fingers, when extended, exhibited fine tremor; the skin was moist, and the hands and neck showed yellowish pigmentation. There had been no cramps, but the patient had fainting attacks, flushes, and occasionally showed some temporary puffiness of the face. There was incontinence of urine; the urine was clear, amber-coloured, acid, specific gravity 1015, and had contained a trace of albumin. The pulse had ranged from 92 to 124. Thyroidectin had been given in 5-gr. doses twice a day. On two