the parietal peritoneum and omentum. A broad vascular pedicle was then discovered, connecting it to the mesentery of a portion of small intestine; this was transfixed and ligatured in two portions. Several smaller adhesions to the intestines, and a broad membranous one to the left broad ligament, were separated, and the left ovary and tube were then found to be adherent to a fringe of solid growths along the lower border of the cyst. I therefore transfixed the left broad ligament, and removed the ovary and tube along with the tumour. This led to its being included among my ovariectomies, where it will be found as Case 33.

The solid portions of the tumour were very vascular, and arranged in fringes along its borders, their edges tapering like the margins of the liver. The solid part weighed 6 lbs. 4 oz., and there were 19 pints of serum like that removed at the tapping. Unfortunately, some portions removed and preserved for microscopic examination were lost, but I have no doubt that it was a cysto-sarcoma, as the solid portions contained numerous small cysts.

The patient did remarkably well for the first week, and the wound healed by first intention throughout. After the removal of a large mass of cotton-wool, which filled up the hollow over the stomach, she became sick, and, on the eighth day, she brought up two pints of purplish-black fluid.

On the ninth day, I could grasp a much-dilated stomach through the parietes, and, shaking it, could hear the gurgle of much fluid mixed with air. I applied the stomach-pump, and removed a pint of grass-green fluid and much gas; then thoroughly washed out the stomach with warm carbolic water, and applied a firm padding of cotton-wool under straps. The fluid removed contained sarcinae in abundance, torulae, and bacteria, and striped muscle-fibre (remains of food), all dyed a deep emerald-green. Sulphite of soda was given in twenty-grain doses every three hours.

Enormous quantities of this green fluid were vomited on the tenth day, and the patient was so exhausted that I gave up hope. Diarrhoea was also troublesome. During the night, she took brandy and egg freely, and next morning the temperature had dropped from 101.6° to 99.0°, and the pulse from 152 to 96. During forty-eight hours, she took by the mouth twenty-four ounces of brandy, and twelve ounces of brandy and egg mixture; and had sixteen ounces of port wine in beef-tea enemata. The greater part of the brandy was given between 11 P.M. on the night of the tenth day, and 10 A.M. on the morning of the eleventh day. It was given by the nurse, after I had practically given up all hope of saving the patient, and I have not the smallest doubt that she owed her life to this free and constant stimulation. The change in her condition in the morning astounded me. The bowels remained rather loose for twenty-four hours, and then she rapidly improved, and left the hospital strong and well on the twenty-first day after operation.

It is worthy of remark that, during the discharge of this large quantity of fluid from the stomach, the emaciation was so rapid, that it seemed almost as if one could see the wasting. Certainly the difference was marked between the visits, which I paid for some time every two hours. More than five years have passed, and she remains in good health.

I have twice, in the course of ovariectomy, removed cysts from the omentum, and a brief note of them here may be of interest.

The first was a small multilocular cystic tumour, of the size of a black Kentish cherry, which I found attached by a small pedicle in the lower border of the omentum, in the case of M. S., aged 41, mother of one child. (Case 29 in Ovariectomy Tables.) There were ruptured papillomatous tumours of both ovaries, with extensive papilloma of the pelvic *culs-de-sac* and other peritoneal surfaces. This little omental growth contained several cysts, much of a size, all lined with epithelium, like that commonly found in ovarian cysts; in fact, it was a perfect multilocular ovarian tumour in miniature, and, I have no doubt, owed its origin to cell-infection. It is worthy of remark that, as in some other cases of papilloma which I have recorded, the patient made a good recovery, and remains in good health, five years after the operation, all trace of the peritoneal papilloma having disappeared.

The second was a tumour of the size of a small cocoa-nut, with a very thick whitish fleshy wall, and a small central cavity, which had a puckered lining membrane, and contained three or four ounces of thick yellowish fluid. The tumour was attached to the omentum by a thick vascular pedicle, and lay high up in the abdomen, under the right border of the liver, so that I nearly overlooked it.

The operation was my 236th ovariectomy. The patient, a married woman of 47, with grown-up children, sent to me from Malaga by Dr. Clarence Visick. She was very emaciated, and had an unpleasant cachectic look, and had already had a sarcomatous polypus scraped out of the uterine cavity by Dr. Visick.

I enucleated a large cysto-sarcoma of the left ovary, separating unusually extensive mesenteric and intestinal adhesions, also a large lobulated solid brain-like sarcoma from the head of the caecum; the pedicle of this was so little vascular that it required no ligatures, merely a light touch over with Paquelin's cautery.

I left behind a very large fibroid uterus, and somewhat suspicious-looking right ovary, and was glad to get the patient safely off the table. Thanks to Mr. Meredith's kind care (I was taken ill a few days after the operation), she made a good recovery, and left the hospital on the twenty-fourth day after operation. In September of this year, Dr. Visick, writing about another case he sent over to me, says: "I have just seen Mrs. A. Hers is a most wonderful case. Her health at present seems perfect, and she looks very much younger, and has no kind of suffering." Mr. Doran was kind enough to examine the tumour for me, and found that the solid portions were mixed sarcoma.

One other case may be added here, which might well have been mistaken for a real omental tumour. On April 2nd, 1881, I operated upon Mrs. H., aged 33, and found a dermoid cystic tumour, with a pedicle attaching it to the right side of the omentum, and a band connecting it with the right ovary, which also contained a dermoid cyst. After removing the tumour and the cystic right ovary, I found on the left side a twisted stump where the ovary should have been, and a blocked and twisted Fallopian tube, which I removed. Evidently, the dermoid tumour attached to the omentum in the right side of the abdomen was the left ovary twisted entirely off, and receiving its nourishment from the omentum. This reading of the case was supported by notes taken many years before I operated, I first saw her in 1874, and at that time she had had two children, and both were dead. She had then a small tumour on the left side, but, as it was giving no trouble, I did not interfere with it. In 1874, 1876, and 1878, she bore children without trouble, the tumour remaining quiescent. In 1880, she came to me again, in the third month of another pregnancy, complaining of a severe attack of pain in the left side; this occurred at the time for menstruation each month, except the sixth, till she was confined; it was each time accompanied by some feverishness. She got well through her labour; but finding, when she was about again, that the tumour was larger and more painful, she came to me again, and I advised its removal. When I came to examine her, I found that it was now in the right side of the abdomen, and could not be drawn over to the left. It is obvious how easily this case might have been recorded as one of tumour of the omentum. The cystic tube might easily have been mistaken for an ovary by an inexperienced operator, and the case would have been far more puzzling had I not been able to refer to my old notes.

The first two of these omental tumours, I should say, were both due to cell-infection. In sponging out a peritoneum infected with ovarian papilloma, one is frequently struck with the way in which little growths occur in depressions and places where cells are likely to rest for some time undisturbed.

OBSERVATIONS ON SIX HUNDRED CASES OF DIABETES TREATED AT NEUENAHN.*

By RICHARD SCHMITZ, M.D., Neuenahr.

SIX hundred patients have been under treatment; of these, 420 were Germans, and 180 foreigners; 5 were under 10 years old, 25 between 10 and 20 years, 56 between 20 and 30, 104 between 30 and 40, 134 between 40 and 50, 196 between 50 and 60, 60 between 60 and 70, and 20 between 70 and 80 years of age: 248 of the patients came of families in which diabetes had already appeared; 51 came of families in which some serious psychosis had manifested itself, and 45 more had relatives who were remarkable for eccentricity or irritability, and 42 came of families which were markedly tuberculous; 93 of the cases were Jews, and of these 48 had diabetic relatives, 18 had relatives with psychoses, and 9 tuberculous relatives. In 8 cases, both husband and wife were at the same time suffering from diabetes. In 183 cases, the immediate exciting cause of the disease appeared to be some acute disturbance of the nervous centres, and only in 18 was there any essential disease of the nervous system; in 153 cases, the diabetes was attributable to an excessive indulgence in sugar and saccharine food. In 45 cases it was attributable to gout, and, in several instances, alternated with a gouty attack. It was in these cases that alkaline waters and salicylate of soda were most useful; in 22 cases, diabetes seemed to be the result of the exhaustion consequent on some severe and long continued disease. The specific gravity of the urine varied from 1025

* Abstract of a paper communicated to the Medical Society of London.

to 1035; the highest was 1042, the lowest was 1013, and in this latter 1 to 5 per cent. of sugar was found. The average daily amount of the urine was 2,500 c. c. to 3,500 c. c.; in only one case was it 9,000 c. c.; in 14 cases it was as low as 500 c. c. to 800 c. c., in spite of taking 1,600 grains of the sprudel water; but wherever the quantity of urine was small the perspiration was great, and where perspiration became copious the sugar decreased, which may explain the beneficial action of pilocarpin and of Turkish baths. Generally the day urine contained most sugar, exercise diminished it, while mental exertion and nervous excitement and pain increased it. The sugar varied from one to three per cent.; in only one case was it as high as eight per cent. When albumen was present, as not unfrequently happened, it seemed to be in inverse relation to the sugar. After the disappearance of the sugar, a material increase of phosphates, and, in some, of oxalates, was noticed; in four cases, hippuric acid was present. In two cases, sugar was simulated by a form of uric acid when the copper test was used; the fallacy was rectified by the polariscope. When the skin was dry, there were considerable polyuria and much emaciation; if there was a fair amount of sensible skin-action, the emaciation was not marked; 35 cases were very fat, and other 46 had lost little of their former corpulency. The muscular weakness is the consequence, mainly, of degeneration of structure, which affects not only the voluntary muscle, producing the unsteady gait and the easy fatigue, but affects the cardiac muscles, producing the small pulse, the feeble heart contraction, the syncope attacks, and the death by asthenia; the intestinal muscles producing the constipation, and the ciliary muscles producing the errors of accommodation. The cardiac weakness accounts probably for some of the cases of death, with accompaniment of coma or convulsions, which have been attributed to acetonaemia. Of the condition called acetonaemia, there were six cases. That it is caused by the absorption of some noxious product of fermentation in the bowels is certain, but whether this is always acetone is doubtful. The case was relieved as soon as a free evacuation of the dark coloured, very foetid contents of the bowels was secured by castor-oil. If this could not be accomplished, the patient died.

Two forms of hunger are to be noticed: one, the normal hunger produced by the need to replenish the great waste of tissue; the other, a form of bulimia, a ravenous desire for any kind almost of food, which I consider a neurosis. In this connection is to be noticed the frequent insatiable desire for sugar, similar to the alcoholic craving of the drunkard. Thirst is to be looked on as the result of the drain of water, rather than as the result of the passage of sugar. A foetid odour of the breath is proportionate to the amount of sugar passed. Looseness and falling out of the teeth is often an early sign of diabetes. Gastric disorders are rare, in spite of the food being difficult of digestion; but intestinal troubles are frequent, notably constipation, and sometimes diarrhoea. Constipation appears to me to depend less on the nature of the prescribed food, than on the weakness of the degenerate and enfeebled muscular coat of the intestines. When diarrhoea occurs, there is evidence in the grey foetid motions, which are quickly covered with a thick froth of fermentation of sugar, unnaturally present in the bowels; of which the urine, at this time, is found to contain very much less than just before the attack of diarrhoea. Neuroses of various kinds, such as a form of hunger, already referred to, are not uncommon; they are chiefly neuroses of sensibility; of motor neuroses, cramp was the only one noticed. Crural neuralgia was not uncommon; sciatic and lumbar neuralgia less frequent; some cases of cervico-occipital neuralgia were noticed, and one of mastodynia in a man of seventy-five years. For their relief, codeia and salicylate of soda were most useful. The vulvar pruritus common in female diabetics is probably largely neurotic; it is greatly relieved by lotions of salicylic acid. Apathy is probably produced by the direct influence of the sugar-holding fluids on the brain.

Tuberculosis became developed in the course of diabetes in twenty-six cases only. Impotence was frequently present, but, in twelve cases, sexual desire and capacity was increased. Balanitis was occasionally observed, and was relieved or cured by strict cleanliness and salicylic acid lotions. Dimness of sight was frequent, partly produced by accommodation disturbances, and partly by turbidity of the lens, which disappeared with an improvement in the diabetes, except in three cases, where there was cataract, which was successfully extracted in all. Boils were common, produced by nutritive disturbances of the skin, as also erysipelas and phlegmon. The prognosis should not be so discouraging as has hitherto been the custom.

A CENTENARIAN.—A female inmate of the Hampstead Workhouse Infirmary, named Martha Grey, is reported to have died at the age of one hundred years. The cause of death is certified by Mr. A. H. Cook, medical officer of the infirmary, as "senile decay."

REMARKS ON THE TREATMENT OF RECENT WOUNDS.*

By RODERICK MACLAREN, M.D.,
Senior Surgeon to the Cumberland Infirmary.

THE treatment of recent wounds is a matter in which we all have experience. Within the limits of our Branch, we see them not only among a healthy, vigorous agricultural population, but also in town populations with constitutions deteriorated by overcrowding, underfeeding, and the various vices which abound in the lowest strata of the people. As to surroundings, we meet with wounds where we have all that money, mode of life, and skilled nursing can do to promote a successful termination. We have them in hospitals, where the nursing, feeding, and appliances are very much what we think the best for the class of cases; and, on the other hand, wounds have to be treated where every favourable condition is absent, where there is no nursing, where the hygienic conditions are of the worst possible kind, and where the feeding is imperfect. It has, therefore, seemed to me that an interchange of views and experience among us would be specially valuable. In the few remarks I am going to make, I cannot tell you anything new, but merely give you my opinions and experience on certain points more or less familiar to you all. Nor can I pretend to make an exhaustive statement of so extensive a subject; I shall content myself with laying down certain broad propositions, which, in my opinion, embrace the great majority of cases.

In the first place, I may express my conviction that no one method of treating wounds is likely to give the best attainable results under all circumstances and with every variety; and, when a man sets forth that one treatment best promotes the healing of every such injury, I think that he is either generalising on imperfect observation, or allowing enthusiasm to warp his judgment. I purpose considering wounds under their ordinary divisions of incised, contused, and punctured.

First, as to incised wounds: for wounds of small or medium size, not involving bones, cavities, or the sheaths of tendons, I have seen the best results from the most absolutely simple treatment. 1. The first thing is careful cleansing of the wound, and removal of any foreign substances, if such be present. For this purpose, I prefer carbolic lotion (1 to 20); boracic lotion (saturated); or even simple dry rag or other convenient material. I am convinced that the water in common use is often a medium which brings deleterious matter into contact with a wound, and, for that reason, to be avoided. 2. Next to this follows suppression of hæmorrhage; and the more thoroughly this is done, the better is the chance of primary union; indeed, the ability to completely control it is one of the limits to this simple treatment. Ligature of vessels with catgut, and torsion, are the simplest means at our command. Sometimes, specially if a wound be over bone, a pad of absorbent cotton-wool, applied for twenty-four hours, will stop oozing. 3. The next stage is the bringing of the sides of the wound into complete contact. For this purpose, I am in the habit of employing one of two methods—suture or pressure. The sutures I prefer are silver wire, hair, or common sewing-needles. I believe it to be an advantage to use very fine sutures; and, for small wounds, hair answers most admirably; it is very strong, unirritating, and easily procured. A very excellent way of closing scalp-wounds is to push a sewing-needle through the two edges, and bring them together with a thread in figure-of-eight. In using sutures of all kinds, it is of great consequence to pass them through the tissues beyond the wound, whenever this can be done. Thus, with hare-lip, after paring, I pass needles right through the whole thickness of the lip and mucous membrane, keeping them (the needles) entirely from contact with the wound. I have sometimes seen suppuration commence at a suture, and spread from it, breaking up a wound which was promising to heal well. This risk can be avoided by keeping the suture away from the cut surface. Occasionally, a wound is so placed that a pad will close it throughout. Absorbent cotton-wool is the nicest material for this purpose. If it come near the edges, it is an advantage to have it impregnated with an antiseptic. When a wound of the class I am speaking of is efficiently closed, and all hæmorrhage has stopped, I look on any dressing not only as superfluous, but generally as injurious. Simple exposure to the air, keeping the wound dry, cool, and, above all, at rest, are all that is needed. We all know that heat and moisture promote putrefaction; and they should, therefore, be avoided. Sticking plaster is, of all known ways of keeping a wound together, the worst, almost invariably producing suppuration of the parts with which it is in contact. The only departure from the above way of treating moderate-sized flesh-wounds is where the surroundings are unhealthy, and especially in hospital, where the presence of suppurating surfaces and various ailments causes special

* Introduction to a discussion at a meeting of the Border Counties Branch.