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.,
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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.,

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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.