is sufficient to turn the balance. Removal of other so-called causes of insanity, for example, alcohol, business strain, etc., is followed by cure in a certain percentage of cases. I contend that removal of the baneful influence exercised by a loose kidney will also be followed by a definite percentage of cures. This, however, cannot be effected by general treatment, or the special treatment carried out in asylums, but by operation alone. My results surely justify the contention that where the kidneys are found to be movable in an insane person, in justice to the patient and the friends, nephropexy should be advised before the case is sent to an asylum.

GENERAL SUMMARY.

1. Nephropexy is a safe and satisfactory surgical procedure.
2. Renal mobility alone is not an indication for operation.
3. Local pain of sufficient severity to diminish working efficiency is an indication for operation.
4. Chronic functional disturbance of the digestive system may be caused by movable kidney. Such cases often resist all kinds of general and medicinal treatment, and are greatly benefited by nephropexy.
5. Nephropexy is indicated in progressive spinal and cerebral neurasthenia occurring in association with movable kidney, when other measures have failed to cure, or improvement is followed by rapid relapse.
6. Nephropexy is indicated when movable kidney is associated with insanity.

LIPOMA IN THE SITE OF A FEMORAL HERNIA.

By C. J. PATTEN, M.A., M.D., Sc.D.,
PROFESSOR OF ANATOMY, SHEFFIELD UNIVERSITY.

IN a young male subject, aged 25, I observed a tumour in the thigh occupying the position of a femoral hernia. To the touch it seemed pliable and to a certain extent reducible, though from the first I had my doubts as to whether it was a hollow knuckle of tube which I was manipulating.

I made this digital examination before the subject was injected with preservative fluid, and being undecided as to what the tumour was, I proceeded to inject the subject with formalin with a view of hardening the viscera for special purposes.

I was glad that I adopted this reagent, as it also proved most useful in hardening and fixing the shape of the tumour, which on further examination proved to be a lipoma. On dissecting down on it, I found that the saphenous opening had been much encroached upon, and it was only with the greatest difficulty that I could detect the remains of the much stretched

View of the tumour from the front after removal of the cribriform fascia and the anterior wall of the femoral sheath. The lobulated character of the lipoma and two ascending processes are apparent. The long saphenous vein is seen displaced outward.

and thinned-out cribriform fascia which gave a partial covering to the anterior surface of the tumour. That a considerable upward prolongation of the fatty mass

occupied the crural canal, and, moreover, blended with a well marked septum crurale, and that the long saphenous vein was pushed aside in an outward direction, were points which were made out with little difficulty. When the front of the mass was well cleaned and defined it was seen to be elongated in shape; its longest measurement being about 5 in., its broadest measurement 2 in. This surface was much lobulated, and two tongue-like processes could be seen projecting upward and inward. The inner of these burrowed between the adductor longus and adductor brevis; the outer between the adductor brevis and pectineus. On endeavouring to shell out the mass I found it to be anchored by several other processes which had burrowed their way through muscular strata. Thus a portion of the tumour passed outward under cover of the femoral vessels (and apparently outside—that is, behind—the femoral sheath) and vastus externus; another part proceeded upward and outward in the interval between the psoas and pectineus. These last two processes could not be seen until the tumour was partially dislodged, as they took origin from the deep aspect. On removing the tumour from its bed I found that its deep surface was much broader and flatter than its superficial surface, and was not studded with small lobules. The floor of the space occupied by the tumour was formed by part of the anterior surface of the adductor magnus. The fascial covering, which formed a very delicate lipoma-capsule, seems to have been derived from the fascial envelopes of the various muscles in the neighbourhood. The cavity in which the tumour lay was 2 in. deep, and presented the following boundaries in a fairly definite manner:—Inside, adductor longus and adductor brevis; outside, pectineus and femoral vessels; floor, adductor magnus; roof, integument, superficial and cribriform fascia, and higher up the anterior wall of the crural canal; upper limit, Poupart's and Gimbernat's ligaments.

The circumscribed position which this mass of fat occupied renders this case interesting, though at the same time difficult to explain. Fat was not unduly collected together in other regions; in fact the subject was on the whole rather spare. The corresponding region of the other (right) thigh bore no evidence of fat deposit other than the ordinary layer of superficial fascia. The muscles of the body generally had not shown signs of having undergone fatty degeneration. There is just one suggestion which I would offer, namely, that this aggregation of fat at the site of a femoral hernia may possibly have represented a hypertrophic condition of the septum crurale, which is mainly composed of extraperitoneal fatty tissue. Indeed the presence of a firm plug of fat, which quite filled up and even distended the crural canal, and which, on the one hand, was in direct continuity with the rest of the tumour, and, on the other hand, with the enlarged, fat-laden septum crurale, would seem to point to such an origin.

BILATERAL NEPHRO-LITHOTOMY,

IN WHICH THE KIDNEY WAS KEPT OUTSIDE THE WOUND FOR SEVEN DAYS BEFORE RETURNING IT TO THE LOIN.

By JOHN CLAY, F.R.C.S.,

ASSISTANT SURGEON, ROYAL VICTORIA INFIRMARY, NEWCASTLE;
DEMONSTRATOR OF ANATOMY, UNIVERSITY OF DURHAM.

WHEN both kidneys contain stones, the mortality of the operation for the removal of the stones is very high, and any modification of the usual procedure which promises to diminish the risk is worth consideration. In the case given below both kidneys contained a large number of stones, the urine contained thick pus, and the patient was in a weak and exhausted condition. After removing the stones from the right kidney it was not, as is usual, returned to the abdominal cavity, but was kept outside the wound for seven days. By doing this, the possibility of losing our patient from haemorrhage was reduced to a minimum, as bleeding points could easily be seen and dealt with. It also seemed that the place for an organ, dripping with decomposing urine and pus, was outside the abdominal wall, and not in its loose soft bed in the loin.

The following are the notes of the case:

Eliza S., aged 34 years, married, was sent by Dr. Spencer, of Wallsend, on April 13th, 1908, to the Royal Infirmary under my care.

History.—For nearly two years the patient had been in poor health, and had a dull aching pain in the small of her back. For five weeks she had noticed that her urine was thick and opaque, and that micturition was painful and frequent.

On examination the patient was very emaciated, and palpation showed the right kidney to be much enlarged and tender. A cystoscopic examination was attempted, but it was impossible to get the bladder sufficiently clear to see the ureters.

First Operation.

On April 16th, 1908, an oblique incision immediately below and parallel to the last rib on the right side was made. The kidney was exposed and found to be full of stones, occupying both the pelvis and calyces. The parenchyma was so disorganized by inflammation that nephrectomy appeared to be the best way of dealing with it. Before doing so, however, it was necessary to find out the condition of the other kidney. For

Stones removed from the pelvis and calyces of the left kidney, one-half natural size.

this purpose the peritoneal cavity was opened and the hand passed to the other side. The left kidney was then found to contain stones and to be in much the same condition as the right, making it not advisable to remove the latter, but to remove the stones from it. The right kidney having been brought out of the wound, the stones were taken from the pelvis and calyces. Haemorrhage was controlled by putting clips on the vessels, as, owing to the sepsis present, suturing the kidney substance was to be avoided. The tissues were so friable that ligatures would not hold. For this

reason, and for those given at the commencement of the paper, I determined to treat the kidney extraperitoneally, and keep it outside the wound well wrapped in gauze. The free haemorrhage showed that there was no tension on the pedicle.

The bed from which the kidney had been removed was packed with gauze, and the patient returned to bed. In the after-treatment proctolysis was employed. On the seventh day after the operation an anaesthetic was given, the gauze removed from the loin, and the kidney, which was now covered with healthy granulations, returned to its place.

On May 18th, 1908, the patient was sent home considerably improved.

Second Operation.

She was readmitted on August 6th, 1908, to have the stones removed from the other kidney. At the second operation, as the previous one had been so satisfactory, exactly the same course was followed, but this time the kidney was returned to its bed four days after bringing it out on to the abdominal wall. She again made an excellent recovery.

On December 3rd, 1908, she was shown to the members of the Northumberland and Durham Medical Society. She had greatly improved in appearance and expressed herself in every way relieved.

After the first operation the patient was very ill indeed, and her recovery was largely due to the skilful manner in which Sister Mathewson managed the continuous rectal injection of normal saline solution.

Though the plan of keeping the kidney outside the wound was adopted on the spur of the moment, yet, as it diminishes the dangers of attempts to save lacerated or septic kidney, I think it is an addition to the conservative surgery of that organ.

REMOVAL OF A LARGE VARIX OF THE ORBIT.

By SIR WILLIAM J. COLLINS, M.S., M.D.,

B.Sc.LOND., F.R.C.S.ENG.,

SURGEON TO THE ROYAL EYE AND LONDON TEMPERANCE HOSPITALS
OPHTHALMIC SURGEON TO THE HAMPSHIRE AND NORTH-WEST
LONDON HOSPITAL.

MRS. JANE W., aged 42, had had three children; the last was 7 years old. A fairly healthy woman, always had a high colour, more marked on the right side. Fourteen years ago—some three months after the birth of the last child but one—the right eye began to become prominent. Some large vessels began to show at the inner canthus. For the last three years the proptosis had become gradually more marked. The right eye was projected forwards and outwards on to the cheek, and large worm-like veins

formed a plexus at the inner side of the globe. The lids did not close over the eyeball, and in profile the whole mass projected in a repulsive and unsightly fashion beyond the line of the nose. She had sought advice, but an ophthalmic surgeon had said it was too dangerous to operate on. She was greatly distressed, and was unable to go about in consequence of the deformity. A loud *bruit de diable* was audible with the stethoscope over the orbital swelling. The vision of the right eye was reduced to J. 20; that of the left was $\frac{5}{6}$ and J. 1. The fundus of the right eye showed the veins of the optic nerve rather larger than usual, otherwise nothing abnormal. The pulse was rapid (104); heart sounds normal. There was a large varix in the right thigh, and she had suffered from haemorrhoids. I admitted the patient into the London Temperance Hospital in November, 1905.

November 23rd. Under chloroform I tied the right common carotid artery just above the omo-hyoid. This

Full face before operation.

Profile before operation.

Full face one year after operation.

produced, however, no appreciable effect on the swelling or proptosis.

December 7. Under chloroform I slit the right external canthus freely so as to obtain easier access to the orbital cavity. I excised the eyeball. I found I could pass my finger round the plexus of veins, they being apparently encapsuled and easily detachable from the orbital periosteum. I passed a pair of bent clamp forceps down as far as they would go to the apex of the orbit and clipped the pedicle of the venous bunch. I tied the pedicle with silk after cutting the mass away on the distal side of the clamp. The orbit was then lightly packed with iodoform gauze. The bleeding was astonishingly little. Healing was uninterrupted. The mass proved to be a cavernous angioma, and contained a few phleboliths.

The appearance before and after the operation (a glass eye *in situ*) is shown in the accompanying sketch and photograph. There had been no return up to the end of 1908.

THE members of the first class of Filipino medical students trained under the American rule received their degrees from the Philippine Medical School at Manila on February 27th.