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.*

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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.