treatment, even if rather prolonged, in preference to a formidable operation from which they would naturally shrink.

Several of the cases are of three and four years' standing, yet none of those discharged cured have returned, and a few have written letters saying how well they still feel.

THE WORK OF A VENEREAL DISEASE CLINIC.

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In October, 1918, I published in the JOURNAL a short account of the first 500 cases attending the King Edward VII Hospital Clinic at Cardiff. I have now analysed a further 1,000 cases, and the figures may be of interest as showing the source of infection in 1,500 consecutive male patients.

	Prostitutes.	Amateurs.	Others.
First 500	279	183	38
Next 1,000	481	328	191
Totals	760	511	229

The amateur infections thus show an increased percentage in the last few months and the "other sources" a marked increase. Out of the 191 "other source" cases, 71 men definitely blame their wives, the bulk of the remainder denying connexion or being uncertain as to which of more than one woman infected them.

Some hundreds of the cases have recently been discharged from the services while suffering from, or having recently suffered from, venereal disease, and a very large percentage of these were infected in French licensed houses.

The "salvarsan substitute" used during the last twelve months has been novarsenobillon, given concentrated and always intravenously. I have seen no ill effect of any sort in the last 5,000 injections. Intramuscular injections of mercury have been little used, the bulk of the patients being colliers; as they work in a cramped position, these injections caused inconvenience.

The clinics have suffered from overcrowding, 80 or 90 cases sometimes attending at a time, and as all train fares are refunded, men attend from a large area.

I should like to add two facts which have struck me:

1. The small number of men infected while drunk. This is possibly owing to the difficulty of obtaining drink, but it rather does away with the argument that without drink few men would be infected.

2. The hopelessness of expecting men to take any preventive measures after running the risk. As I stated in my previous note, in two brigades in which every facility was provided no one availed himself of them. Since then, out of some hundreds of soldiers reporting at a certain dépôt, with venereal disease contracted in every theatre of war, I did not find one man who had used the appliances provided. In this civilian clinic, too, I do not recollect more than two or three men who had taken any precaution, and I have had one man on the books three times for separate infections.

As the bulk of the male population has served in the forces, it will apparently be the case that men who would take no trouble in units away from their homes, will surely not bring suspicion on themselves by visiting the suggested disinfecting stations in their own localities.

THE first congress of the association of French-speaking gynaecologists and obstetricians will be held at Brussels on September 25th, 26th, and 27th. The following subjects are proposed for discussion: Biological diagnosis of gestation, indications and technique of hysterectomy in the treatment of suppuration of the adnexa, early getting up of women after confinement and operation, operative treatment of cancer of uterus, the value of different incisions in laparotomy, gynaecology and obstetrics, protection of pregnant women and wet-nurses.

A CASE OF PRIMARY SARCOMA OF THE LIVER.

BY

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The following case is interesting on account of its rarity.

History.

A man, aged 42, was admitted to the hospital in a condition of advanced emaciation. He stated that his health had been good until about a year previous, when he began to feel pain in the stomach about half an hour after food, and had a constant sense of discomfort during the intervals between meals. Flatulence was a prominent feature, but there had never been any vomiting. There was no noteworthy constipation. There had been a steady progressive loss of weight.

Condition on Examination.

The abdomen was distended by a large smooth solid tumour, extending from the costal margin to the brim of the pelvis; at its lower edge a distinct fissure could be felt in the middle line. There was some bronchial catarrh, with a persistent irritating cough. The urine was normal. A blood count showed only a slight secondary anaemia (red cells, 4,000,000; haemoglobin, 70 per cent.), total white cells, 10,000, and differential white count normal. A Wassermann test was negative. The patient gradually sank, and died on the fourth day after admission.

Post-mortem Examination.

The body was greatly emaciated. There were no signs of injury, discoloration, jaundice, or external growth. The most noticeable feature was a bulging forwards of the upper part of the anterior abdominal wall. No enlarged subcutaneous veins were visible.

On opening the abdomen the liver was seen to have a mottled appearance and to be greatly enlarged, extending on both sides as low down as the iliac crests. The surface of the liver presented a large number of greyish-white areas of new growth, some of which were about the size of a pea, while others were larger, umbilicated, and slightly raised above the surface. The general "mottling" appeared to be due to the coalescence of these nodules, forming large greyish patches which were little, if at all, raised above the surface.

The great omentum was spread out and appeared to be normal. In the gastro-hepatic omentum, and in the mesentery, slightly enlarged lymphatic glands could be felt, and those about the head of the pancreas were particularly large and matted together. There was only a small amount of clear fluid in the abdomen. The stomach, pancreas, intestines, kidneys, and suprarenal bodies were thoroughly scrutinized, but nothing abnormal was found. The liver was easily removed from the body, being quite free from adhesions, and was found to weigh 14½ lb. and to measure 23 in. in transverse diameter. The gall bladder and bile ducts were free from growth.

The lungs showed numerous small whitish patches scattered over the surface. These were almost uniform in size, none of them being larger than a sago grain. The lungs were free from adhesions, and there was no effusion into the pleural cavity. The mediastinal glands were slightly enlarged. The heart and pericardium were normal. The head was not allowed to be examined.

Morbid Anatomy.

When the liver was incised no abscess or cystic growth could be found. The left lobe consisted almost entirely of a firm whitish growth, with the exception of a small seam of liver tissue running across the surface near the lower anterior border. The growth extended to the right beyond the middle line, and formed the greater part of the substance of the upper and anterior portions of the right lobe, penetrating backwards to within two inches of the posterior surface. Small nodules, separate from the main growth, were scattered about in the remainder of the liver substance. The liver tissue was friable, and pale and fatty in appearance.

Pieces of the liver and of the lungs and some of the enlarged lymphatic glands were excised, fixed and hardened in 10 per cent. formalin, and sections cut and stained in the usual way with haematoxylin and eosin. On microscopical examination the growths from each of the above tissues were found to present the same histological features, and the following description applies to the appearance of the sections made from the liver.

Histological Characters.

Microscopically the growth was seen to exhibit an alveolar structure—strands of fibrous tissue forming alveoli which enclosed groups or clusters of cells. The fibrous strands varied considerably in thickness, some consisting merely of a few fibres, while others formed well marked bundles. The cells enclosed within the alveoli showed great diversity in size, shape, and numbers. In most of the alveoli the predominating cell was rounded or polygonal, with abundant cytoplasm and a deeply staining round nucleus. Other alveoli showed a preponderance of small round cells with scanty cytoplasm.

A number of spindle-shaped cells could also be seen in most of the alveoli, mixed with the above types of cell. No fibrous tissue was observed between the cells which formed the clusters.

The blood vessels were rather scanty, ill formed and of a capillary type, and haemorrhages were present. The liver cells adjoining the margins of the tumour showed signs of degeneration. They stained badly, were granular, some were irregular and broken, and their nuclei were difficult to discern or altogether absent. Scattered among the liver cells in this region were numerous dark pigment granules and many well stained cells similar to those found in the tumour. These cells appeared to have advanced from the main growth along the blood channels; in fact, some of the vessels in cross section were seen to be packed with them.

The growth under consideration was undoubtedly malignant, and in view of the facts, first, that no evidence of a growth could be found, after a most careful search, in any of the other abdominal organs, and, secondly, of the enormous size of the growth in the liver, it may reasonably be inferred that the tumour was a *primary* growth in the liver. It is, of course, known that very large tumours in the liver may be secondary to quite small growths in other organs, but here, as already stated, no such growth could be found.

The determination of the precise nature of many malignant tumours of the liver is frequently difficult. In the present case, however, all who examined the sections of the growth were agreed that the microscopical characters were those of a mixed-cell sarcoma of an alveolar type.

Primary sarcoma of the liver is a decidedly rare growth, as the following brief summary of the literature shows. Hale-White, in 1890, recorded the fact that not a single case was met with at Guy's Hospital during the twenty years 1870-1889, both inclusive. Byrom Bramwell and Leith, in 1897, were only able to collect 25 cases, and they concluded that few of these could be regarded as true examples. Vecchi and Guerrini critically examined 45 published cases and accepted only 21 as being undoubtedly primary sarcoma of the liver. Pepere also tabulated a list of 45 cases, and Rolleston collected 32 cases in adults.

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THE OCCURRENCE OF CLUBBED FINGERS IN HEALTHY PERSONS AS A FAMILIAL PECULIARITY.

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CLUBBING of the fingers is so well known as an acquired pathological condition, especially in connexion with disease of the thoracic viscera, that its occasional occurrence in healthy persons as a familial (and doubtless also congenital) peculiarity deserves some attention. I regard the following cases as having a peculiar interest from the life assurance aspect.

In the present year I had to examine two (twin) brothers, aged 25 years, for appointments and for life assurance. Both of them showed clubbing of the fingers in both hands. The toes were not affected in the same way. In one of them (A. M. K.) the thorax was not very well developed, but the peculiarity in the fingers was slightly less marked in him than in his rather better developed brother (W. H. K.). Both of them appeared free from any visceral disease. A. M. K. had been severely wounded in the left leg during the war, but had quite recovered (from the life assurance point of view). I regarded both lives as suitable for insurance at ordinary rates. An elder brother, aged 30 years, had the same peculiarity of the fingers I was informed, but I did not myself see him. They had no other brothers and no sisters. I am not aware if the father (who died at the age of about 56 years) had clubbing of the fingers, but the mother (still living) had not.

In November, 1918, I examined an apparently healthy young Irishman (M. J. R.), aged 25 years. The only special point to be noted in regard to his condition was that he had incurred nails, with clubbing of the *fingers and toes*, on both sides of the body. This he said he had

had ever since he could remember. It was an inherited peculiarity, not associated with any thoracic or other disease. His father and three of his brothers and one of his sisters were said all to show the same abnormality—at least as far as the fingers were concerned. It may be observed that Mr. M. J. R. had been accepted in 1909 and 1911 for life assurance at ordinary rates.

There is one published record of a familial peculiarity apparently of the same kind. Von Eiselsberg,¹ in 1911, described a congenital and familial condition of the terminal phalanges in a man aged 35 years, resembling clubbed fingers in appearance. One of his grandfathers, one uncle, and one sister were known to show the same condition, which von Eiselsberg suggested might be of "lymphangiomatous nature."

I would rather not use the term "lymphangiomatous" for such cases, but would suggest that some of the isolated cases of clubbing of fingers for which no cause can be ascertained may be of the same nature, even when a history of familial occurrence of the abnormality is not forthcoming. As far back as August, 1897, I met with a man, aged 46 years, who had had typical clubbing of all his fingers—not his toes—ever since he could remember. I found no cause for the clubbing. He had psoriasis, but it was of more recent date than the clubbing.² S. West³ mentioned the case of a woman, aged 50 years, who came under treatment because she had swallowed some ammonia by mistake. Both her fingers and toes were clubbed. No cause could be found for the clubbing, which was supposed to have commenced three to four weeks previously. If this really was so the case could hardly be placed under the present category. West likewise recorded clubbing of fingers and toes in an otherwise apparently healthy medical man aged 38 years. In a third case of clubbing he could also find no cause.

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Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

OSSIFYING SARCOMA OF VASTUS EXTERNUS.

A. W., aged 14, when first seen on March 9th, 1918, stated that for six weeks he had had stiffness and almost continuous pain in the right thigh. About a week later he noticed a small swelling just above the middle of the thigh on the outer side, which grew rapidly. There was no history of injury. He was a fine, well set-up lad; he walked with the aid of a stick, keeping the right knee slightly flexed and the heel off the ground. There was a pyriform swelling just above the middle of the thigh on its antero-lateral aspect. It was 4 in. or 5 in. long and nearly 3 in. across its upper pole, tapering downwards. The skin over the tumour was somewhat discoloured, but was not fixed at any part. The tumour itself could be moved freely on the bone. No fluctuation could be made out. There was no enlargement of the inguinal glands, and palpation of the abdomen did not reveal any swelling therein. The heart and lungs, and the urine were normal. A diagnosis of sarcoma of muscle was made. Dr. J. N. Collins operated on March 21st; a short incision was made over the tumour, and some muscle fibres had to be divided before the bony nature of the growth was disclosed. It was decided to amputate the limb. Disarticulation at the hip-joint by the anterior racket method was performed. There was little bleeding, and the patient stood the operation well. The recovery was uneventful. Three days after the operation injections of Coley's fluid were commenced and continued for six weeks; the patient then left the hospital in good condition and with the wound practically healed.

The tumour was situated in the vastus externus muscle, and appeared to be limited to it, there being a definite layer of degenerated muscle fibres over it. The deep surface was smooth and somewhat flattened. On sawing through the tumour longitudinally it was seen to be composed of cancellous bony substance, with a fairly definite outline except at its upper and lower poles, where it was