TRAUMATIC PNEUMONIA.

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ACUTE inflammation of the lungs bearing a definite relation to the application of physical violence is, I think, of sufficient rarity to warrant publication. The following are the notes of such a case recently under my care.

History.—Arthur M., an A.B. in H.M. navy, age 20, while on duty in a steamboat at 7 p.m., May 28th, tripped and fell, striking his left arm and left side of chest violently against the gunwale. When he returned on board the *dépôt* ship he made no complaint, and "turned in" without assistance.

Admission to Sick Bay.—At 7 a.m. the following day, feeling very faint and stiff, he lay down in the galley until 7.30 a.m., when he was brought to the sick bay. He then complained of headache, inability to move his left arm, vague pains over the left side of the chest, and a desire to pass water. His skin was hot and dry, his cheeks flushed, and his bladder distended. Temperature was 104° F., pulse 120, respirations 28. He was put to bed, 30 oz. of clear non-albuminous urine were drawn off by catheter, an enema was administered, and a diaphoretic prescribed thrice daily. No physical signs were observed in the heart or lungs.

At noon, dry, crepitating rales could be heard over the left base; there was also impaired resonance and considerable tenderness to percussion over this region. By 9 p.m. the skin was acting moderately.

Progress.—May 30th. Percussion of the left base showed marked dullness with increased V.F. and T.V.F. Short, painful cough with rusty sputum was also present. At 8 p.m. he had an attack of shivering fits and vomited.

May 31st. He passed a restless night. At 4 a.m. he again vomited.

June 1st. Slept well. Cough is not so painful and expectoration is less tenacious, but still contains altered blood. Tubular breathing is marked over the left base, the right lung remains normal. He can now move his left arm freely. There has been no more vomiting.

June 2nd. Temperature fell by crisis.

Result.—June 15th. He was allowed up, and from this date onwards made an uninterrupted recovery. Treatment throughout was diaphoretic and stimulant, and diet consisted of broths, milk, and eggs.

REMARKS.

The interest of this case centres in the fact that a severe blow over the left lung of a robust and temperate young man was followed, some few hours later, by the onset of a definite left-sided pneumonia. It is possible, of course, that at the time of the accident the victim was already in the incubation stage of the disease, but against this possibility it may be urged that there was no history of chill from exposure to wet or cold, or of any previous attack of the malady; the weather had for long been perfect, and pneumonia was not prevalent in

the port (Portland), in a word, no predisposing influence other than traumatism was known to be present. The fact that the left lung was the seat of disease is also in favour of the view of a traumatic origin, for in ordinary acute pneumonia the right lung is the more often attacked in the proportion of five to three (Fagge).

In cases of this nature I incline to the assumption that an involution form of the specific pneumococcus finding itself, if I may be allowed the expression, in a favourable environment, to wit, damaged lung tissue, undergoes a rapid evolution into the higher and more virulent variety associated with acute pneumonia. This latter variety subsequently either refers to the lower and more primitive saprophytic type, as, for instance, when the host dies owing to the disease, or succumbs to phagocytosis during the recovery of the patient.

I am indebted to Surgeons Elystan O'Leary and Norman Jacob for some of these notes and for much of the care and attention bestowed upon this case. The pneumococcus has been discovered in the saliva of some 5 or 10 per cent. of normal individuals. See Mr. J. Eyre on the bacteriology of pneumonia in *Quain's Dictionary of Medicine*, 1902.

HYSTERECTOMY FOR FIBROID DISEASE IN THREE SISTERS: RECOVERY.

By ALBAN DORAN, F.R.C.S.,
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IN the course of the Harveian Lectures on Fibroids of the Uterus and its Ligaments I dwell on the family history of fibroids. I referred to the case of three sisters under my care, all single, all between the ages of 30 and 40 years, and all troubled with fibroid disease of the uterus. In two the tumour suddenly increased in size, and I operated with good results. I further stated (speaking in November, 1902) that in the third the tumour was the largest of the three six years ago; it remained stationary for five years, and recently seemed to have grown smaller and harder. Hence, I observed, family history is not a sound guide to prognosis and treatment. The further history of the third case will now be related and compared with the first and second.

I must note that since I delivered the Harveian Lectures the subject of family predisposition to uterine fibroid disease has been discussed by Macpherson Lawrie¹ who operated upon four sisters, whilst a fifth underwent the same operation in a London hospital. Three of these five sisters who submitted to subtotal hysterectomy for uterine fibroid² also suffered from cataract; two other sisters had cataract without fibroid disease, and two others were free from either of these maladies. In the Harveian Lectures I spoke of a family under my own observation; I removed a fibroid uterus from a patient, and a fibroid polypus from her sister. Two other sisters had uterine fibroids, and one had died of uterine cancer. Their mother had undergone hysterectomy for fibroid, and her sister had died of uterine cancer.

The three patients under my own care were Dutch women, all single and between the age of 40 and 45 at the date of operation. They were free from any history of acute or chronic disease.

CASE I.

B. H., age when operation was performed 42. An attack of dysuria occurred in October, 1897; soon afterwards the patient noticed a lump in the abdomen. It began to grow much larger early in 1898. On February 28th in that year Dr. Olibborn, of Bridport, detected a large fibroid. The catamenia were regular every twenty-four days, the show rather free for five days, but not freer since the appearance of the tumour. I could define a deeply lobulated solid growth filling the lower part of the abdomen. It extended upwards to about 2 in. above the umbilicus, and downwards deeply into Douglas's pouch. The cervix was high up under the pubes. I operated on March 15th, 1898. Part of the tumour was enucleated out of the left broad ligament, the bladder was drawn up on the anterior surface of the tumour, which posteriorly was united to the pelvic peritoneum by very vascular adhesions.³ Both ovaries were removed, and no period was ever seen after the operation. The patient, never troubled with any severe menopause symptoms, was in good health in July, 1905, seven years after the operation.

CASE II.

H. H., age when operation was performed 40. Early in 1898, her attention being turned to the subject by her sister's

illness, she discovered that she had an abdominal tumour, and consulted me. I noted "small uterine fibroid, no troublesome symptoms, no bleeding." The period was regular, appearing every twenty-eight days. In the course of the year, after I examined the tumour, the show became more frequent, and small clots passed. In January, 1899, I found that the tumour was much enlarged, a lobule bulged into Douglas's pouch, and another into the right fornix. The upper limits of the tumour lay 3 in. above the umbilicus, the lower part occupied Douglas's pouch; the posterior lip of the cervix was involved in the growth, the anterior being drawn upwards nearly to the level of the pubic arch. I operated on February 21st, 1899. I enucleated part of the tumour out of the left broad ligament and sigmoid mesocolon and another lobe out of the right broad ligament. The bladder was drawn up on the anterior surface of the main tumour, but there were no adhesions. Both ovaries were removed. Nevertheless, the period persisted, though it became irregular for two years; at the same time the patient was troubled with flushings. Abel⁴ would attribute the continuance of the period to the presence of some endometrium, the uterus being amputated about half an inch above the os internum. After the cessation of the period there were no more flushings, and when I saw the patient last July—six years after the operation—she was in perfect health.

CASE III.

J. H., age when the operation was performed 43. The abdomen began to enlarge a year or more before I operated on Case I. In August, 1898, she came over from Holland and consulted me, declaring that the swelling had been stationary for some time. I detected a typical fibroid deeply lobulated, reaching about 3 in. above the umbilicus, but it did not extend downwards below the level of the pelvic brim. I advised her to see me from time to time, and for five years I found from my notes that it tended rather to diminish in bulk than to increase, and it certainly became harder. But in 1904 it began to grow again, and a lobe extended down into Douglas's pouch. I advised operation, which the patient postponed for a year, by which time the abdominal enlargement had become very unsightly. The catamenia, quite unaffected by the tumour, were regular, appearing every twenty-six days, and the show was always moderate.

In June, 1905, I noted "solid, elastic tumour, consisting of several distinct lobes, one reaching epigastrium, another passing deeply into Douglas's pouch." The cervix was drawn up very high under the pubes. I operated on July 6th, 1905, removing a lobulated tumour weighing 8 lb. 2 oz. There was no difficulty as in the other cases, for the broad ligaments were not opened up; on pulling the mass out of Douglas's pouch, the cervix was rotated backwards, it was rather elongated, and contained two very hard interstitial fibroids of the size of cob-nuts, which I dissected out, but I amputated the uterus above the os internum, removing the left ovary only. The patient made a good recovery.

OBSERVATIONS.

The fibromyoma of the uterus was of the same type in all three cases. The growths were interstitial, subserous and submucous in all, the first type prevailing, least marked in Case I, and most in Case III, where there was a large pedunculated lobe. In all, the cervix was involved and displaced. None of the cases was of the typical "bleeding fibroid" type; the catamenia were quite unaffected by the tumour in Cases I and III, although there was a submucous growth of some size in Case III. There was, it is true, distinct menorrhagia in Case II, but it was quite trifling compared with the growth of the tumour, and caused no anaemia. The fibroids in all cases grew slowly at first and quickly afterwards. Case III remained stationary for some time. Their history shows the importance of closely watching all cases of fibroid when for any reason operation is postponed. All the patients, being single women, desired operation mainly on account of the unsightly abdominal enlargement, and all were in an ideal general condition for a surgical operation when hysterectomy was performed, being free from obesity, alcoholism, and visceral disease.

REFERENCES.

¹ Remarks on Five Successful Hysterectomies for Fibroid Disease in One Family, *BRITISH MEDICAL JOURNAL* vol. i, p. 357. ² In one of these cases an ovarian cyst was removed as well. ³ In all three cases I amputated the uterus about half an inch above the level of the os internum. ⁴ Referate über die Behandlung der Myome, *Zentralbl. f. Gynäk.*, 1899, p. 616.

PAROVARIAN CYST WITH TWISTED PEDICLE.

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THIS case is interesting, since so far as I can ascertain, it is unique. I removed the cyst from a married woman, aged 23, who had never conceived. She first menstruated when 15 years old, and this function though regular was accompanied by dysmenorrhoea and latterly menorrhagia. The patient was admitted into the Chelsea Hospital for Women complaining of a dull aching pain in the left lower abdomen, dyspareunia, and painful micturition with difficulty of control.

On examination the uterus was found retroflexed and a round cystic swelling was detected lying on its anterior surface.

On opening the abdominal cavity the appearance first sug-

gested a supernumerary ovary, but a closer examination proved that the Fallopian tube as the result of the cyst's axial rotation had invested the ovary and cut it nearly in half. Its removal was quite simple and the recovery was normal.

I showed the cyst at a meeting of the Obstetrical Society, and the following is the report of its Pathological Committee:

This cyst was removed from the right side of the body. The pedicle, consisting of Fallopian tube, mesosalpinx, and including the ovary and its ligament, has been twisted upon itself by rotation in the antero-posterior direction. In the twist the Fallopian tube has invested the ovary and by pressure atrophy has divided the gland nearly completely into two portions. There is, however, a part of the ovary which has escaped division and which still unites the two segments by a narrow band of ovarian tissue in the neighbourhood of the hilum. The portion of the tube engaged in the strangulation has been completely divided.

The pedicle was untwisted for illustrative purposes so that a plainer representation could be made of the divided ovary.

COLLOID CARCINOMA AT TWELVE YEARS OF AGE.

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THE following case appears to me to be unusual, not only in the occurrence of colloid carcinoma at so early an age, but also in the unusual type of symptoms manifested:

The patient, A. C., aged 12 years, first complained of abdominal pain about 7 a.m. on August 10th. The temperature was 97° F., and soon afterwards the bowels acted and he vomited once. He was given castor-oil.

No particulars about his previous health could be obtained, beyond the fact that he appeared to be in his usual health on the previous day, though never very bright.

By noon he had passed four or five motions, which were, it was said, not offensive nor blood-stained, but simply loose.