with her exhaustion and emaciation to a skeleton, made the diagnosis more than probable, but the specific gravity of the urine (1040) and the chemical analysis confirmed it thoroughly. There appeared scarcely anything to be done for this patient, who constantly felt nausea, and vomited after everything she took; but, of course, the results of my first case, in 1870, made it my duty to resort at once to the D. or diabetic koumiss of Messrs. Chapman and Co. of London; so it stopped the vomiting, brought on appetite, sleep, and strength, diminished the specific gravity of the urine to 1034. Within ten days, the patient was up again, and in a fortnight she came with her husband and sister to my house. Shortly afterwards, she went into the country to her sister, where she remained for some time. A few months later, however, her husband called upon me and told me that she had died of peritonitis.

In concluding this paper, I think it may prove interesting to some of you to peruse also some cases reported by other professional brethren upon the same subject on which I have had the honour of addressing you. I, therefore, refer you to those cases in the *Lancet* of December 12th, 1874, by Dr. A. S. Myrtle of Harrogate, who gives four cases treated by koumiss: one of *marasmus* in the adult with unchecked vomiting—successful; one of *pyæmia* with sickness and unchecked vomiting—successful; one of *phthisis* (advanced) with ulceration of mucous membrane, diarrhoea, and hectic—successful; one of *rheumatic fever* with gastric irritability of a most formidable nature—also successful; and in the *Lancet* of January 9th, 1875, by Mr. Carter Wigg of Southminster, Essex, of an equally interesting case of *heart-disease* and *albuminuria* with constant sickness, retching, and vomiting—likewise successful.

From the above cases, you may fairly judge the effects of sparkling koumiss, and I heartily recommend it for your use in such and similar cases. There is no doubt that remedies of this kind, more especially in the expectant mode of treatment, have the advantage over some medicines in being harmless at the worst; they occasion no anxiety to the physician, and are not only not to be reserved for cases in *extremis*, when all hope of recovery by other means has vanished, but are especially the more rational means with which to commence the early and primary treatment.

OSTEO-SARCOMA OF THE FEMUR AND LUNG.*

By F. A. HEATH, M.R.C.S.,
Surgeon to the Royal Infirmary, Manchester.

Primary Osteo-Sarcoma of the Femur: Amputation of the Thigh: No Return in the Stump, nor in Glands of Groin. Secondary Osteo-Sarcoma of the Lung: Death.—The following case, though presenting no novelty, is interesting in its surgical aspect, as tending to confirm the opinion laid down by the late Sir William Fergusson, in his lectures on the Progress of Surgery before the Royal College of Surgeons: that large malignant growths, springing from the long bones, do not, after amputation, if the whole of the diseased structures be removed, return in the stump, but at some distant part; and that, therefore, it is not necessary to amputate above the knee in the case of the tibia, or at the hip-joint in case of the femur.

R. A., aged 19, was admitted into the Royal Infirmary in 1875, with a large tumour connected with the right femur. At a consultation of the medical and surgical staff, some difference of opinion was expressed as to whether amputation at the hip-joint should be performed, or whether it would be sufficient to amputate at the upper third of the thigh. The latter operation was decided upon, and was performed on June 4th, 1875. The patient recovered, and was discharged as cured.

The examination of the tumour was as follows. The lower portion of the thigh was converted into an immense globular mass, beginning just below the knee and extending two-thirds up the thigh. This large mass had a circumference of forty-six inches measured transversely, and thirty-six inches measured in the vertical plane, and, after detaching the foot and leg, the tumour weighed twenty-seven pounds. On making a longitudinal section, it was found that it was a tumour springing from the periosteum of the lower two-thirds of the femur, and surrounding it equally on all sides. It had absorbed all the soft structures, and was just covered by their atrophied remains and the dense glistening skin. The microscopic examination showed the tumour to belong to the class of osteo-sarcomata.

In September, rather more than three months after the operation, hearing that my patient was dying, I went to her home in the country and persuaded her to come again into the infirmary, where she was admitted, on September 25th, in a very exhausted state. The body

temperature seemed much below the normal; the extremities were cold, and the body covered by cold clammy perspirations. She was suffering from intense dyspnoea, and was unable to assume the recumbent posture. She was perfectly conscious, complained of no pain, and had up to the last few days enjoyed a remarkably good appetite. The face and upper extremities were intensely cyanotic and oedematous. The superficial veins of the head, neck, and arms formed prominent large tortuous cords, and the thorax was of an enormous size, with distinct bulging of the right side. The whole of the right side of the chest-wall, both in front and behind, was absolutely dull on percussion, and its dulness extended over to the left side to a line vertical through the left nipple; the left supra- and infra-clavicular and supra- and infra-scapular regions gave normal percussion and sound. On auscultation, no breath-sound could be heard on the right side; while on the left, both in front and behind, harsh vesicular breathing, with loud sonorous rhonchi, were audible. The respirations were 45 per minute. The heart's impulse was felt in the left axillary line, in the fifth intercostal space; the apex-beat was feeble; the sounds of the heart were normal, but weak and irregular; the pulse 110, thin, and easily compressible.

The girl died on October 1st, and, at the *post mortem* examination, on removing the sternum, the right lung was found extending across the anterior mediastinum, displacing the heart and compressing the left lung into a small space by the side of the spinal column. The right lung had assumed truly gigantic proportions, weighing fifteen pounds, and resembling more a solid body; the left lung and heart forming, as it were, a mere appendix. The microscopic examination showed it to have exactly the same structure as the tumour of the femur, which I need not describe; but I may mention that some beautiful sections were kindly made for me by Dr. Dreschfeld, Lecturer on Pathology to Owens College, and may be seen in the Microscopic Section in the Museum. The left lung weighed sixteen ounces; it contained, in the lower lobe, three small nodules of the same nature as the tumour in the right lung. The rest of the organs were healthy. Neither the inguinal, femoral, axillary, nor mediastinal glands were in the least enlarged.

One other case occurred in my practice, where I amputated at the hip-joint for a very large tumour of a similar nature (the whole limb, after removal, weighing nearly forty pounds). The man recovered, but died some months afterwards, with no return in the stump; and your President, I have no doubt, can recall to mind other cases. We have, therefore, I think, sufficient evidence before us to show that we must amputate wide of the disease; but still, as far as possible, from the great centre of the body; and, consequently, with a necessarily diminished risk.

A CONTRIBUTION TO THE CONTROVERSY RESPECTING CHEIRO-POMPHOLYX AND DYSIDROSIS.

By JOHN TWEEDY, F.R.C.S.,
Late Assistant Medical Officer in the Skin Department of University College Hospital; etc.

ALTHOUGH I may, perhaps, after Dr. Tilbury Fox and Mr. Jonathan Hutchinson, claim to have most personal interest in the controversy respecting dysidrosis and cheiro-pompholyx, I have not hitherto thought it necessary to take a public part in it; but recent events seem to demand that I should break silence, and to lay before the profession some facts which, I trust, will assist to clear up some of the matters in dispute.

I regret that Dr. Thin's contribution to the *BRITISH MEDICAL JOURNAL* of December 1st compels me to refer to the question of priority; but I shall do so as briefly as possible, as I am most concerned to record my own experience of the nature and seat of the disease which Dr. Fox has described under the name dysidrosis.

For more than five years, from the beginning of 1870, I regularly attended the Skin Department of University College Hospital, and for nearly four of these years, I held the post of Assistant Medical Officer therein. With few exceptions, I saw all the patients who attended during that time, numbering at least five thousand different individuals; but at no period in those years did it appear that Dr. Fox was a perfect stranger to the disease which, in the year 1872, he decided to call dysidrosis. I became acquainted with it at the commencement of attendance in the skin department, and was not long in discovering that, although not described in books, it was by no means rare. Under these circumstances, I feel justified in concluding that Dr. Fox had recognised the peculiarities of the disease sufficiently to point them out to his pupils even before the year 1870; how long before, it is not my business to inquire.

* Read in the Section of Surgery at the Annual Meeting of the British Medical Association in Manchester, August 1877.