aneurysmal sac having compressed the left lung in front of it, and become attached thereto. The greater part of the cavity of the aneurysm was filled with laminated clot. The blood channel penetrated the clot posteriorly, and where the descending aorta began the degenerated wall formed the posterior boundary of the channel. No part of the thoracic aorta except the ascending part was normal to the naked eye. The lung was firmly bound to the wall of the aneurysm, and showed numerous scattered patches of grape-like tubercles. The liver on cross section presented numerous white, firm, opaque, triangular masses not larger than 3 or 4 mm. across, embedded in the upper part of the organ. They came into relation with the capsule, but this was not thickened. The kidneys showed very early sclerotic change. In the left was a small cyst the size of a pea containing a jelly-like substance. The suprarenals were normal. No abnormal change was detected in the pancreas or bowels.

Microscopically the aorta was in an advanced state of mes-aortitis; in parts there was little of the normal tissue left, and very little of the elastic tissue. The masses in the liver were granulomatous. They were all connected with Glisson's capsule. Many showed an increase of small bile ducts, and some of these presented advanced catarrh. The whole substance of these areas was permeated with round cells, epithelioid cells, and connective tissue cells in various proportions. Necrotic patches were seen in nearly every one of the areas. In parts there were many new blood vessels. No micro-organisms could be detected by the ordinary methods of staining, and no tubercle bacilli could be found after a careful search. The rest of the liver tissue was very hyperaemic in parts, and showed much increase in intracellular connective tissue. The arteries occasionally had thickened walls, but there was no marked change in the direction of endarteritis obliterans.

The case presents many interesting features besides the uncertainty of accurate diagnosis. Statistics show that aneurysm in women, as compared to men, is about in the

A, Diminished breath sounds; B, dullness, pulsation, soft systolic murmur in December, dullness only in April; C, nipple; D, apex beat; E, pulsation, dullness, soft systolic murmur, ringing second sound; F, transmitted pulsation. The shaded area shows absolute dullness.

proportion of 1 to 10, though a good many practitioners answering offhand would put down the proportion very much smaller.

The absence of a clinical history of syphilis, as compared with the *post-mortem* findings, is perhaps now common enough.

It is surprising, however, that with such a large tumour none of the usual pressure signs or so-called extrinsic signs of aneurysm could be obtained. It is difficult to understand how a tumour that reached from the front of the thorax on the right side to the back of the thorax on the left side, did not yet appear to interfere with, for instance, the oesophagus and the act of deglutition.

A point of great interest is that we were able to watch the growth of the aneurysmal sac and also its healing. I think it not unfair to assume that the few isolated attacks of pain in August, 1908, marked the time when the main dilatation began to bulge back into the left lung. If so, we can allow about three and a half months for this dilatation to reach the back wall, and another three and a half months before it was finally filled up with clot. In addition we must remember that the wall of the aneurysm was composed of degenerated and thickened aortic tissue. I do not know what information there is on the time taken for arterial walls to hypertrophy, and for an aneurysm to grow a certain size, or for a laminated clot to be formed.

It was further of interest that the apex beat was not displaced, and that, in spite of the enormous size of the aorta, even in its ascending portion, there was no regurgitant murmur at the aortic orifice, but, on the contrary, a sharp clear second sound.

SEVERE ANTE-PARTUM HAEMORRHAGE DUE TO SPONTANEOUS RUPTURE OF VAGINAL VARIX.

BY

C. E. PURSLOW, and GUY J. BRANSON,
M.D., M.R.C.P., B.A., M.D. LOND.

THE case appears to be worthy of record, in view of the prominence given by all writers to placenta praevia and accidental haemorrhage as being practically the only forms of haemorrhage occurring spontaneously in the later months of pregnancy. In all the authors consulted, the only possibilities really entertained appear to be these two.

Mrs. J., aged 27, was in the thirty-second week of her first pregnancy, which had been quite normal in every respect up to November 15th, 1909. On that morning, when she first got out of bed, she was seized with profuse haemorrhage from the vagina, and very soon fainted. Dr. Branson was sent for, and on his arrival found her greatly collapsed, exsanguine, and with an almost imperceptible pulse; a chamber utensil half filled with firm blood clot was produced, as representing a portion of the blood lost. The os was found high up, and quite closed; there was a vertex presentation, but the head was free above the pelvic brim, and there was no evidence of labour; the haemorrhage had ceased.

Dr. Purslow was called to see the case in consultation, and found the patient as above described, though she had rallied slightly, and had a perceptible, though very feeble, pulse; the bleeding had not recurred.

Placenta praevia was diagnosed, and, as the patient could not obtain adequate nursing at home and lived some distance from Dr. Branson's house, it was decided that it would be advisable to remove her to hospital. The vagina was firmly plugged and the patient removed on an ambulance to the Queen's Hospital, where she was admitted under the care of Dr. Purslow.

The vaginal plug was removed next day and the bleeding almost immediately recommenced. A Sims's speculum was then passed and the vagina well cleansed with swabs preparatory to further treatment. On making an inspection, the blood could be seen coming in a profuse and steady stream from the vaginal wall at a point about 1½ in. above the urethral orifice and slightly to the left of the middle line.

The patient was at once taken to the operating theatre, anaesthetized, and placed in the lithotomy position. On making a careful examination of the vagina, the bleeding spot was seen to be a hole in a localized varicosity of a vein. This opening was seized with catch forceps and the varicose portion of the vein drawn away from the vaginal wall; an incision through the mucous membrane was made around it, and the varicose portion with one or two adjoining veins, which appeared to form a small plexus, was ligatured and excised.

The tissue removed was hardened, and on section showed distinctly the varicose enlargement of the vein, with marked thinning of the wall around the site of the rupture.

There was no further haemorrhage and the patient went on well, except that there was troublesome retention of urine, requiring the catheter, during the greater part of her stay in hospital. She went home on November 25th and was again under the care of Dr. Branson; her progress was uneventful and there was no further sign of haemorrhage. She was delivered on December 15th of a macerated fetus and made a normal recovery.

From the time of the haemorrhage she never felt any fetal movements nor could movements or fetal heart sounds be detected either during or after her stay in hospital.

It is worthy of note that careful examination failed to disclose varicosity of veins in the vulva or legs, or in any other part of the body.

The main point of interest in the case is its extreme rarity; reference to a large number of textbooks shows that they practically all mention a varicose condition of the veins of the vulva as a possible source of serious bleeding, especially in connexion with traumatism—for example, a kick; they also mention the occurrence of vaginal haematoma or thrombus from rupture of a vein in the vaginal wall during the second stage of labour and subsequent extravasation into the tissues; but the possibility of serious haemorrhage from rupture of a vein in the vaginal wall during pregnancy is not referred to; one exception is Hirst's *Textbook of Obstetrics*, where on p. 217 it is stated:

Varices of the vagina may be dangerous if the veins are large and their walls thin. The part should be guarded from traumatism, which might result in rupture of the distended veins, and an alarming, if not a fatal, haemorrhage.

There appeared to be no traumatism in the case recorded above. The question of coitus was inquired into, and it was ascertained that the last act had taken place one week previously.

An extensive search into the periodical medical literature has failed to discover the records of a similar case.

The effect of the hæmorrhage upon the child is interesting; it seems clear from the history that the child's death took place about the time of the hæmorrhage, and it seems probable that it was directly due to the great loss of blood which the mother experienced.

Memoranda :

MEDICAL, SURGICAL, OBSTETRICAL.

EMPHYEMA TREATED BY ANTISEPTIC PLUGGING.

THE proper treatment of empyema is still a matter of discussion. My last eight cases I have treated by free incision of the chest wall, and completely removing the pus, by retracting the ribs, and raising the patient on his side so that the opening was in the most dependent position; the wound was then packed tightly with iodoform gauze. The plug was kept in for three or four days and then withdrawn, the patient being put in the same position to empty the pleural cavity. On the first occasion, in a favourable case, about a cupful of sanguinolent fluid will be discharged; in one case it was clear serum. The plug is renewed, and if the case goes well in another three days there will be about a teaspoonful of discharge, and the wound may then be allowed to heal. If there is still considerable discharge the plug should be renewed.

The object of the gauze plug is to disinfect the fresh wound after the passage of the pus, to prevent the ingress of other germs so as to avoid a mixed infection, and lastly, by firmly closing the wound, to prevent collapse of the lung, and, if much air has entered at the operation, to allow its absorption and draw the lung towards the side, and thus tend to abolish the cavity.

This treatment I found successful in cases of two or three weeks' standing. If a case is opened earlier a good result is not certain. In one case the pleural cavity became so fetid that gangrene of the lung was suggested; but after putting in a pinch of powdered potassium permanganate and leaving out the plug, the cavity soon became sweet. The case was a long time in recovering, and probably there was an opening into a bronchial tube. In another case, which was very slow, with no fetor but much pus, there was probably a small pin-point perforation in the lung, which caused a mixed infection from the lung, and so defeated the action of the plug.

These cases prove the existence of a pre-existing lung complication as the cause of empyema. Just as purulent peritonitis is in all cases the result of perforation, so is empyema the result of perforation.

An old empyema is very quickly cured by this method. There is none of the mess and repeated dressing required where a drainage tube is used, and there is the advantage of the contracting influence caused by the absorption of any enclosed air pulling the sides of the cavity together; or if the lung be bound down hopelessly, tending to produce a compensatory emphysema of the neighbouring lung so as to fill up the cavity, especially if the plug is covered with a pitch plaster so as to seal the wound hermetically.

On account of the possibility of a perforation it is better to wait two or three weeks till the lesion of the lung is healed before emptying the pus, unless its removal is urgent, when ordinary drainage should be employed.

PETER TYTLER, M.D.,

Honorary Surgeon, Ancoats Hospital, Manchester.

IODINE CATGUT.

As there is so much interest in suture material I may perhaps give the method of preparation which I have worked out for absorbable iodine catgut, which is as follows: Catgut, defatted by lying in ether for twenty-four hours, is boiled in absolute alcohol for one hour. It is then laid in a solution made of 1 part of liquor iodi fortis (linimentum iodi) and 11 parts of water for one week. It is preserved in and used from a solution made of 1 part of liquor iodi fortis and 50 parts of rectified spirit.

Catgut must be boiled. It must be antiseptic.

Birmingham. FREDERICK EDGE, M.D.Lond., F.R.C.S.Eng.

Reports of Societies.

LEEDS AND WEST RIDING MEDICO-CHIRURGICAL SOCIETY.

Friday, January 21st, 1910.

J. B. HELLIER, M.D., President, in the Chair.

The Use of the Cystoscope.

MR. J. F. DOBSON read a paper on the use of the cystoscope, illustrated by lantern slides. He said that of the various instruments the new Nitze cystoscope was probably the best; with a cold lamp, wide field, and clear definition, it was a great improvement on its predecessors. The Luys cystoscope was useful for the female. The various difficulties in obtaining a view of the bladder were discussed, and cases were described in which cystoscopy had been of great value in making a diagnosis. But, valuable as it was in bladder conditions, it was in the investigation of renal diseases that the cystoscope found its greatest field of usefulness. In cases of pyuria, hæmaturia, and bacilluria of doubtful origin accurate information could almost invariably be obtained. The presence of lesions of the bladder could be eliminated or confirmed; disease in one or both kidneys could be recognized, and if one kidney was disorganized the functional capacity of the other kidney might be ascertained. Nephrectomy, except in cases of extreme urgency, should never be performed, unless a preliminary cystoscopic examination had been made. Statistics bearing on this point were given. He said that the methods of investigating the state of the kidneys were: (1) Cystoscopy alone. This was thought to be insufficient. Details were given of a case of advanced tuberculous pyonephrosis in which the orifice of the ureter showed no abnormality. (2) Cystoscopy and the segregator. Though useful in some cases in slight hæmaturia and pyuria, the segregator was not reliable. (3) Chromocystoscopy (Voelcker and Joseph). This was a method of considerable value, which should, however, be supplemented by the use of the ureteral catheter. (4) Ureteral catheterization. The difficulties and dangers of this were discussed, and he considered that with proper care and the selection of cases the dangers were very small. He described the various methods of estimating renal permeability, such as the injection of methylene blue and indigo carmine, the production of phloridzin glycosuria, and of artificial polyuria, etc. Illustrative cases were related.

Abdominal Effusions.

Dr. O. C. GRUNER read a paper on the laboratory examination of abdominal effusions. A description was given of several of the more reliable chemical tests which the author was accustomed to employ. The reactions for different varieties of albumoses were specially advocated, and it was pointed out that the richer the fluid poured into the peritoneum was in protein derivatives the more likely was the case to be one of cirrhosis of the liver or of cancer involving the peritoneum. One or two new applications of existing tests were referred to, and the value of a thorough analysis of these fluids was indicated.

Oxygenated and Warmed Ether as a General Anaesthetic.

Mr. S. T. ROWLING showed an apparatus for the administration of oxygenated and warmed ether vapour for general anaesthesia. The apparatus consisted of a long cylinder containing ether, through which oxygen was passed. The gas was warmed, both before and after—before, in order that more ether vapour might be taken up, and after, to counteract the chilling of ether evaporation. The warmer contained hot water, and the gas passed through coiled tubes inside. The face mask had a hollow perforated frame through which the ether passed.

Epilepsy.

Dr. E. F. TREVELYAN showed (1) two twin Jew boys aged 13, with typical epilepsy. They were the third and fourth of a family of ten children, all of whom had suffered from fits during teething. The fits, which had persisted in these boys and had recently become more frequent, appeared to be controlled by bromides. (2) A man, aged 41,