(two boys and one girl, weighing each about 5 to 6 lb.) are now thriving.

Playfair quotes statistics showing that the relative frequency of the occurrence of quadruplets varies from 1 in over 2,000,000 births in France to 1 in 185,000 in Ireland.

PRIMARY MALIGNANT GROWTH OF LIVER.

By J. BRUCE-BAYS, M.D. LOND.,
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THE following case, the fourth of a series under my care, is of interest from the obscurity of the symptoms and the rapidity of the fatal termination.

Dassien, a Kaffir aged about 40 years had been engaged on Friday in unloading heavy goods from the train, and was then apparently in good health. On Saturday at midday he passed water, but on Sunday being unable to do so he sent for me. I found him lying in his hut complaining only of inability to micturate. There was no history of previous illness, nor of any injury. The abdomen, somewhat distended, was dull in the lower part on percussion. On passing a soft catheter a few drops only of urine flowed away. As the man was somewhat collapsed, though able to stand upright, I sent him into the Albany General Hospital, under my care, where he died soon after admission.

On making a *post-mortem* examination the abdomen was found to contain a large amount of clot, the blood having apparently come from the liver, which was much enlarged, weighing 7 lb. 7 oz., about half of it consisting of new growth. All the other viscera were healthy, no trace of any tumour being found in any other organ. Dr. G. C. Purvis, who kindly examined the growth, described it as a multiple cylindrical cancer of the liver, and reported as follows:

"The individual tumours varied very much in size; the smallest was about the size of a pea and the largest that of a walnut. The tumours were scattered throughout the liver. The colour of each growth was almost white, the consistence that of cheese. Each growth was surrounded by a white fibrous tissue capsule, and the liver cells in the immediate neighbourhood of the capsule much atrophied, and contained yellowish grains of pigment. The tumour itself was composed of irregularly-disposed tubules of columnar cells, and the lumen of the tubules contained some secretory substance of a homogeneous appearance, which stained of a greenish colour with methylene blue, and of a deep red tint with eosin. The stroma, which was apparently composed of ordinary white fibrous tissue, was scanty, so that the tubules almost touched each other. Many of the nuclei of the cancer cells were undergoing mitotic changes.

SINGLE KIDNEY: URETER PASSING TO OPPOSITE SIDE.—A singular anomaly has been reported by Horand ("Absence congénitale du rein droit, uretère droit desservant le rein gauche." *Bulletins et mémoires de la Soc. Anat. de Paris*. April, 1905). In the necropsy on an infant born at the seventh month, which had died of athrepsia when under 4 months of age, he found that the right kidney was entirely wanting, nor was there any trace of a right renal artery or vein. The left kidney was in normal position, hypertrophied and lobulated. The left renal vessels showed no anomaly. The pelvis of this single kidney passed into a ureter of large calibre, which ran downwards towards the right, passing in front of the left common iliac artery, much posterior to the left sacro-iliac synchondrosis, and sweeping round the inner wall of the bony pelvis on the right side internal to the vessels. Finally, it passed through the walls of the bladder, opening on the right side at the normal level of the right ureteral orifice. A left orifice was detected; it was permeable and passed into a rudimentary left ureter. This canal ended in a thin filament at the point on the brim of the pelvis where the normal left ureter passes downwards; it was totally disconnected from the left kidney. The left vesicula seminalis was absent, but the left vas, epididymis, and testis showed no abnormality. The left suprarenal capsule was well developed, the right was detected greatly atrophied and flattened against the right side of the vertebral column; it possessed a small capsular artery and vein. Horand observes that the surgeon might be badly puzzled in examining a patient with renal disease if an anomaly of this class existed. The cystoscope would show urine issuing from the right ureteral orifice, whilst the left, apparently normal, gave passage to none. The symptoms might justify nephrectomy, but in such a case the surgeon might remove the left kidney under the false impression that its fellow existed and was normal.

SEVENTY-THIRD ANNUAL MEETING

OF THE

British Medical Association.

Held at Leicester, July 24th, 25th, 26th, 27th, and 28th, 1905.

PROCEEDINGS OF SECTIONS.

SECTION OF STATE MEDICINE.

PHILIP BOOBYER, M.D., President.

A DISCUSSION ON ISOLATION HOSPITALS.

I.—GEORGE WILSON, M.A., M.D., LL.D., F.R.S.E.,
Medical Officer of Health, Mid-Warwickshire Combined District.

IN undertaking to open the discussion on this wide and now much vexed question of hospital isolation, I may explain at the outset that the facts and opinions which I have to lay before you are based on the experience gained in the sanitary supervision of a large combined district comprising three urban and seven rural districts during the long period of thirty-two years. I wish also to make it clear that, like a great many other enthusiasts in those early days, I held the strongest possible views concerning the value of hospital isolation, not so much for the benefit of the patient, or of the householder, or employer of labour, but for the benefit of the public at large, as a most important aid in controlling the spread of such dangerous infectious diseases as small-pox, scarlet fever, diphtheria, and enteric fever. I therefore commenced to urge the erection of isolation hospitals shortly after I was first appointed, but in order that they should not become too heavy a burden on the rates, I have all along advocated combination of districts to embrace as wide workable areas as possible, and by that I mean areas with an outside radius of about twelve miles from the hospital site. For half of the districts, and more than half of the population, such combinations were secured and hospitals erected for other diseases as well as for small-pox at a comparatively early date, but with respect to the other districts there were recurrent difficulties in inducing sanitary authorities to combine, and, failing combination we had to do the best we could: we had recourse to quarantine as much as possible, paying for nursing in severe cases, as well as other precautionary measures, and on the whole with very gratifying results. I for one, therefore, welcomed the passing of the Isolation Hospitals Act of 1893. This Act ought to have greatly facilitated the combination of large hospital districts in administrative counties, but, unfortunately, small boroughs of 5,000 or 10,000 inhabitants were exempted from the operation of the Act unless with consent, and that is generally by no means easy to secure. Then, too, another difficulty has arisen with regard to the new rural districts embraced in unions extending into adjacent counties which were created by the Local Government Act of 1894. It turns out that adjacent county councils have no power to issue a joint order to embrace the separate districts in any such overlapping union, even when the district councils concerned have agreed to combine. As an instance in point, I may mention that such an order was issued nearly two years ago by the Warwickshire and Northamptonshire County Councils, combining three districts, including the town of Rugby, and also an adjoining rural district, after a full legal agreement had been entered into by the district councils concerned, but the order was found to be *ultra vires*. It therefore devolved upon the Local Government Board to hold a separate inquiry, and a Provisional Order has at last been obtained.

I refer to this phase of the subject in passing because I hold that until larger powers are conceded to the Local Government Board and county councils to include in a county any borough, whether small or large, in a hospital district, to rearrange such districts, and to issue joint orders so as to include districts in adjoining counties, it would be a sheer waste of money for small urban or rural districts to provide properly-equipped hospitals for their own separate and sole use. I think, too, that districts without hospital accommodation situated in the neighbourhood of county