in the median line below the umbilicus, and divided the peritoneum to the extent of three inches. A free cyst was tapped, emptied, and drawn out with a solid mass at the base. There was a long pedicle, and I was able to pass a silk ligature and tie the pedicle in two portions without including the Fallopian tube. I cut the ends of the silk close to the knots, leaving very little tissue beyond the ligatures on cutting away the tumour. The tied pedicle and the knots of the ligature were allowed to fall back into the pelvis. On examining the uterus and other ovary with one finger, I was doubtful which ovary I had removed, though I believed it was the left. The uterus did not feel as large as a walnut, and I could not feel an ovary, nor the ligature I had just applied. The wound was closed by silk sutures passed in the mode I usually practise in ovariectomy. During the passage of the sutures, there was more difficulty than usual in preventing escape of intestines and omentum, but there was no other peculiarity in the operation. A little ascitic fluid came away after the cyst.

The solid portion of the tumour weighed three ounces, and the cyst contained twenty ounces of fluid. In the solid portion, there was a mass of bone covered with true skin, from which grew a quantity of long light hair. The hair was rolled into balls and matted together by sebaceous matter. The skin covering the bone was perfect, and lay on a bed of adipose and areolar tissue. The bone was proved on section to be true bone, not a mere calcareous degeneration. A full description of this cyst was given by Mr. Thornton when it was shown at the Pathological Society; and the specimen will be preserved in the museum of the Royal College of Surgeons.

During the first and second days after operation, the little patient had some pain, and was rather feverish. After the third day, recovery was uninterrupted, and she sailed from Liverpool for New York on the 21st of February, twenty-five days after ovariectomy.

After the operation, I received a letter from San Francisco from Dr. Lane, in which he said—"In October, 1873, I was called in by Dr. Regensberger. There was a large abdominal tumour lying behind and beneath the umbilicus, and of such dimensions as to cause considerable anterior protrusion of the abdomen. Our diagnosis was an intra-abdominal tumour of the cysto-sarcomatous type, in which the cystic element greatly predominated. The solid portion, susceptible to palpation, lay to the left of the median line near the umbilicus. By relaxing the abdominal wall, the growth could be moved in all directions. One month later, I again saw the child, and was convinced that the tumour was rapidly enlarging, whereupon both Dr. Regensberger and I strongly advised the parents to consult you."

I was unable to ascertain with anything like accuracy when the tumour was first observed.

I shall be obliged to any member of the Association who can furnish me with references to other cases of ovariectomy in young children.

ICHTHYOSIS LINGUÆ FOLLOWED BY EPITHELIOMA LINGUÆ.

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SINCE the publication of my paper on this subject in the *BRITISH MEDICAL JOURNAL* of February 21st, 1874, I have had the good fortune to listen to Mr. Fairlie Clarke's communication to the Royal Medical and Chirurgical Society, of "Cases of (so-called) Ichthyosis Linguae".

The briskness of the discussion which followed amongst the Fellows of the Society left no time for visitors to take part in it; Mr. Clarke and I differ, however, upon a few points, as to which I should have liked to say a few words.

He considers the essential nature of the disease to be a chronic inflammation accompanied by an overgrowth of the papillæ. But when the disease reaches the stage of epithelial cancer (which, sooner or later, he tells us it always does), the rete mucosum "increases enormously at the expense of the papillæ, reducing them in many places to mere threads, and dipping down between them in the form of large club-shaped processes." It would thus seem that, as the ichthyosis advances, the hypertrophied papillæ, which are its leading feature according to Mr. Clarke, must necessarily pass back to their normal size as they gradually dwindle down into a state of atrophy. The inference then is, that there is a stage in the progress of the disease when part of its essential nature—viz., an overgrowth of the papillæ—no longer exists; or, in other words, that as the disease is growing worse and worse, it gradually recovers.

The importance attached by Mr. Clarke to the hypertrophy of the papillæ, leads him to suggest the name "papilloma" as more appropriate than "ichthyosis"; and to regard this affection in its earlier stages as allied to warts, corns, and the "papillary tumour of the gums" described by Mr. Salter. He says, however, that it is distinguished from these affections in two ways; 1, so-called ichthyosis linguæ attacks only the tongue and the inside of the mouth, but no other mucous membrane; 2, it slowly spreads, but gives only slight inconvenience, and no pain. But neither of these are real distinctions between ichthyosis linguæ and the "papillary tumour of the gums", for surely this latter is a disease of the mucous membrane of the inside of the mouth, and no other mucous membrane is, I imagine, subject to it; while, as regards the second so-called distinction, Mr. Salter tells us that his case of "papillary tumour of the gum" was painless and continued to spread, and in Sir William Fergusson's case there is no mention of pain, and the growth increased and recurred frequently. In spite of some similarity in the microscopical characters of the growths in these two cases on the one hand, and of ichthyosis linguæ on the other, there is this great difference; the growths were actual tumours, with shaggy villous surfaces, and they occurred in a situation where, normally, there are numbers of papillæ: whereas ichthyosis of the tongue and oral mucous membrane has not the appearance of a tumour, but is a mere thickening of normal tissues, chiefly of the epithelium, extending over a large superficial area; and it may appear on a cicatricial surface where no papillæ exist, as, in Case I, I reported. For these reasons, the term papilloma does not seem to me a suitable one. The papillæ, in many cases of ichthyosis linguæ, do certainly become hypertrophied, owing to the immense increase in their epithelial sheaths; and there is, too, sometimes a great hypertrophy of the subepithelial fibrous layer of the mucous membrane, as Dr. Goodhart's admirable drawing shows. In both these particulars, we have a resemblance to what is often found in ichthyosis of the skin.

I cannot agree with Mr. Clarke in regarding this change in the mucous membrane of the mouth as one due to chronic inflammation excited by irritation. For reasons I have elsewhere stated, the source of irritation ought to be very well defined before a change in the tongue is attributed to it. The irritation arising from inveterate smoking counts for little, when we find that ichthyosis linguæ occurs in those who have never been great smokers, and when we remember that hundreds of smokers of short pipes, and short cigars, too, take in "very hot smoke", but do not suffer from this disease. It unquestionably occurs in persons whose tongues have never been exposed to any excessive or unusual irritation, whether from smoking, tongue-scraping, glass-blowing, or otherwise; while the case quoted by Mr. Clarke, in which disease of the ear preceded ichthyosis linguæ, affords no more support to the theory of inflammation from irritation than it does to that of altered nutrition simply. I do not know if Mr. Clarke has been able to prove that persons with ichthyosis linguæ have a strong inborn tendency to the development of warty growths; nor do I see how treatment directed to the digestive organs can benefit (as it seems to do ichthyosis linguæ) a condition due solely to irritation in a person with or without such a tendency. It is admitted that ichthyosis linguæ never gets well under treatment; but, being of the character and kind it is, ought it not, if produced by irritation, to disappear soon after the removal of the irritation? Should we not expect the dogma of the schoolmen—"Sublatâ causâ, tollitur effectus"—often enough erroneous, to be, at least in this case, verified?

As regards operative treatment, the wisdom of excising the affected tissues depends upon the degree and extent to which they are involved. When the disease is localised, and of a severe form, excision seems advisable, whether the patient is seen in the early or middle stage. If it be widely diffused over the surface of the tongue or buccal mucous membrane, would it be well, at any stage, to attempt to cut away the whole? I think not. When epithelioma has supervened, the surgeon must be guided in his treatment of the twofold affection, as he is in the treatment of epithelioma alone.

My own cases support Mr. Clarke's conclusions; (1) That ichthyosis linguæ is more common in males, (2) is a disease of manhood, (3) is not necessarily or constantly connected with syphilis, (4) runs on in time to epithelioma.

Some of the cases mentioned by those who took part in the discussion prove an association in the same person, and also in persons of the same family, of ichthyosis linguæ and ichthyosis of the skin; so that, clinically as well as anatomically, the name given by Mr. Hulke ten years ago is shown to be well chosen. The objection that ichthyosis of the skin is a congenital malformation is not a strong one. Though often congenital, it often does not attain its greatest development till towards puberty, and it is stated on authority to appear occasionally late in life.