sound. The uterine cervix was bent on itself behind the pubes, and the os was firm and closed, as in a primipara. On the left of the uterus, in Douglas's space, was a very soft swelling; it seemed to give the sensation of a thin cyst, containing a thin fluid, and was of the size of an orange. This I was inclined to regard as ovarian. I came to the conclusion that the patient was probably in the fourth month of pregnancy, and that the vaginal swelling would most likely prove to be ovarian.

On January 8th, 1882, Dr. Godfrey wrote that he now heard the uterine *souffle*, and that the foetal movements were distinct. The globular body in the vagina was unaltered, and the os was still small, and tilted up behind the pubes. Later on, Dr. Godfrey again informed me by letter that she was delivered on May 9th of a healthy child, under chloroform, with forceps, and that a large fluctuating tumour could be felt on the left side of the abdomen.

On June 10th, I was requested to meet Dr. Godfrey in consultation. The patient was suckling her child at the time of my visit, but in a few days she was obliged to discontinue it. The abdomen was greatly enlarged and pendulous. The swelling previously mentioned in the vagina had disappeared, and nothing abnormal here could be detected. Over the abdomen, from the umbilicus to the pubes, the percussion-note was dull; above this the note was tympanitic; turning on the right side of the abdomen elicited resonance on the left, and *vice versa*. I considered that there was a large flaccid non-adherent ovarian cyst, containing a thin fluid. The patient was rapidly losing flesh and strength, and looked very ill. Pain and pyrexia were considerable; but, as she had been only confined a month, and there were no symptoms demanding immediate interference, I advised that the operation should be postponed, and the patient carefully watched.

On July 5th, Dr. Godfrey informed me by letter that, since my visit, the pain and pyrexia had increased, and that he regarded her state as critical. He inquired whether the cyst could be tapped or removed, with a chance of success, whilst the temperature was continually at 102°. On visiting the patient at 6 P.M., I found her in great pain and unable to move, as peritonitis had been present for some days. I advised that we should keep the patient as quiet as possible, and under the influence of enough opium to subdue pain. I pointed out the necessity of waiting a little to see whether the temperature would fall before having recourse to ovariectomy; tapping, in my opinion, being out of the question. If, however, the patient should become worse, I recommended that the operation should not be delayed, even though the temperature should continue high. For the next few days, the temperature fluctuated between 99° and 102°, and the patient was obviously going from bad to worse.

On July 11th, Mr. Spencer Wells, with the assistance of Dr. Emmett of New York, Dr. Godfrey, Mr. Meredith, and myself, removed a large multilocular ovarian cyst. The cyst was very thin. Extensive adhesions to the abdominal wall and to the omentum were separated, after the cyst had been emptied of a large quantity of turbid flaky fluid, not at all foetid. The pedicle was secured by ligature, which was returned. The left ovary and uterus were healthy. On the third day after operation, Dr. Godfrey reported that the patient was going on well. Temperature 99°; pulse 94; pain diminishing.

Mr. Spencer Wells removed all the stitches on the ninth day. The wound had healed perfectly by first intention, and the patient went on recovering without interruption. The case is a very striking example of the subsidence of fever, as soon as the cause of the fever had been removed.

A CASE OF RHEUMATIC NODE.

By GEORGE MAHOMED, M.R.C.S., L.S.A.

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I AM led to record the following case, which I believe to be one of rheumatic node, because the existence of such a condition is still doubted by many.

In text-books of surgery, rheumatism is enumerated among the possible causes of nodes, and we are told, in the way of treatment, etc., that "If rheumatism or syphilis be suspected, the appropriate constitutional treatment must be adopted," but this is all the information on the subject that they usually afford.

Moreover, in an article in the *System of Surgery*, Mr. Holmes says: "It is extremely difficult to be certain of the existence of any specific affection of bone due to the rheumatic diathesis," and he records a statement to the same effect by Rokitsansky.

Doubtless, the paucity of our knowledge on this subject is due to the comparative unimportance of the local disturbances which would generally co-exist with more serious conditions. Its chronicity offers an additional explanation, as our attention is not drawn to it by the complaints of the patient.

This must be my excuse for not having noticed it earlier during a ten months' attendance on the present case, which is that of E. G., aged 54, unmarried.

When I was called to the case, she had been suffering from her first attack of subacute rheumatism for about four months. She was confined to her bed, the knees and wrists were crippled, and she was sweating continuously. She improved slowly under treatment, and after about three months was admitted into the hospital, that her knees, which had become contracted in the earlier part of her illness, might be straightened. This was effected by breaking down adhesions (outside the joint) under chloroform, and she went out with good movable joints, though the muscles had wasted from disuse, so that she was unable to stand upright without assistance.

Until her illness, she had led a very active life as sick nurse, though she had latterly begun to grow stout; but since she has been lying up she has developed fat very quickly, and, lately, my efforts have been mainly directed to counteract this, as I think her heart is becoming burdened. A short time since, while examining the fit of some knee-caps she had made for herself, I casually passed my hand down the tibia, and noticed that she shrank, and that the surface was uneven.

On closer examination, both tibiae appeared enlarged, and tender at the upper part; and, on moving the thumb and finger down the edges, she likened it to "scraping the bone with a knife." On the inner surface of the right tibia, about two inches above the ankle-joint, a vaguely defined, doughy swelling, tender to touch, especially at the lower part, and measuring about one inch by three quarters, was discovered. When I examined this she winced, and exclaimed, "Ah! that's where it always hurt." In answer to my questions, she said it was always more painful by night than by day; that she had no remembrance of any injury to the part, and that there certainly had been no pain there until after the first attack of rheumatism. I had no suspicion of syphilis, for, as I have said, she was unmarried, and, during ten months, I had observed no other symptom which would lead one to expect it. Notwithstanding, my next step was to put her on bichloride of mercury for ten days; but this did not diminish the pain, nor alter the character of the swelling in any way.

I am therefore led to look upon it as a true case of rheumatic node, and it appears to exhibit the characteristics which Mr. Holmes thinks would probably distinguish that variety; 1, the large extent of bone implicated; and, 2, the irregular outline (contrasting with the ovoid nodes of syphilis). Respecting the third feature, namely, the longer course they run before affecting the bone itself, this instance offers only negative evidence.

In the way of treatment—having tried with success the suggestion of Dr. Orton, in the *BRITISH MEDICAL JOURNAL* for January 7th, in reference to the use of salicylate of soda as an external application in rheumatism—I determined to employ it here, and ordered a lotion containing that salt in saturated solution, together with glycerine and a little oil of cajuput, the latter to ensure its being used, and to stimulate the cutaneous circulation so as to favour absorption. At the end of ten days I examined the swelling, and found it more fluid, and the patient thought it was less painful at night. She had experienced considerable burning pain in it after the last examination.

I have continued to watch the case for two or three weeks, but there has been no further change, and she now thinks it is as painful as ever at nights.

Whether its becoming fluid was due to the salt, or to the friction, or whether it only became apparent from the softening of the skin, I do not know, but I am not very sanguine of any considerable improvement.

I noticed another curious symptom in this case which, perhaps, it is worth while to mention. While examining the bones of the forearm, and thumbing down their edges, I experienced the sensation of deep crepitation, exactly similar to that presented by a fracture. I produced this several times, but was unable to explain it, as there was no history of injury at any time, and I thought I must have been deceived by the crepitus of extravasation into the synovial sheaths. But my patient gave me the clue, in exclaiming, "You are squeezing the bones together." I therefore concluded that this was due to the degeneration of the interosseous membrane from the effects of rheumatic inflammation, thus allowing the bones to fall together. I confirmed this observation at a subsequent visit, and found that, on holding the arm between the thumb and fingers, the bones could be considerably approximated, and the grating produced; the patient, during the proceeding, experiencing sensations the reverse of pleasant. She said that when she tried to turn her sewing machine, the bones rubbed over one another in a similar way. I may mention that the upper part of the shafts of these bones were over sensitive, as in the tibiae, and there was a painful spot near the styloid process of the right ulna.