is still further delayed the patient may actually begin to starve from lack of food, and backward pressure may produce dyspnoea.

The present case is that of a boy of 13 years, who came under my care at Salford Royal Hospital in January last.

His history was as follows: When 14 days old he was taken to a doctor because of difficulty in sucking; after examining the mouth and tongue and dividing the fraenum, the doctor noticed, and pointed out to the mother, a small "lump" the

size of a pea in the floor of the mouth. Until the boy was 12 years old this "lump" grew very slowly, but then it began to enlarge so quickly that in less than a year, at the time of admission to hospital, it was so large that the boy could not close his mouth; in fact, he could not even bring his lips together. The tongue, the tip of which could be seen pressed against the upper incisors and hard palate, was only slightly movable. Liquid food only could be taken, and swallowing was performed with considerable difficulty, saliva dribbling from the angles of the mouth all day and night. The sublingual mucosa appeared to be tightly stretched by

the cyst, and at one point on the left side, just above the lower lateral incisor tooth, the thinning was so marked that it seemed likely to give way at any moment. The cyst was removed through the mouth under general anaesthesia by simply incising the mucous membrane covering it, and then by blunt dissection, the fibrous band connecting the cyst wall and lower jaw being divided by scissors. Some now redundant mucous membrane was cut away, and the edges brought together by catgut sutures.

After removal, the cyst proved to be about one and a half times the size of a golf ball.

Should a sublingual dermoid be too large for removal in this way, an incision would be necessary, running from the

Sagittal section through tongue and cyst. D, dermoid cyst; P, hard palate; S, base of skull; V, i, ii, iii, iv, v, atlas, axis, and lower vertebrae; Hy, hyoid bone; A.C., arytenoid cartilage; T.C., thyroid cartilage; C.C., cricoid cartilage; G.H.G., genio-hyo-glossus; Man., lower jaw; Myh., mylo-hyoid; G.H., genio-hyoid.

symphysis menti to the hyoid precisely in the middle line. The right and left mylo-hyoid muscles and genio-hypoglossi are retracted and the cyst dissected out, after puncturing it and removing the contents if necessary.

A CASE OF VIPER BITE IN EPPING FOREST.

BY
B. F. PENDRED, M.R.C.S., L.R.C.P.,
LOUGHTON, ESSEX.

Cases of viper poisoning in this country are either extremely rare or very infrequently recorded, and since the victim on this occasion was an observant, intelligent man, and well able to describe events and symptoms, I have thought it worth while to publish his story:

On a bright sunny morning in April of this year, Mr. F. H., aged 28 years, was cycling through Epping Forest. He dismounted, and sat down on a dry bank covered with thick undergrowth, and almost immediately felt a prick on the back of the right hand. On looking down he perceived an adder, drawn up, head raised, mouth wide open, and prepared to strike again. This occurred at 9.30 a.m. He immediately jumped up, put his foot on the snake, and cut it about the head with a penknife. Whilst doing this his hand was smarting as though stung by a wasp, and at the site of injury he noticed two red punctures, about half an inch apart, with a bluish-white swelling around them. Blood was trickling freely, and he sucked the place vigorously, drawing a quantity of blood, which he estimates at a tablespoonful. It was then about 9.35 a.m.

He now felt considerable pain in the small of the back and stiffness in both arms, like the pains of "muscular rheumatism," and his vision became blurred and indistinct. However, he was able to wrap the snake up in paper and tie it to his bicycle, which he then mounted and attempted to ride home, a distance of about four miles (9.40 a.m.). The pain in the back was not quite so bad, and the left arm had recovered, but he felt giddy.

After riding three-quarters of a mile he got some brandy at a public-house, and was seized with a violent shivering fit, which lasted about ten minutes, then he began to feel sick, and noticed a painful swelling of tongue and lips. Notwithstanding this, he got on his machine again, and struggled on for nearly two miles. A severe pain, paroxysmal in character, had now commenced in the pit of the stomach, and this, combined with the increasing pain in his injured arm, vomiting, and impaired vision, caused him at length to collapse. This was at about 10 a.m. He was picked up by a passing motor car, and conveyed to my surgery, which he reached at 10.25 a.m.

His condition was then as follows: He was unable to walk without support; his face was very pale, had an expression of great agony, and was covered with cold, clammy sweat. Breathing was short and jerky, with much groaning, speech spasmodic, one or two syllables at a time. He had intense pain in the epigastrium, which he described later as being like that produced by a blow on the "mark" or having the "wind knocked out" of one. The position of greatest ease was sitting huddled up with the head between the knees. There was retching and vomiting of clear, pale yellow gastric fluids, almost continuous. The pulse was 120, very soft, and difficult to find. The pupils were dilated; there was no sign of convulsions, and the pain in the hand and arm was completely submerged in the agonizing abdominal crises.

The two punctures on the hand could easily be seen, with a bluish-red areola around them, the hand and arm being already swollen and oedematous. On being informed of the nature of the injury, an elastic ligature was placed round the arm; but on learning that it was an hour since the bite, this was removed as being too late to be of any use. Strychnine and morphine were injected hypodermically, and a teaspoonful of sal volatile in water was given by the mouth. Seven minims of a solution of potassium permanganate, 1 in 30, were injected at the site of injury. About twenty minutes later the symptoms had slightly abated, and the patient was conveyed to the local hospital.

At mid-day the pulse was still rapid, but much better in quality. The severity of the abdominal pain was reduced, partly by hot bottles, and also by a second hypodermic injection of morphine. Retching continued, but was not so incessant.

In the evening the oedematous condition of the tongue and lips was evident, and the arm was very swollen and painful. Temperature was never above normal.

The following day all except the local symptoms had subsided.

On the third day the arm presented a peculiar bluish-green discoloration along the lymphatic routes, like a "black eye" about its fourth day; there were also ecchymoses in places. The axillary glands were tender, but not enlarged.

Recovery was rapid and uneventful, and the patient was out walking on the fifth day, feeling quite well except for stiffness and tenderness of the arm and some vague "rheumatic" pains about the loins and shoulders.

It is some comfort to know that in this country the adder, or viper, is very shy, and will always avoid other creatures if possible. Also that the venom, or the quantity of it, is not sufficient to kill a full-grown man in good health. But deaths have occurred to little children, aged and feeble persons, and drunkards.

The adder in this case was about 23 in. long, and its species was easily recognized by the wide, flat head marked with a V, and the zigzag marking all along the back. It is possible that, owing to the earliness of the

season, it was still in a rather lethargic state, thus permitting a human being to get close to it, otherwise it would have been off at the first approach.

AN ENORMOUS PAROTID TUMOUR IN A CHINESE WOMAN.

By HAROLD BALME, F.R.C.S.ENG.,

SCHOFIELD MEMORIAL MISSION HOSPITAL, TAI YUAN FU, NORTH CHINA.

THE accompanying photograph is that of a Chinese woman, aged 53 years, who was first seen by me at a mission station in Southern Shansi, North China, in February, 1910. According to her history, she had first noticed a lump some eleven or twelve years previously, which she described as a small, round, hard substance, near the right ear. The tumour had grown quite slowly for the first few years, but during the last eighteen months it had increased much more rapidly, until its dimensions and weight had become so considerable that she could not bear it unsupported. For the last few months she had been obliged to sit on the Chinese kang all day long supporting the tumour with her hands. She was advised to make her way to the Baptist Mission Hospital in Tai Yuan Fu, the capital of Shansi, where she arrived some days later.

Condition on Admission.

The patient was very *sallow* and *emaciated* on admission; this was attributed to the fact that she was an opium smoker. On the right side of the neck, extending from the malar bone to the level of the breast, and from the middle of the chin to some distance beyond the posterior border of the sterno-mastoid muscle, was an enormous tumour firmly attached to the structures in the parotid region but quite separate from the lower portion of the neck, which it overhung. The tumour was firm and elastic and definitely lobulated; its total circumference, so far as it could be measured, was considerably larger than that of the patient's own head. The skin was freely movable over the growth, on the surface of which several large vessels ramified; the tumour itself was apparently encapsulated.

Before any surgical interference was possible, the patient underwent the ordinary course of treatment for the breaking off of the opium habit, and it was not until she was almost free from opium, and in a more favourable condition of health, that an operation was attempted.

Operation.

With the assistance of Dr. Paula Maier, an enormous elliptical incision was made from the malar bone to the

sternal end of the clavicle, and back to the lobe of the ear. Little difficulty was experienced in shelling out the tumour, though a great number of large vessels were met with, and in the enfeebled state of the patient these all needed to be isolated and clamped before section. There was a large hollow between the angle of the jaw and the mastoid process, forming the bed of the tumour, the surrounding bone having to a considerable extent atrophied from pressure. A large portion of skin, which was extremely redundant, was removed with the tumour, and the wound was closed in the ordinary way.

After-Treatment.

It was necessary to give two or three pints of saline intravenously before she left the operating table, and for the first twenty-four hours the patient suffered severely from shock. She needed close attention for some considerable time after this, and for the first two or three days Dr. Paula Maier remained almost continuously with her. Her subsequent recovery proved uneventful. When leaving the hospital she had a remarkable hollow behind the angle of the jaw, but I have since heard that this has to a large extent filled up.

Description of Tumour.

The tumour, which weighed over 20 oz., has been presented to the Museum of the Royal College of Surgeons, and the following report upon it has been received from Mr. Shattock:

Tumour from Neck of Chinese Woman.—This is a myxo-endothelioma. No cartilage found in the sections examined. Some parts of the stroma are very cellular, indicating rapid growth, but the zone of fibrous tissue limiting the growth excludes any sarcomatous change having occurred at the periphery.

PERFORATED ENTERIC ULCER: OPERATION: RECOVERY.

By WILLIAM WASHBURN,

SURGEON TO THE GLOUCESTERSHIRE ROYAL INFIRMARY AND EYE INSTITUTION.

J.M., male, aged 10 years, was admitted to the Gloucestershire Royal Infirmary on February 3rd, under Dr. Grosvenor, with enteric fever, characterized by dry tongue, constipation, much evacuation, and a temperature ranging up to 102°. There was a positive Widal reaction. On March 1st, during the fifth week of his illness, he suddenly became collapsed, and complained of pain in the right side of the abdomen. His temperature fell to 97° and the pulse rose from 110 to 156. The abdomen was retracted and hard, and there was considerable impairment of movement on respiration.

The house-physician, Mr. H. Hopps, recognizing that in all probability perforation had occurred, immediately sent for me, and within three-quarters of an hour of the onset of the collapse I opened the abdomen in the middle line below the umbilicus, and found a perforation of the ileum $\frac{1}{2}$ in. in diameter, some 3 in. from the ileo-caecal valve. The intestines were bathed in clear serous fluid, and there were about 3 oz. of a similar fluid in the pelvis. There was no other evidence of commencing peritonitis. I closed the perforation with a sero-muscular purse-string suture of fine silk, mopped the fluid from the pelvis, and inserted a small rubber drain. The wound was closed with through-and-through silkworm gut sutures.

The patient was back in bed within half an hour of his leaving the ward. The tube was removed twenty-four hours after the operation. Its insertion was probably an unnecessary precaution.

Recovery was uneventful, and the patient is now (May 9th) in excellent health.

At the request of the Bishop of London, we draw attention to the seaside camps for London working boys. The first of them was opened some twenty-four years ago, and year by year the work has extended, until last year about 3,700 lads were provided with accommodation for a week or two at the seaside. Many readers have probably seen these camps, and none can have any doubt as to the physical and moral advantages likely to be derived from their upkeep. Each boy contributes to the expense on an age scale, but, of course, the total outlay is not covered thereby. Contributions will be gladly received by the secretary of the movement, Mr. A. Abel Bloxam, 22, Northumberland Avenue, W.C.