estimate to a nicety the tension of the cervix, and so cause dilatation to proceed quickly or slowly as the occasion demands. As dilatation progresses the replacement of one of the blades removed will still allow sufficient room for the finger, until finally all the blades may be replaced, there being still room to admit the finger between any of the blades. I know of no other 8-bladed dilator on the market which will admit of one or more blades being removed or replaced without taking the whole instrument asunder.

Working upon past experience, when a case comes under my care which for one reason or another requires induction of labour, and great haste is not essential for the safety of the patient, I shall, if the os be small, dilate up to about No. 16 or 18 Kelly's dilators, inserting then into the uterus three of the largest bougies capable of passing through the os at the same time, and tightly plugging the vagina with sterilized gauze.

If this had not the desired effect in twenty-four hours I would repeat the treatment, and as soon as the cervix was partly taken up, if uterine contractions were not strong I would use the Frommer to stimulate them, and allow Nature to complete delivery if no complication arose later. Should it happen—and so far I have been fortunate in its not occurring with me—that the membranes were accidentally ruptured during manipulation with the dilator, then, and not till then, would I be tempted to use the hydrostatic dilators to assist me in the induction of labour.

THE SPREAD OF CANCER BY THE THORACIC DUCT.

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IN the BRITISH MEDICAL JOURNAL of April 29th, 1905, is published an interesting and instructive case by Dr. Mitchell Stevens of latent carcinoma of the stomach, spreading by means of an infected thoracic duct to the left side of the neck. It is one of the very few recorded cases of definite involvement of the thoracic duct in cancer within the abdomen, and will greatly strengthen the view advocated by Toisier and others that the thoracic duct plays an important part in the spread of cancer.

I have often observed that malignant disease of the glands of the neck occurs much more frequently on the left side than on the right, and I have frequently seen cases of apparently primary cancer in these glands, in people of middle or old age, without any evident focus of infection such as cancer of tongue, mouth, oesophagus, or tonsils. Although necropsies have been frequently made in such cases, I have never carefully examined the thoracic duct, and it is possible that some latent cancer within the abdomen may account for these glandular infections through the thoracic duct.

The writer of the case referred to was able to diagnose cancer of the stomach apparently from the appearance of enlarged glands in the left supraclavicular region, and this was confirmed *post mortem*.

In the case under my care recently I was not so fortunate, although in the light of my present knowledge I had ample grounds to suspect such a condition. The following is a brief account of it:

Primary Carcinoma of the Pancreas, with Secondary Infection of the Cervical Lymphatic Glands and Orbit.

A. H., aged 46, a labourer, was admitted into Mill Road Infirmary, March 30th, 1905, complaining of general weakness and a swelling in the left side of his neck of eight weeks' duration.

History.

Has always been a healthy and temperate man, has had to work very hard all his life as a labourer at the docks, lifting very heavy weights. No history of syphilis. For the last six months he has complained of want of appetite, constipation, and increasing weakness, with a gradual and steady loss of flesh. He has never suffered from attacks of pain or jaundice. He was treated by a medical man for anaemia, but with no good result. Four months ago he noticed a great difficulty in moving his bowels. Strong purgatives were required, but the stools were always large and well-formed; no blood. Two months before admission a hard, inflamed swelling appeared on the left side of his neck, extending upwards behind the ear and downwards to the clavicle. It was very painful. At the same time he noticed loss of vision in the

left eye, with some projection of the eyeball, and considerable headache, but no vomiting. He had in the last two months lost over 2 st. in weight, but had no active gastric symptoms.

Condition on Admission.

The patient is a strong muscular man, well nourished, but somewhat anaemic. No oedema or jaundice; pulse 80, moderate tension, regular. Heart and arteries show nothing abnormal. The lungs appear healthy, and although it was thought that possibly there might be a primary mediastinal growth in the chest to account for the enlarged glands in the neck, the most careful examination failed to reveal it. There is a moderate distension of the intestines which is uniform, and on deep palpation over the splenic area there is some pain and a sense of resistance. In the left supraclavicular region there is considerable general swelling, redness and slight oedema, extending above the lobe of the ear. No pain on deep pressure and no evidence of suppuration. A diagnosis of lymphadenoma was made, and he was informed that operation was not advisable.

Progress of Case.

April 10th. The patient has become generally weaker since admission, he is losing weight, and the difficulty of evacuating the bowels continues, although no cause can be detected. Every system was carefully examined, but nothing definite could be detected to account for his condition, excepting the growth of glands in his neck.

April 20th. A curious feature has developed in the case. He complained of pain in the left orbit with inability to read with the left eye. In the course of a few days there has developed a marked proptosis with total loss of vision. The eyeball has the appearance of being forcibly pushed forwards by some intraorbital growth of very rapid development.

April 22nd. The patient is rapidly going downhill, is drowsy and partially delirious. There is some more distension of the abdomen, but the bowels are acting regularly. He died to-day after becoming comatose two hours before death.

Necropsy.

The examination was made twenty hours after death. The body was emaciated. Rigor mortis pronounced. On opening the abdomen there was found a general distension of the intestines with slight ascites. All the organs were found healthy with the exception of the pancreas, which was transformed into a large irregular cancerous mass involving chiefly the body and tail, the head remaining comparatively free from growth. Several enlarged cancerous glands were found in the locality of the pancreas, some very large and hard, and compressing the splenic flexure of the colon, thus accounting for the difficulty of evacuating the bowels. The thoracic duct in this region was not examined. There were no secondary growths in any of the viscera. On opening the chest the organs were found healthy with the exception of recent oedema of the lungs. The left side of the neck comprising all the triangles was involved in an irregular cancerous growth, evidently originating in the deep part of the subclavian region. The thoracic duct near its termination was found involved in the cancerous growth, and was greatly thickened and enlarged. Microscopically, the sections of pancreas, secondary glands in abdomen, and neck show a typical glandular (scirrhous) carcinoma.

It is possible that a more minute search in all cases of abdominal cancer would point to the more common spread to other viscera and lymphatic glands by means of the thoracic duct, and I intend in future to pursue this line of inquiry.

In this case it is easy to understand the rapid enlargement of the neck glands, but not so the secondary growth in the orbit, which was of the same nature pathologically, and was pressing forwards the eyeball without being in any way attached to it. Another point of great clinical interest was the entire absence of symptoms which would point to involvement of the abdominal viscera. The wasting without obvious cause would of course suggest malignant disease, but not until the swelling appeared in the neck was there anything definite on which to make a diagnosis. I place on record this case in association with that of Dr. Mitchell Stevens in the BRITISH MEDICAL JOURNAL of April 20th, 1905, as I feel certain that the question is of great importance in the investigation of the spread of cancer.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

DILATATION OF THE GALL BLADDER SIMULATING OVARIAN CYST.

THE interesting clinical lecture by Mr. Alban Doran under the above heading (BRITISH MEDICAL JOURNAL, June 17th, p. 1316) prompts me to add a brief record of the following case upon which I operated last year.