roused with difficulty. Gradually, a typhoid condition came on, in which she remained for some days, and then sank.

Necropsy.—On removing the scalp and sawing through the calvarium, the diploë in the frontal region was found to be completely absent, the space between the tables of the skull being hollowed out into several thin-walled cavities extending upwards and downwards, and quite empty. The dura mater was healthy; on its removal, a small quantity of fluid distended the pia mater posteriorly. On removal, the configuration of the brain was normal; five ounces of blood and sanious serum escaped during its removal, draining chiefly from the base of the skull and spinal canal. The arteries at the base of the organ were slightly enlarged; their coats of a whitish colour, but not materially thickened. The middle division (the anterior parietal of Duret) of the arteria fossæ Sylvii of the left hemisphere, at its breaking up into two branches, was blocked, a transverse section under the microscope showing it to be filled with granular detritus; the arteries at the right side were normal. The various cranial nerves appeared healthy; the third nerves were, however, very easily detached. The pons, medulla, and cerebellum appeared normal. On examining the hemispheres, the left ascending parietal convolution, for two inches and three-quarters of its length, extending from one inch below the longitudinal fissure into the fissure of Sylvius beneath, was completely softened and broken down into a whitish pulp throughout its entire thickness, the pia mater being adherent to the surface and incapable of being stripped without bringing with it portions of the brain-substance (fig. 6). Beyond a general wasting

Fig. 6.—Softening of Lower Two-Thirds of the Left Ascending Parietal Convolution; "Foyer" of Softening in the Central White Matter of the Hemisphere.

and separation of the convolutions by wide and shallow sulci, no further cortical lesions, either on this or on the right hemisphere, existed. On cutting into the brain, a "foyer" of softening, circular in outline, and with a diameter of two inches, occupied the centrum ovale of Vieussens of the left hemisphere, commencing two inches and a quarter behind the apex of the left frontal lobe and terminating three inches and one-eighth anterior to the apex of the occipital lobe. This region of softening extended from above the level of the corpus callosum, right through the white matter of the hemisphere, and was continuous with the softened ascending parietal convolution. The intraventricular portions of the opto-striate bodies and the basal ganglia appeared normal. Microscopical examination showed the softened tissue of the cortex to contain numerous granular bodies and broken down nerve-fibres. Many of the ganglionic corpuscles had, however, still retained their normal appearance. A prepared section through the third left frontal convolution revealed a pigmented and granular condition of the nerve-cells and a widely dilated state of the perivascular canals, many of which contained globular débris of nervous disintegration; the majority of the vessels under observation were contracted and shrivelled; their coats were not morbidly thickened. Spots of miliary sclerosis were present in great numbers both here and in a section through the left crus cerebri. The heart was enlarged, the walls of the left ventricle being much hypertrophied and covered with a layer of fat. The mitral valves were not apparently diseased; the aortic were puckered and thickened at the edges, and on one curtain was a minute vegetation. The aorta was dilated, and its lining membrane studded with atheromatous patches and cicatrices; the coronary arteries were enlarged and atheromatous; both kidneys were granular on the surface. Microscopic examination revealed hypertrophic thickening of the walls of the arterioles, with a circularly arranged layer of connective tissue externally. The epithelial lining of the tubules was generally present, filling the latter, of a yellowish colour, clouded and granular. Many of the Malpighian bodies appeared to be shrunken and broken. The

condition of the brain in this case was without doubt due to embolic softening of the region included within the area of distribution of the middle division of the arteria fossæ Sylvii (anterior parietal of Duret), aided probably by the general changes in the walls of the vessels. The cortical lesion was strictly located in the left ascending parietal convolution; but, as I have said, the softening was not confined to the cortex, the white matter of the centrum ovale beneath the fronto-parietal convolutions being also involved; and to this must, in all probability, be attributed the extent of the paralysis, though Charcot, indeed, has shown that destruction of a single convolution in the motor zone is sufficient to account for a loss of power in the hand, arm, and leg. Here the localised *ramollissement*, by interrupting the continuity of the conducting fibres passing from the cortical centres to the ganglia beneath, over a wider area than the cortical lesion itself extended, virtually destroyed the activity of motor centres not themselves affected, causing a cessation of function, and, as a result, paralysis of the region which they motorially governed. Softening may exist in certain portions of the white matter of the centrum ovale, without producing paralysis, if such be situated beneath or outside the course of the conducting fibres passing from the cortical motor centres to the ventricular ganglia. Such in all probability was the condition in the case recorded by Dr. Keibell in the *Lancet* for May 5th, 1877, where a tubercular cavity extending for a distance of three inches and a half through the anterior and middle lobes of the hemisphere existed without any motor derangement being present, this softening being probably beneath the level of the conducting fibres to which I have alluded.

These six cases, gentlemen, which I have now related, in all of which localised lesions of the convolutions, either in the non-motor or motor regions, existed, and which were accompanied by negative or positive symptoms, according to the seat of the disease in the non-motor or motor zones, tend, in a greater or less degree, to support pathologically the fundamental doctrines of cerebral localisation, and as a slight contribution to this *questio vexata* of modern medical science, are, I trust, worthy of being placed on record.

MENSTRUAL FLUID RETAINED IN THE LEFT FALLOPIAN TUBE, SIMULATING OVARIAN TUMOUR; ABDOMINAL SECTION DURING ACUTE PERITONITIS.

By LAWSON TAIT, F.R.C.S.,
Surgeon to the Birmingham Hospital for Women, etc.

MISS M., aged 38, was sent to me in the beginning of 1877 by my friend Mr. Alfred Freer of Stourbridge. In November 1876, she had an ill-defined illness, during which she had obscure pelvic pains accompanied by fever. Previously to this illness, she had been in good health and had menstruated regularly. After it, she had severe pain during the whole period of menstruation, and she gradually increased in size until Mr. Freer discovered a pelvic tumour in February last. I found the tumour to be pear-shaped, quite movable, attached to the uterus at the left cornu, evidently unilocular, and about the size of an infant's head. I diagnosed it as a cyst of the parovarium, and advised that it should be tapped after it had increased in size sufficiently to warrant interference. She returned to me in May, with the tumour increased so as to be felt above the umbilicus. I advised her to come again in a month. She came, however, before the expiry of that period, on account of a sudden accession of serious symptoms; and when I saw her on June 20th, there could be no doubt she was suffering from peritonitis. Her pulse was 130; the temperature was 38.4 deg. C. (101.12 deg. Fahr.), and rose to 39.6 deg. C. (103.28 deg. Fahr.) in the evening; and there was excessive pain all over the abdomen, with considerable flatulent distension. I administered opium freely, and applied counterirritation over the epigastrium.

On the morning of the 21st, she was easier, but the temperature and pulse had not fallen. I therefore had her placed under the influence of ether by Dr. A. H. Carter, and proceeded to open the abdomen, assisted by Mr. Priestley Smith. The tissues of the abdominal walls were extremely vascular, and it was necessary to use a large number of ligatures to arrest the bleeding. The peritoneum was found to be intimately adherent to the tumour; and, as soon as the latter had been laid bare for a short distance, it became evident that it was not an ovarian tumour, but presented the red muscular appearance of the uterus. Passing the forefinger of my left hand down as deeply as I could in front of the tumour, with that of my right hand in the vagina, I made out distinctly enough that my original conception of the relations of the tumour to the uterus were perfectly correct.

Under the suspicion that it might be a tubal pregnancy, I did not separate the tumour further, as I had not opened the peritoneal cavity, but cautiously opened the cyst in the middle line by means of a knife. As soon as I had reached its inner coat, I passed my small trocar in and evacuated about six quarts of thick dark brown fluid, having the peculiar smell of menstrual fluid. After the cyst was emptied, I passed my finger through the hole made by the trocar; and to my amazement, I found that the cyst had contracted; and as I kept my finger in the cavity, I distinctly felt it contracting round and grasping my finger. Passing the finger of the other hand into the vagina, I made out that what I had opened was, beyond doubt, the left Fallopian tube, and that I must have opened it close to its fimbriated extremity. I could find no canal leading into the uterus, and did not deem it advisable to make one. I washed out the cavity freely with weak carbolic lotion, by reversing the syphon action of my trocar. The wound was closed by four deep sutures, one of which was so arranged as to fasten in a loop of wire drainage-tube; but before this was done, I acted on a hint from Mr. Priestley Smith and snipped off a piece of the cyst-wall for microscopic examination. This fragment proved to be composed of an abundance of unstripped muscular fibre, conclusively supporting the view that this singular tumour was a distended Fallopian tube. After the operation, I treated her exactly like a case of ovariectomy. Her temperature fell slowly. The wound suppurated freely, and shreds of what was undoubtedly mucous membrane came away with the discharge in large quantity. The drainage-tube was removed on the twenty-first day, and its track continued to discharge till the beginning of August. It then healed, and she is now (October 18th, 1877) in perfect health, save that she has occasional pain in the wound. She has never menstruated since the operation.

From the fortunate issue of this case much is left to speculation, but of the nature of the tumour there is no doubt. As to its origin, it seems to me that it may be accounted for by the supposition that the illness from which all her symptoms dated was a localised salpingitis, which resulted in the closure of the two ends of the tube. The peritonitis, which she undoubtedly had when I operated on her, I suggest was due to a threatening rupture of the tube, and possibly a slight escape of its contents. If this be so, it is evident that it was only the accident of my determination to act promptly which saved the patient's life.

REPORTS

OF

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF GREAT BRITAIN AND IRELAND.

SAMARITAN FREE HOSPITAL.

CONSULTATIONS.

APRIL 26TH.—*Uterine Fibroid impacted in Pelvis.*—Dr. PERCY BOUTON introduced for consultation a young woman who had come from a provincial town for advice concerning an abdominal tumour. On vaginal examination, he found the cervix uteri displaced under the pubes and a firm elastic solid tumour blocking up the pelvis behind it. He reduced the growth and introduced into the vagina a Hodge's pessary to prevent it from falling back again. A sound could be passed three inches into the uterine cavity, and the enlargement then could be felt behind that instrument. The left ovary was enlarged and rather tender. Dr. Boulton desired the opinion of his colleagues on the case and the necessary treatment required, before sending her back to the country. He himself had no doubt that a fibroid tumour existed at the posterior aspect and right side of the uterus. He intended the patient to wear the pessary, and to take ergot, as her periods were profuse and frequent.—Mr. SPENCER WELLS observed that the cervix lay in the normal position, the tumour having evidently been completely reduced by Dr. Boulton. The morbid growth felt like an uterine fibroid, but it might be an enlarged ovary adherent to the uterus.—Dr. BANTOCK believed that the tumour was an extramural fibroid.—Mr. KNOWSLEY THORNTON observed that the tumour had fallen back into the pelvis, the pessary having been removed by his colleagues to facilitate examination. He had no doubt that the disease was fibroid. The remainder of the staff present were of the same opinion; and all agreed to the course of treatment suggested by Dr. Boulton, who again reduced the tumour and replaced the pessary.

Large Uterine Tumours.—Dr. DAY called the attention of the staff to the case of a married woman, aged 28. In her right iliac fossa, a firm solid tumour could be detected on palpation. It was freely

movable; and on vaginal examination, the cervix uteri was found to move with it. In the left iliac fossa, another firm but smaller solid tumour could be felt; it moved quite independently of the cervix. Both growths were in all probability fibroid. The patient had menstruated regularly until the last period, which continued eleven days and was excessive. Dr. Day intended to confine the treatment to the administration of tonics.—Mr. SPENCER WELLS had no doubt that the tumour on the right side was a large sessile fibroid growth, whilst that on the left was of similar pathological character, but connected with the body of the uterus by a long, thin, flexible pedicle.—The rest of the staff were of similar opinion.

Ovarian Tumour; Uterine Adhesions; Supposed Peritoneal Infection.—Mr. KNOWSLEY THORNTON requested his colleagues to examine a patient aged 33. In September 1873, she had consulted Mr. Spencer Wells, who detected a hard tense swelling in the left iliac fossa, which felt like a pelvic abscess; but on tapping her, two pints of clear fluid escaped. In February 1874, three pints were removed by the aspirator; in the following November, a pint and a half was withdrawn; on this occasion, the tumour was punctured *per vaginam* by means of a trocar. The fluid was in every case ovarian, both in chemical and microscopical characters; it was clear and of a bright yellow colour at first; but at the last tapping, it looked like turbid beer, the cloudiness being due to immense numbers of inflammatory granular aggregations; ovarian granules were also very abundant. In March 1877, she was again tapped, and twenty-one pints of mixed ovarian and ascitic fluid were removed. Mr. Wells then thought that the connection of the tumour with the uterus was so close that the patient ought to wait till the growth was so large as to compel an operation. In February of the present year, Mr. Thornton tapped the patient at her own house and removed nineteen pints of mixed fluid containing an immense quantity of cell-groups, which he had always found to be diagnostic of peritoneal infection from ovarian growths. He believed that the uterus was so imbedded in the tumour and fixed in the pelvis, and this condition was so clear by combined pelvic and abdominal examination, that not even an exploratory incision was advisable. Then added to this grave complication was the evidence of peritoneal infection, which of course also contraindicated any operation but tapping.—Dr. GREENHALGH questioned the extreme danger of making an incision; but on examining the patient, he thought, considering how firmly the uterus was fixed, that ovariectomy should not be attempted.—Mr. SPENCER WELLS considered that the evidence of peritoneal infection rendered any surgical interference inadvisable; otherwise an exploratory incision might be undertaken to find if there were any possibility of removing the tumour.—Dr. WYNN WILLIAMS had opened the peritoneum for the exploration of tumours, which had been found to be malignant, without fatal results. But as in this case the growth could evidently not be removed, incision was useless.—Dr. BANTOCK remarked that the evidence, in this case, of communication existing already for some time between the cyst and the peritoneal cavity was in itself a most unfavourable complication.—Dr. CHAMPNEYS was also opposed to interference; after frequent tapping the solid parts of the tumour had much increased and become adherent to the uterus; besides, the thickening he could detect in the left vault of the vagina and the fixity of the uterus denoted old inflammatory complications.—Mr. DORAN also thought the case quite unfit for ovariectomy; the physical symptoms were so evident as to render an exploratory incision as needless as it would be dangerous.

Pelvic Tumour of Uncertain Nature.—Dr. BANTOCK called attention to a woman, aged 31, who had enjoyed good health till four months ago, when she gave birth to her sixth child. Three days after her confinement, she had a rigor, followed by two more in the course of a few days. She felt no pain till she got out of bed, a month after delivery. Seven weeks ago, diarrhoea came on; the motions were very dark in colour. At present, she feels weak, but is not in pain, and the bowels are not relaxed. The uterus is very high in the pelvis, the cervix is soft, the os patulous. A firm elastic swelling can be detected, immediately connected with the uterus, and extending across to the left iliac fossa; it is quite movable. There is also a slight projection towards the right iliac fossa. Dr. Bantock believed the tumour to be a pelvic hæmatocele. The dark colour of the motions, he thought, aided in his diagnosis. He intended to enforce rest and administer chloride of ammonium.—Dr. GREENHALGH considered that the tumour was made up of the hardened products of pelvic cellulitis.—Dr. WYNN WILLIAMS had seen pelvic cellulitis accompanied with little or no pain, as in this case; but he thought that it would be very difficult to prove by palpation whether the tumour was due to that disease or was a hæmatocele surrounded by indurated tissues.—Dr. CHAMPNEYS was of opinion that the primary affection in this case was pelvic peritonitis, the peritoneum being more involved than the