CASE III.—Fall of an Infant from a Height of 45 ft. without Injury.

A baby 11 months old was taken to the Royal Infirmary having, it was stated, fallen from a fifth-story window. The infant suffered from shock, but the only injury that could be found was a slightly bruised buttock. She was detained for observation; all that was noticed was that instead of being a lively child she was very quiet. After three days she was discharged as no serious injury could be found. The absence of injury was so striking that it seemed probable that the history and the distance fallen had been much exaggerated. In view of this I visited the scene of the accident and interviewed the eye-witnesses. The mother stated that whilst she was working about the house the baby had crawled on to a low stool beside an open window, the lower edge of which was only about 2½ feet from the floor. The window was on the fifth story of a tenement house and was about 45 feet from the ground. The child fell to the pavement of the street consisting of large stone flags, almost hitting a neighbour who was leaning out of the window below and who stated that had she known the child was falling she could have caught it.

The accident occurred over a year ago and since then the child has been visited on several occasions with a view to ascertaining if any after-symptoms developed. The last visit was a few weeks ago, when the child was found to be in good health and in all respects normal. The absence of injury might be more easily understood if the child had been wrapped in thick woollen shawls, but at the time she was wearing a flannel vest and two cotton petticoats. That the petticoats acted as a parachute, and to some extent broke the fall, seems out of the question when their nature and size are considered.

OVARIAN CYST COMPLICATING LABOUR.

BY

C. J. GORDON TAYLOR, M.A., M.D. OXON.,
BRIDLINGTON.

THE following case presents certain interesting features which make it worth putting on record.

On August 3rd, 1924, Mrs. T., aged 25 years, a 2-para, and living in a somewhat remote country district, was attended in her third confinement by two medical men. Her two previous confinements had been quite uneventful and of such recent date that no difficulty with the third child was anticipated. Labour at first proceeded normally; then it was found that the head was not advancing as rapidly as it should have done, and examination demonstrated an occipito-posterior position. Under an anaesthetic the occiput was rotated forward and forceps applied. As the head was being drawn down a lump was felt coming down in advance of it, and this lump was delivered somewhat precipitately immediately before the head was born; the child, a healthy living male, was then extracted without any difficulty, and the placenta was expressed shortly afterwards. The lump appeared to be a cyst, and as the woman showed obvious signs of shock it was deemed advisable to bring her into the Lloyd Hospital, Bridlington. The baby had been delivered at 2 p.m., and the patient arrived in hospital shortly after 6 p.m. As the above details had been given to me before her arrival I decided to defer any examination until she had been anaesthetized and placed on the operating table.

As soon as possible after her arrival an anaesthetic was administered by Dr. C. R. Taylor and the patient put up in the lithotomy position. Investigation then revealed a rounded cystic tumour, four inches in diameter, protruding through a rent in the perineum. The posterior vaginal wall was quite undamaged except for a tear of about half an inch at the junction of the mucous membrane with the skin. On drawing the cyst gently downwards the fimbriae of a Fallopian tube could be seen spread out over the upper portion of its circumference. The cyst was attached by a broad pedicle covered by peritoneum, which could be traced up into the abdominal cavity through a hole in the floor of Douglas's pouch. An effort was made to sterilize the parts by a liberal application of eusol, and then the pedicle was ligatured as high up as possible by a series of interlocking catgut sutures which included the accessible portion of the presenting tube; the cyst and attached portion of tube were then removed and the pedicle returned within the abdominal cavity. The tear in Douglas's pouch was closed by means of a purse-string suture, and repair of the perineum carried out in layers as in an ordinary perineoplasty. No drainage was provided. The cyst on examination proved to be an ovarian dermoid containing sebaceous matter and a large mass of hair.

Subsequent progress was satisfactory for the first four days, then abdominal distension set in, accompanied at first by diarrhoea; symptoms of obstruction developed, and on August 9th I opened the abdomen in the middle line. The peritoneal cavity contained a large quantity of clear dark-brown fluid; the small intestine was greatly distended. The obstruction, which was located in the left iliac fossa, involved the small gut about three feet from the ileo-caecal junction and was caused by a fibrino-plastic band of adhesions. The band was divided and the obstruction relieved. The opportunity was taken to examine the ovariotomy stump: its condition was quite satisfactory; it was found that it had been the right ovary and tube which had been involved. The patient never rallied from this operation and died eight hours afterwards.

One of the chief points of interest in this case is the path followed by the cyst in its escape from the abdomen. The posterior vaginal wall was pushed forward and stood the strain without giving way except for the small tear at the vulvar orifice. It is noteworthy that the cyst was delivered intact in spite of the enormous stresses to which it was subjected, and bleeding from the damaged parts was practically negligible.

It is unfortunate that sepsis brought about a fatal termination of the case, but the danger of this from the first was realized as being very serious. The risk run by draining through the perineal wound was considered to be greater than that incurred in closing the wound completely; as events turned out this view was possibly mistaken.

There is a lesson to be learned from the history of this case: the first two labours were entirely uneventful, and the second child was born less than two years before this catastrophe; yet it is hardly possible that the cyst was not present at the time of the second labour; the chances are it was present in the first labour as well. The case certainly supports the contention of those who urge that vaginal examination should be an integral part of the routine ante-natal examination. A well timed Caesarean section would have avoided the tragedy of a living child and a dead mother.

British Medical Association.

PROCEEDINGS OF SECTIONS AT THE ANNUAL MEETING, BRADFORD, 1924.

SECTION OF SURGERY.

Sir CUTHBERT WALLACE, K.C.M.G., C.B., F.R.C.S.,
President.

THE CLINICAL FEATURES AND DIAGNOSIS OF HYDRONEPHROSIS.

BY

H. P. WINSBURY WHITE, F.R.C.S.,

Honorary Surgeon to the Genito-Urinary Department, St. John's Hospital, Lewisham; Surgical Registrar, Royal Free Hospital.

(With Special Plate.)

ONLY the shortest outline of this subject is possible in the brief time that is allowed for this communication.

I am dealing with the pelvic type of hydronephrosis, commonly called intermittent and sometimes described as congenital. My remarks are based on personal observations made upon 23 cases and a review of 27 other cases.

A study of the age incidence shows the disease to be much more common in the third than in any other decade. It may, however, commence very early or very late in life. It involves either kidney in about equal frequency. It is twice as common in the female as in the male. From my investigations it appears that in hospitals where a predominant proportion of beds is not given over to male patients, and where all suspicious cases are investigated by the proper methods, it is one of the commonest renal conditions requiring surgical interference.

The signs and symptoms are inconstant. The so-called cardinal symptoms—intermittent attacks of colic associated with a palpable renal enlargement, both of which signs disappear as a result of an abundant discharge of urine—are seldom in evidence. Pain in attacks is the most constant symptom, and is most severe in the earliest cases. In exceptional instances pain may be quite absent. A palpable enlargement of the kidney is as often absent as present, and the passage of an abundant quantity of urine terminating the attack is a rare manifestation. Frequency in attacks or a chronic form occurs in a considerable proportion of cases. It is due to pyelitis, evidence of which was to be seen in all of the kidney specimens that I had an opportunity of examining.