College of Surgeons several specimens which admirably illustrate the relation to Gimbernat's ligament of the neck of a femoral sac. The accompanying drawings (Figs. 5 and 6) of one of these specimens show clearly that while Gimbernat's ligament lies opposite to the constricted neck of the sac, it is not the direct cause of the constriction. The neck is obviously smaller than the canal in which it lies, and the narrow constricting band completely encircles the neck, although it is best developed on the side of Gimbernat's ligament. The manner in which this constricting band protects the femoral vein from pressure is clearly shown.

I recently operated on a case in which the neck of the sac was constricted in an entirely different manner, and in which the cause of the constriction produced symptoms of a very unusual nature.

A man of 45 was sent into my wards with a diagnosis of renal colic. At long intervals he had had attacks of pain spreading from the right iliac fossa into the groin and accompanied by frequency and scalding on micturition. These attacks had increased in frequency and severity and were accompanied by the appearance of a swelling in the right groin. On examination he was found to have a small right femoral hernia, and the diagnosis was made of a femoral hernia containing a portion of the bladder wall. On exploring, however, no sign of the bladder could be found, but passing round the neck of the sac posteriorly was a dense round cord. Further examination showed that this was an obliterated hypogastric artery, with an abnormal origin from the external iliac. Traction on this cord drew down a part of the bladder wall and no doubt accounted for his symptoms, which have entirely disappeared since the operation, when the cord was divided and a radical cure of the hernia performed.

If in this case the hernia had been strangulated it is highly probable that the bladder would have been pulled down, and in such an event the division of Gimbernat's ligament as usually advised would involve a very real danger of injury to the bladder. It should be remembered that protrusions of the bladder are by no means uncommon complications of femoral hernia.

Conclusions.

I venture to think that the points to which I have referred are of practical importance in the diagnosis and treatment of a femoral hernia. They may be briefly summarized as follows:

1. In most cases the presence of a femoral hernia is characterized by the appearance of a soft, spherical swelling in the angle between Poupart's ligament and the tendon of the adductor longus.
2. The pubic spine is not so satisfactory as Poupart's ligament itself as a boundary between inguinal and femoral hernias.
3. Gimbernat's ligament is not directly concerned in the strangulation of a femoral hernia, and its division serves no useful purpose, and may be dangerous.

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EPITHELIOMA OF THE SKIN AFTER PROLONGED EXPOSURE TO CREOSOTE.

(With Special Plate.)

BY

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THE following case is an example of occupational cancer. It is an instance of epithelioma of the skin of the right hand in a worker exposed for many years to creosote. It will be noted that he had also a few warty growths on the left arm, one of which presented evidence pointing to possible early malignant changes.

The patient, who was 66 years of age at the time of his death, had worked for thirty-three years in a creosote factory; his work was to carry wood after creosoting, and he stated that he was "up to the eyes in creosote." A good many years ago (certainly fifteen

a small swelling (?) appeared at the back of his right hand, "like a corn." Every now and then it cracked open and healed up again. Eight years ago the growth had increased to the size of a two-shilling piece; subsequently it gradually spread until just before operation it was a large fungating ulcer covering the dorsum of the hand (see special plate).

A portion of the edge of the ulcer, removed and examined histologically previous to amputation, proved to be a squamous epithelioma.

A circular amputation above the elbow was performed by Mr. S. Raw, surgeon to Sunderland Royal Infirmary, to whom, and to Dr. Gilbertson of Sunderland, I am indebted for the clinical history. Seven or eight weeks later the patient died suddenly and a *post-mortem* examination was made.

Post-mortem Examination.

There were a few small warts on the left forearm. Beyond changes common to his age, the organs were healthy, save that there were small secondary epitheliomatous deposits in both lungs, in the liver, and in both kidneys. There were also two secondary deposits in the heart walls—one the size of a walnut in the left ventricular wall, involving its whole thickness and beginning to break down in the interior, and the other, the size of a pea, at the right border of the right ventricle.

The case is put on record because it appears fairly certain that creosote was the cause of the malignant growth and subsequent death of the worker. It will be noted that the internal organs showed numerous secondary deposits of cancer. The large deposit involving the wall of the heart projected into its interior. The glands in the right armpit were enlarged and invaded by malignant disease. The amputation wound was in excellent condition.

REINFLATIONS IN ARTIFICIAL PNEUMOTHORAX TREATMENT.*

BY

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THE importance of rest in the treatment of active tuberculosis is well recognized. Rest of the body and of the diseased part, followed by training of the body and rest of the diseased part until the lesion has healed, is now a common method of treatment. In pulmonary tuberculosis the lung can best be rested by artificial pneumothorax. When a lung is collapsed no special skill is required to put a needle into the pneumothorax cavity and inject gas. But it is only by experience that the amount of gas, and when it should be given, can be judged. A common mistake is to give a definite quantity of gas at definite intervals. Not only does the rate of absorption vary considerably in different individuals, but the optimum degree of collapse also varies. Moreover, the same patient may require more or less gas at refills as the treatment proceeds.

When starting pneumothorax treatment I give small frequent refills until the lung is well collapsed. I like to get a good collapse after about a fortnight and some five or six refills. I then find the degree of collapse which is best for the individual patient. Some require full collapse and others do much better when the collapse is less complete. We have next to discover how long the optimum degree of collapse will last without a refill; this is best done by means of *x* rays. If the patient does not do so well when the intrapleural pressure is higher than -2 cm. water, any further collapse of lung causing such symptoms as dyspnoea and loss of weight, it can be seen by *x* rays how much collapse of lung there is at this pressure, and by frequent screening when the lung begins to re-expand. If it is seven days the refills should be given weekly; if four days, then two refills a week are required. If, when the refill is due, the intrapleural pressure is -12 cm. water, then we know that the optimum pressures are between -2 and -12 cm., and the correct quantity of gas to give is that which will raise the pressure from -12 to -2 cm. By this means the lung is kept completely at rest; it is not collapsed beyond the optimum degree and the intrapleural pressure is never allowed to reach that stage at which re-expansion occurs. As time goes on it is usually found that the gas is absorbed less quickly and so longer intervals can be allowed between the refills. The object is always to keep the lung at rest. Sometimes

* On behalf of the Medical Research Council.

H. A. COOKSON: EPITHELIOMA OF THE SKIN AFTER PROLONGED EXPOSURE TO CREOSOTE.

FIG. 1.—Epithelioma of right hand of creosote worker.

FIG. 2.—Section of squamous epithelioma arising in right hand of creosote worker.

FIG. 3.—Section of wart on left forearm of same patient. Note downgrowth of epithelium.

J. A. WHITE: ELEPHANTIASIS NOSTRAS AFTER LYMPHATIC INJURY.

F. P. STURM: PEDUNCULATED TUMOUR OF THE TONSIL.

Photomicrograph of section of pedunculated tumour at lower lateral aspect of left tonsil. ($\times 3$.)