the body was permitted, also that I have mislaid my notes of this remarkable case; but the leading facts cannot fail to be of interest just now, and their interest is much enhanced by the certainty we possess that nothing liquid or solid could have been received into the patient's system; also that there existed no motive for deception.

CASE OF PERITYPHLITIC ABSCESS: WITH REMARKS.

By JOHN A. CAMPBELL, M.D.,

Assistant Medical Superintendent, Cumberland and Westmorland Asylum.

J. M., a female, aged 49, was admitted on July 27th, 1867. She was stated to have been insane seven months, and to have refused her food prior to admission. She laboured under melancholia, and seldom spoke. She was of average height, dark complexion, and stood in whatever attitude she was placed.

On examination, she was found in very feeble health; but no actual bodily disease was discovered. She took her food with the greatest reluctance. On July 30th, she was improved in appearance. On August 8th, for four days she had had pneumonia in both lungs, the lower lobes being affected. She was getting large quantities of stimulants and nourishing diet, but there was great difficulty in making her take them. She had œdema of both legs up to the knees, and of that side of the face on which she happened to lie. She continued in a very weak state up to August 17th, when she coughed up several teaspoonfuls of blood, became feebler, and died next day.

Autopsy Fifty-five Hours after Death.—There was considerable discoloration from commencing putrefaction over the abdomen, and on the right side it presented two protuberant portions, which on percussion were found resonant. With the exception of the brain-substance being paler and softer than natural, there was nothing abnormal in the brain or its membranes. The right lung was attached to the wall of the chest by recent adhesions; its external lower and posterior part was gangrenous to the extent of three inches—dark, shreddy, and bathed in purulent matter. On section, the gangrene was found to extend upward in the part lying along the spine for about three inches. The rest of the lower lobe was in a state of red hepatisation, passing in some parts into grey infiltration: sections of it sank in water. The middle lobe was in a state of red hepatisation and œdematous, and the upper lobe was congested. The left lung was free in the cavity; the whole of its lower lobes was in a state of red hepatisation except some small portions where grey infiltration had taken place. The lower posterior portion of the upper lobe was also in a state of red softening. The heart-valves were competent; externally the fatty tissue of the heart was œdematous; the lining membrane of the heart and of the aorta for two inches was thickened and tinged red. On opening the abdomen, the whole of the right side of the cavity from the outer edge of the rectus muscle was cut off from the rest by peritoneal adhesions. The anterior and inferior parts of the right lobe of the liver formed the upper boundary of this cavity. The peritoneal covering of the liver in those parts was thick and rough, as also the peritoneal covering of the right kidney. The peritoneum was not acutely inflamed in any part. The cavity contained foetid air, and was lined with a coating of fecal matter, most abundant near the cæcum. On pressing the bowel, air passed into this cavity. The stomach was normal, and the intestine was so to the cæcum. In the outer side of the first part of the cæcum there was an opening about half an inch in diameter (the cæcum was adherent to the parietal walls round this opening). There was a smaller opening in the posterior part of the ascending colon about two inches from the valve; it communicated with the cavity. In both places the openings looked as if they had been punched clean through the gut, and there was no surrounding ulceration or thickening; the rest of the ascending and transverse colon was normal. The liver in structure was found normal, except under the thickened peritoneum, where its substance was almost black in colour to the extent of almost half an inch, and near the portal vein where there was a small abscess. The spleen was normal; the kidneys were both slightly fatty; the uterus was normal.

REMARKS.—In this case there were no signs that called attention to the abdominal lesion. The bowels were not in any way unusually irregular; there was no peculiarity about the tongue; the pulse was always feeble; but the small quantity of food that the patient took, and her hardly having taken any for some time prior to admission, accounted for its state. The decubitus was on the side. She hardly ever spoke, and never showed any symptoms of pain in the abdomen. No doubt the state of her nervous centres may have prevented her from feeling pain,

as is commonly seen in cases of insanity. The conditions found at the *post mortem* examination—viz., 1. The thickening, adhesions, and exudations of the peritoneum, with the absence of acute inflammation; 2. The injured part being completely shut off from the rest of the abdominal contents by firm adhesions, and the perfectly healthy appearance of the peritoneum and intestines outside these adhesions; 3. The adhesions between the cæcum and parietal walls outside and round the ulcer in the cæcum, the absence of ulceration or thickening round this opening, or the one in the ascending colon—lead me to think that the ulcerations had existed for some time; that the opening in the ascending colon had been agglutinated to some adjacent structure in the same way as the opening in the cæcum; and that this adhesion from some cause had given way, and the fecal matter and flatus passing out had given rise to the abscess.

I was unable to get a history of this case; but I think it probable that the ulcers were the sequelæ of enteric fever, as ulcers in the caput cæcum and ascending colon are rare, except those caused by dysentery, tubercular deposit, or enteric fever. The appearance of the ulcers in this case was unlike those of the two former diseases; and the ulcers of the latter disease have been found to attempt to heal by agglutination, and to present healthy edges.

A PECULIAR CASE OF OVARIAN TUMOUR: OVARIOTOMY: DEATH.

By G. D. McREDDIE, Civil Surgeon, Hurdni, Oude.

THE patient, a Mussulman female about 35 years of age, a widow, who had had seven children, was admitted into the Government Charitable Dispensary at Hurdni on the 25th June, 1869, with ovarian dropsy. She stated that three years before she had felt her abdomen enlarging, but was unable to say whether or not the enlargement was at first lateral. At this time her menses stopped. On admission, she presented a greatly enlarged abdomen, as if far advanced in gestation. Her general health was very good. She was tapped on the 26th of June, and two gallons of a dark glutinous liquid were drawn off. After the tapping, a body simulating the liver by its narrow inferior edge, and to some extent by its position, if this organ were enlarged downwards, became perceptible. At the time the body was regarded either as an enlarged liver, or as the viscus retaining its usual size, but placed much below its natural site. The edge could be felt running in a curve in the right hypogastric and lumbar regions. I was inclined to the supposition that the body thus placed was the liver much enlarged; but against this the state of the general health seemed to argue. Against the supposition of displacement, there was the want of an adequate cause to account for the abnormal position. The impossibility of determining, with any precision, the superior boundaries of the body, added to the difficulty.

By the 20th August, the abdomen had regained its original size, its circumference being three feet five inches. As every circumstance seemed to warrant a favourable issue, and as it was useless to tap again, ovariectomy was determined on.

August 21st, 7.15 A.M.—Chloroform having been given, an incision was made from the umbilicus downwards, and was subsequently enlarged upwards also. The muscles having been divided, a dark mass suddenly started into the line of incision, and was cut into, though I used the knife cautiously in order to divide the peritoneum on a director, before coming on the ovarian tumour. Immediately on the occurrence of the accidental incision, a large quantity of liquid, of the same character as had been previously removed by tapping, spurted out, drenching the patient and running over the floor. The hand introduced into the cavity thus cut into and emptied, passed over a smooth surface; none of the viscera were perceptible. After some manipulation, the body previously regarded as the liver was felt; and, on examination, it proved to be the right ovary, greatly enlarged. It was eleven inches in diameter, with a thickness of two inches and a half in the centre. Its whole substance was hypertrophied; its cells were of the size of walnuts, containing glairy viscid matter. It was drawn out of the wound, and its attachment—upwards of two inches in diameter—had two ligatures put on, and then the mass was divided between the ligatures. No arteries were met with; but the ligatures slipped off, and the loose mass passed back through the wound. The intestines now came into view, through the opening made by the removal of the ovary. The walls of the sac were seen to be throughout adherent to the abdominal walls—hence nothing more could be done. The abdomen was sponged out; a few interrupted sutures were put in, skin-deep only, the deeper ones being deferred to a future time; lint soaked in carbolic acid solu-

tion was applied; and the patient was put into bed. The whole operation lasted half-an-hour. She did not rally after the operation. Spirits were given; the inhalation of ammonia was kept up for some hours; hot bottles were applied to the extremities. Vomiting occurred two or three times. Throughout the night of the 21st, she continued in a dangerous state. At 1 P.M. of the 22nd—twenty-nine hours after the operation—she died.

Post Mortem Examination.—The abdomen was laid open. No blood had been effused into the diseased sac. An examination of the walls of the sac showed that they were composed of peritoneum. That portion of the serous membrane constituting the broad ligament was greatly thickened and expanded. It appeared clear, on inspection, that the sac cut into was not a dilated ovarian cell, inasmuch as the membrane was attached circumferentially to the enlarged ovary. No peritoneum could be discovered on the abdominal walls. On separating the sac from its attachments, the muscles came into view; some blood was found effused between the walls of the sac and the muscles on the right side, caused by the stretching of the membrane in drawing out the ovary. The whole of the sac was greatly congested, being of a port-wine colour. All the viscera were pushed far back; the liver was discovered lying far against the posterior abdominal walls, and seemed atrophied from the pressure to which it had been subjected. All the other organs of the abdomen and those of the chest were natural. The uterus and left ovary were quite healthy. The great omentum was united to the superior and anterior aspect of the sac. The adhesions of the sac were strong anteriorly and inferiorly, but they were easily broken down posteriorly. It would have been impossible to remove it during life, without causing a dangerous amount of hæmorrhage and increasing the shock of the operation. Death was due to peritonitis and shock combined.

My idea of this extraordinary tumour is, that the sac was formed by the broad ligament of the right side becoming a detached sac—that is, as the ovary is situated in the posterior layer of the peritoneum of the broad ligament, it seemed to me that the anterior layer became firmly attached circumferentially to the ovary and formed a shut sac, which, as it increased in bulk by liquid poured into its cavity, kept on enlarging till it coalesced with the reflection of peritoneum which lines the abdominal walls anteriorly—and that these reflections, uniting, formed the anterior and lateral walls of the sac, while the posterior wall was formed by the broad ligament only.

It was impossible, during life, to diagnose a tumour of the unique character revealed by the operation. Everything pointed out the case as one promising a successful issue; but, unfortunately, events belied these expectations.

The whole tumour has been forwarded for preservation to the Medical College Museum of Calcutta.

OBSTETRIC MEMORANDA.

MISSED LABOUR.

By MAURICE G. EVANS, M.D., Narberth.

THE following case, unquestionably one of extrauterine foetation, may prove interesting, as analogous to one published in the BRITISH MEDICAL JOURNAL, 3rd March, 1866.

M. T., aged 33, married, became pregnant in July 1866. During the period of gestation she suffered much and continued pain in the right iliac region; still she enjoyed tolerable health. At the end of nine months she was supposed to be in labour for about twelve hours, when the labour-pains gradually diminished, and eventually ceased altogether, leaving her in a very weak and prostrated condition, her life being quite despaired of. But by great care and good nursing, after the expiration of many months she gradually recovered her health and strength, the abdominal tumour remaining about the same, which during the past two years has very sensibly diminished. I met her casually at one of my vaccination-stations, having accompanied a sister who wished to have my opinion of the case, when I learnt the foregoing particulars. She appears now to be in the best of health, strong and robust, the abdomen being about the size it was at the fifth month of pregnancy. On examination, a hard immovable tumour can be felt occupying the hypogastric and right iliac regions, slightly sensitive to the touch, the parietes of the abdomen gliding over it. I expressed an opinion that it was a case of extrauterine foetation, that the encysted remains of the foetus would gradually diminish, and that at so remote a period very little if any danger was to be apprehended unless she became again pregnant, a circumstance far from probable, considering her age and the time that has elapsed since the pregnancy in question.

HISTORICAL NOTES.

OUR esteemed associate, Dr. McIntyre, of Odiham, has sent us an extract from a work published in 1776, which gives instances in proof that the manipulation method of reducing dislocations of the femur was then practised. The work in question is the third volume of *Medical and Philosophical Commentaries*, published by a Society in Edinburgh. It would appear that the discoverer of this method was Mr. Thomas Anderson, of Leith. The following is Mr. Anderson's published narrative of his cases.

"TWO CASES OF DISLOCATION OF THE FEMUR, WITH AN ACCOUNT OF THE METHOD OF REDUCTION.

"By Mr. THOMAS ANDERSON, Surgeon in Leith (1776).

"CASE I.—In September 1772, Mr. Bruce, Surgeon at Musselburgh, sent to me, desiring I would meet him at Lord Abercorn's coal-work, one of the colliers having dislocated his left thigh-bone. I there found Messrs. Bruce and Stewart, surgeons in Musselburgh, and Messrs. Simpson and Clarkson, surgeons in Dalkeith, who had just begun to attempt the reduction by pullies. With these, several trials were made; but the lacque round the knee slipping, it was taken off. By this means I had an opportunity of examining it. I found the left knee protruding three or four inches further than the right, and the one could not be brought within eight or ten inches of the other, the foot being turned out. When it was moved upwards and downwards, if done gently, he found little pain; but I observed when it was nearly or altogether extended, the head of the bone became fixed; and he complained more, when it was in that situation, if any rotatory motion was attempted with the femur, which gave him no uneasiness when the thigh was brought up towards the abdomen. From the above appearance, it was certain the head of the bone was displaced from the acetabulum, and lodged downwards and inwards in the large foramen of the ischium and pubis. I was convinced that attempting the reduction, in the common method, with the thigh extended was improper, as the muscles were all put upon the stretch, the action of which is perhaps sufficient to overbalance any extension we can apply. But, by bringing the thigh to near a right angle with the trunk, by which the muscles would be greatly relaxed, I imagined that the reduction might more readily take place, and with much less extension. When I made this examination, he was lying on a table on his back. I raised the thigh to about a right angle with the trunk, and, with my right hand at the ham, laid hold of the thigh, and made what extension I could. From this trial, I found I could dislodge the head of the bone. And at the same time that I did this, with my left hand at the head and inside of the thigh, I pressed it towards the acetabulum, while my right hand gave the femur a little circular turn, so as to bring the rotula inwards to its natural situation; and, upon the second attempt, it went in with a snap, observable to the gentlemen standing round, but more so to the poor man, who instantly cried out he was well and free from pain. His knees could then be brought together; the legs were of the same length, and the foot in its natural situation. The knees were kept together for some time with a roller, to confine the motion of the thigh; and, in three weeks, he was at his work, without the least stiffness in the joint."

"CASE II.—A boy, eight years old, of a strong healthy constitution, while he happened to be carried on his sister's back, lost the hold he had of her neck, and fell to the left side. She, however, held him by the legs, which were round her waist, so as to occasion considerable stress to the parts. He was carried home, and complained of the left thigh and haunch, which he said was from a fall from his sister's back. The parents being poor, and imagining it to be only bruised, were eighteen days before they called any assistance. At this time, I found him lying in bed on his back, the fore part of the femur turned quite in; the knee lying on the right thigh was fully four inches shorter, the leg turned out, and considerable swelling and tension on the hip. From the appearance, I suspected a fracture at the neck of the bone; but, on examining it, was soon convinced of the dislocation, and that the head of the bone was lodged upwards and backwards from the acetabulum, in the concave part of the ilium where it joins the ischium. The smallest attempt to carry the thigh outwards from the position in which it lay gave him the most exquisite pain; and he could only allow it to be gently moved upwards, if, at the same time, the knee was kept over to the right side. From the motion made to discover its situation, he complained so much, that the reduction was not attempted at that time. The hip was fomented, rubbed with camphorated oil, and a poultice applied for that night. Next forenoon, I called on him with two young gentlemen; he was placed across the bed, the thigh raised so as to