a branch of the pulmonary artery into the aneurysm; probe B into the phthisical cavity into which the aneurysm had burst.

Post Mortem Examination.—In the apex of the left lung was a cavity of the size of a hen's egg; near the root of the same lung was an aneurysm of the size of a walnut, communicating with a branch of the pulmonary artery, the sixth division of that vessel; it contained blood. Its sac had a smooth interior, and its wall, which was a quarter of a line thick, was separable from the surrounding tissue. It projected into, and nearly filled, a phthisical cavity, into which it had ruptured, and which also contained blood. The mouth of the aneurysm, which was smooth, was a quarter of a line in diameter. Both lungs were studded with caseous masses of lobular pneumonia, most of which were encapsuled by condensed tissue; many had undergone softening, and in some the broken-down material had been removed and cavities left. The trachea and bronchial tubes contained blood. The heart, aorta, and abdominal viscera were sound.

REMARKS.—Pulmonary aneurysm occurs chiefly in chronic phthisis, arising from chronic catarrhal lobular pneumonia, or scrofulous pneumonia, where the lungs are the seat of cheesy masses. It is, I believe, most frequently found towards the root of the lung. Its mechanism of production is uncertain; it may be due to ulceration of the vessel, or, more probably, to loss of support of the vessel from softening, and removal of the caseous matter around it. In F.'s case, in the centre of each cheesy mass were seen by the naked eye an arteriole and a bronchiole; and, where the central part of these caseous masses had broken down and been removed, the vessels in the centre were seen to be unsupported. Blood had found its way into the trachea from the phthisical cavity, into which the aneurysm had burst, by means of a bronchial tube, which communicated between the cavity and the trachea. Hæmoptysis in such cases is usually sudden, profuse, and repeated at short intervals. It is a question whether, in the case recorded, the aneurysm was the source of blood in each attack of hæmoptysis. No other aneurysm, nor evidence of previous hæmorrhage, being found elsewhere in the lungs, it is reasonable to suppose that the bronchial tube, leading from the cavity into which the aneurysm had burst, had been temporarily plugged; and that the plug had been removed at each attack of hæmoptysis. Pulmonary aneurysm may occur at any age; it is a common cause of fatal hæmorrhage from the lungs. Dr. Reginald Thompson states, that of 383 deaths in the Brompton Hospital in three years, 26 were due to hæmoptysis, in 12 of which pulmonary aneurysm was the cause. I am indebted to Dr. Malet (house-physician) for notes of the above case.

M. GAUTHIER has given notice to the Academy of Medicine that he has discovered that concentrated human saliva contains venoms analogous to those found in the cadaveric alkaloids, and that he intends shortly to read a detailed paper on the subject.

ON TWO CASES OF RAPIDLY DEVELOPED UNILATERAL ATAXY.

By DAVID DRUMMOND, M.A., M.D.,

Physician to the Infirmary, and to the Hospital for Sick Children, Newcastle-on-Tyne.

IN the BRITISH MEDICAL JOURNAL of April 2nd, 1881 (page 508), appeared the record of four cases which I published as examples of posterior sclerosis unattended by ataxy of locomotion. Since that date, two other cases of the same description have been under my care—both in women advanced in life, and both presenting, in a marked way, every common symptom of disease of the posterior columns, with the exception of motor inco-ordination.

I now desire to call attention to two cases of ataxy of one side, due to brain-affection. The subject of one case is an adult male, and the other occurred in the person of a little girl aged three and a half years.

CASE I.—George H., a joiner, aged 32, was admitted into the Newcastle Infirmary for what was supposed to be an attack of left-sided hemiplegia. The history of the illness is as follows. Four days before admission into hospital, on the completion of his day's work, he went with some friends to a public-house, where he drank some beer (was not drunk), and played at dominos. He suddenly discovered, whilst playing the game, that he was unable to control the movements of the left hand and arm. His hand, in attempting to perform the moves, swept the tablets off the table. Immediately afterwards he felt sick, and went down stairs, when he vomited. He then returned to the room where his friends were (upstairs), and attempted once more to play; however, he found himself utterly unable to direct his arm and hand. He then got up to walk, intending to go home; but now his left leg failed him, it "jumped about"; in consequence, his companions assisted him to walk home, when it was observed that the left foot was raised at each step high above the ground. He never lost consciousness, and constantly reiterated the assertion, that he had "good power, but no guidance". On the night of the attack, it was noticed that his face was somewhat twisted, and that his speech was *thick*—"could not make my words plain" (anarthria).

My friend Dr. Angus, who saw the patient shortly after the seizure, was much struck with the condition of the limbs—viz., marked inco-ordination without any paralysis.

On admission into hospital, the condition was noted to be as follows. He was very emotional—the slightest allusion to his illness caused him to weep. He could stand, though with difficulty; was inclined to fall to the left side. This difficulty was not increased on closing the eyes. When he walked, which he did with a stick, the left foot was raised much higher than needful above the floor, and brought down forcibly on the heel; in fact, the gait was (so far as the left leg was concerned) characteristically ataxic. There was no loss of power in the leg; this was especially noticeable as the patient lay in his bed. The left arm was also ataxic, while there was no loss of power; he was unable to touch his nose (a prescribed portion of the face) with the forefinger of the left hand when the eyes were closed. Further, he was unable to button, or to perform other actions requiring delicately co-ordinated movements. The muscular sense was unimpaired—he could tell accurately the position of his affected limbs with his eyes closed. There was a complete absence of cutaneous sensory impairment. The knee-phenomenon was markedly exaggerated on the left side, though also increased on the right. The discs were normal. The facial paralysis had completely passed off. His speech was *thick*.

CASE II.—Jessie C., aged 3½, was admitted into the Children's Hospital for so-called weakness of the left arm and leg. Her mother observed, five weeks before her admission, that she could not feed herself with the left hand—"the hand was jerked about". On the following day, it was noticed that the left leg was "jerked upwards" in walking. The condition soon after became aggravated, so that the child was utterly unable to walk on account of the jerking.

When admitted, the ataxy of the limbs of the left side was at once remarked. The child walked across the floor with tolerable ease; at every step the left knee and leg were jerked upwards, and the foot then violently thrust to the ground again. There was some jerking tremor in performing this movement, in which the entire limb shared. The inco-ordination of the left arm was also very noticeable; the same jerking tremor affected it as well. When told to grasp an object held out to her, the child made several jerking attempts to seize it, but, when at length she succeeded, she held it with considerable vigour. She experienced no difficulty in standing in the ataxic position, having the eyes closed. There was no anæsthesia. The discs were normal. The knee-phenomenon on the left side was distinctly increased. There

was very little, if any, muscular paralysis. The irregular jerking movements were quite unlike the movements of chorea; and, though resembling somewhat the tremor of multiple cerebro-spinal sclerosis (an example of which affection I had quite recently under my care, in a child four years old), yet differed from it—inasmuch as, in the present case the tremor was most marked during the attempt to seize a proffered object, which was held tolerably steady when seized; and further, the jerking was more irregular and violent than the tremor of multiple sclerosis. The right side was perfectly normal.

The interest in these cases lies in the suddenly developed ataxy without paralysis—due, certainly in one (former) case, and probably in the other, to cerebral lesion. I do not think a lesion in the cerebellum would be likely to give rise to the phenomena I have described. The gait is against such a view, as well as the existence, in one case, of facial paralysis and anarthria.

I am rather inclined to the opinion that the corpus striatum (caudate nucleus) is in some way responsible, the internal capsule escaping. However, in the present state of our knowledge, it would be useless to attempt to localise the situation of the lesion, beyond a surmise that one of the basal ganglia is at fault.

CASE OF OVARIOTOMY, FOLLOWED BY ABSCESS OF ABDOMINAL WALL: RECOVERY.*

By WILLIAM HENDERSON, M.D.,
Surgeon to the Dispensary, Exeter.

IN January 1876, I was consulted at the Exeter Dispensary by Margaret Helms, suffering from an abdominal tumour, causing considerable pain. On inquiring into the case, I elicited the following history.

The patient, aged 42, unmarried, had been in moderately good health for several years. Thirteen years previously, she had a tumour, of the size of a nutmeg, removed from the left parotid region. She menstruated regularly until the middle of August 1875, when she suffered more pain than usual, the catamenia continuing longer than a week, stopping for a few days, and returning as freely as before. This occurred several times, requiring treatment for hæmorrhage. They then stopped gradually, but recurred every fortnight, until the beginning of November, when, instead of the hæmorrhage, she felt an excruciating pain in the lower part of the abdomen, which continued a whole day.

At this time, she noticed a slight swelling in the left iliac region. This gradually increased in size, and extended over the abdomen, accompanied by pain, which she described as "sometimes shooting, smarting, and stabbing"; stating that she had to "hold the painful part, or it would burst through her, and that it felt as if two surfaces were being compressed together".

About a week after this swelling was first noticed, the catamenia appeared, and continued for three or four days; they then stopped for a day or two, then reappeared in small quantity daily, while the pain remained unabated, extending to the right side of the abdomen, preventing her from lying on that side, and afterwards shooting upwards towards the stomach. I put the patient under treatment at her own home. Her appetite was deficient; bowels costive; cardiac sounds normal; pulse weak, 94 per minute; respiratory system normal; urine normal; uterus normal (but pushed on one side). The measurement round the abdomen on a level with the umbilicus was $38\frac{1}{2}$ inches; on percussion, dull in front, and tympanitic in the lumbar regions. Her general appearance was pale, thin, and worn.

On January 19th, the patient having been prepared for operation, and the temperature of the room raised to 65° , chloroform was administered. The sponges and instruments were dipped in carbolic water, but no spray was used. I began the operation by making an incision from the umbilicus downwards, about six inches; the peritoneum was opened, exposing the surface of the tumour. The hand, well greased with carbolic oil, was introduced all round the tumour, breaking down some slight adhesions, which were felt more in front and towards the left side.

A Spencer Wells's trocar was then plunged into the soft part of the tumour, and, as the contents of the cyst (which was multilocular) escaped, the walls were secured to the cannula, partly by the hooked clamps attached, and partly by a ligature. Traction was then made upon the whole mass, with the assistance of suitable forceps, and the tumour was lifted out. The pedicle was on the left side, and was about six inches wide, a thinner membranous portion being connected

with the broad ligament. This thinner portion was pierced by my finger, and torn through. The pedicle, thus limited in width, was secured by a clamp, and the mass cut away. The fluid drawn off (which was of a dark-brown colour) measured fourteen pints, three ounces. The solid part weighed four pounds two ounces. Particular care was taken not to allow any of the fluid to escape into the abdominal cavity.

Bleeding points were secured by fine carbolic catgut ligatures, which were cut off short; and the peritoneal surface of the abdomen and pelvis was sponged, to remove all blood and clots as far as possible, the sponges being cleaned frequently in carbolic water.

The wound was then brought together with silk sutures, well waxed, and the free surface of the pedicle outside the clamp touched with solution of perchloride of iron. Carbolic lint was applied, a pad of cotton-wool laid over the belly, secured by broad strips of plaster and a flannel bandage. After the operation, the patient complained of much pain, and smarting in front and lower part of belly, relieved at intervals by opium, with a little brandy, and a suppository. Milk and iced water was given occasionally, and her urine was drawn off every eight hours. At 10 P.M., the patient was quiet, and free from pain; she felt sick, but had no vomiting; pulse 100, weak; skin perspiring.

January 20th. Pulse 104; temperature 100° . She had slept a little. January 21st. Pulse 108. She slept at intervals towards the evening; complained of much abdominal pain, which was only partly relieved by an enema of assafœtida, and more so by one of opium. January 22nd. Pain returned about 6 A.M.; it was of a shooting and throbbing character, which she ascribed to flatus. Pulse 100; temperature 99° . She took a little champagne, as well as the milk and ice. The tongue was clean and moist. January 23rd. After drawing off urine, she felt severe pain in the lower part of the abdomen, as if cold water were running up the bowels. The feet and legs were chilly. This was relieved by hot applications, with turpentine and morphia, beef-tea and brandy being also given. Pulse 110, small, and weak. The dressings were changed, and silk sutures removed; but the clamp was left undisturbed. At 10 P.M., urine was passed naturally. She felt better, and free from pain. January 24th. Pulse 90; temperature normal. She took milk and beef-tea freely. January 25th. Pulse 100. She complained of pain at intervals from flatus; takes beef-tea, egg, and milk. January 26th. She had chicken and champagne. January 29th (eleventh day). The bowels were moved with castor-oil and an enema. The clamp, being loose, was removed; also two silk sutures which had been overlooked. The underlying skin was blackened by the iron. Carbolic lint was reapplied, and the bandage. January 30th. Temperature 100; pulse 120. The patient was low and prostrate, with a feeling of being bruised. She suffered from headache and abdominal pains. A morphia suppository was given, and a warm linseed poultice applied to the lower half of the belly. The mouth was in an aphthous state. January 31st. Temperature 100; pulse 98° . She slept better after a suppository; the mouth was cleaning.

The patient went on improving for a week, when, on the twentieth day, feverish symptoms again set in, together with pain, and throbbing in the right iliac region. Just over this part, a circumscribed dullness was felt, which was poulticed for a day or two. The part, on examination, had a doughy feeling—a feeling of obscure fluctuation—and one or two glands in the neighbourhood were harder than usual. On aspirating the swelling, a small quantity of broken-down and strumous-looking matter was withdrawn. In a few days, I observed a discharge of pus from a minute opening close to the line of incision, which had quite healed. Pus was daily discharged in this way, aided by pressure on the abdominal wall. Not satisfied with this mode of procedure (after consultation), I made a counter-opening in the abdominal wall, which drained the abscess effectually, and it rapidly healed. Convalescence was now uninterrupted, the patient being able to take outdoor exercise on April 15th. She has since continued in good health, has menstruated, and has recently married.

REMARKS.—The case is interesting as regards the peculiar pain which she suffered during the rapid development of the tumour—not much more than four months—indicating, I think, a certain amount of peritonitis. There was a moderate amount of hæmorrhage from the adhesions, more especially from the ruptured membranous portion of the pedicle attached to the broad ligament. The feverish symptoms may be in some degree attributed to the free use of carbolic acid, as is alleged to be the case by Mr. Lawson Tait. At the same time, I cannot help thinking that the carbolic acid had a salutary influence on the blood-clot, preventing any decomposition from taking place. I can only account for the occurrence of the subperitoneal abscess in the abdominal wall, by supposing some septic influence had been at work, irritating some of the lymphatic glands.

* Read at a meeting of the South-Western Branch.