complained in no way of the bowel, except when constipated, when he also had a little pain at the upper part of the sacrum. There was no trace of recurrence anywhere, but a little recontraction had taken place since last seen in May. The bowel, however, still admitted the index finger well beyond the narrow spot, and above this all was healthy.

This case appears very encouraging, as showing, like many others recorded, in the first place, the possibility and desirability of an early diagnosis of cancer of the rectum; and in the next, the feasibility of its complete removal with safety to the patient in properly selected cases.

I have requested this patient to present himself occasionally at hospital for examination, and shall report further as to his condition, should there be any recurrence.

NOTE ON THE PRACTICAL APPLICATION OF SPONGE-GRAFTING.

By D. J. HAMILTON, M.B., F.R.C.S.E.,
Professor of Pathological Anatomy, Aberdeen.

As from time to time since I wrote my paper on "Sponge-Grafting" in the *Edinburgh Medical Journal*, cases have been recorded in the *BRITISH MEDICAL JOURNAL* and elsewhere, in which its application for the purpose originally intended has been successful or unsuccessful, I think it may not be uninteresting if I add a few words in addition to what I have already written on the subject in regard to its practical application.

The first experiments I made were by placing a thick slice of sponge in the wound, sufficient to at once fill up the gap caused by the loss of tissue. There are several objections to this procedure, the chief being that a mass of sponge three-quarters to one inch thick placed over a suppurating wound becomes soaked with pus, and prevents any free drain from taking place. The pus so accumulated is almost sure to putrefy, and so interferes with the process of organisation going on in the deep layers. The danger of contact of such a putrefactive mass with an open wound, although less in the case of one that is granulating, is probably not to be underestimated.

I have, accordingly, generally found that in such cases it is necessary to cut off the superficial parts of the sponge, leaving the thin layer, which had become infiltrated with organising tissue, adherent. All this inconvenience can be avoided by adjusting the sponge in successive thin layers over the wound. These layers are not more than an eighth of an inch thick, and must be cut in large slices with a perfectly regular surface. The only method I know by which this can be accomplished is by means of a freezing microtome. I happen to possess a large microtome suited for the purpose, which I employ for cutting sections of the entire brain. It holds an entire Turkey sponge; and, when the latter is frozen, the whole mass can be cut into perfectly regular slices, of any desired thinness. Such a layer can be laid with the greatest facility over the wound, so as to fit into all its irregularities. In a few days, the first layer becomes organised. A second can then be placed over this, and so on, a mass of tissue being thus, in course of time, built up. There is no bagging of pus by this method of applying the sponge, and the danger of putrefaction occurring is reduced to a minimum.

Another precaution that is necessary is, to see that, where the wound is granulating, the edge of the layer of sponge does not come into contact with the pellicle of young epidermis at the side. If so, the epidermis will undermine it, and cause displacement. There ought to be one interval of about an eighth to a quarter of an inch between the edge of the epidermis and that of the sponge.

Dr. Sanctuary, in the *JOURNAL* of December 16th, makes the remark that firm pressure is a *sine quid non* in obtaining adhesion. I agree with him so far that, when first applied, there ought to be firm and equable pressure all over the surface; but I question, after adhesion has once taken place, whether pressure exerts a salutary influence in promoting organisation. On the contrary, I should consider that the interstices of the sponge would fill up quicker if the vessels of the granulating part had free play. I should almost say that, in the treatment of a granulating wound of the lower extremity, it would be advantageous, when the sponge has once taken firm hold, to allow the limb to hang downwards, and probably to encourage the patient to take gentle exercise. By this latter means, the circulation through the granulation loops will be rendered active, and a certain amount of vascular turgescence is what is really required.

As regards Dr. Ferguson's observation (*BRITISH MEDICAL JOURNAL*, December 16th, 1882) that, in a case where he applied a

layer of sponge, a quarter of an inch thick, to a wound of the calf of the leg, and where, after organisation had taken place, the new tissue proved to be sensitive, I may say that this might quite well be accounted for by small branches of nerves being carried into the interstices of the sponge by the granulation-vessels.

LARGE CYST OF THE MESENTERY SIMULATING AN OVARIAN CYST: OPERATION: DEATH.

By CHARLES H. CARTER, B.A., M.D., B.S. (Lond.),
Physician to the Hospital for Women.

Cysts of the mesentery are exceedingly rare. At present only a few such instances have been recorded. Dr. R. Watts (*American Journal of Obstetrics*, 1879, xii, p. 333) describes one which was mistaken for an ovarian cyst, and operated upon: the patient died; also Péan (*Tumeurs de l'Abdomen*, pp. 1,111, 1,112, and 1,115) describes three such which were operated upon, one of the patients recovering. Mr. Spencer Wells speaks of what he considers to be one in a note on Mesenteric Cyst and Tumours in the *JOURNAL* of December 9th; and Mr. Knowsley Thornton, in the *JOURNAL* of December 23rd, describes another, which, at the time of operating, he considered of ovarian origin, and included in his list of ovariectomies. The following is an account of a cyst which sprang from the left side of the spine in the lumbar region where the mesentery is attached, and either rose between its folds, or from the subperitoneal tissue below it. Its fluid content was peculiar, and differed from that which has been found and described in the few recorded cases. It was about sixteen pints in quantity, a thin, clear, slightly opalescent fluid, alkaline, specific gravity 1009, giving, on boiling, no deposit, but on adding a few drops of nitric acid a very slight film, redissolved on adding more; no change at the line of junction on pouring some of the fluid on a layer of nitric acid; on adding a 10 per cent. solution of nitrate of silver a very copious white precipitate. The fluid, therefore, contained no albumen, but a large amount of chlorides. Dr. Murchison (*Clinical Lectures on Diseases of the Liver*, p. 61) says these are characters which apply to no other fluid in the body, whether healthy or morbid, but to the fluid from an hydatid cyst. The fluid was carefully examined under the microscope, but no hooklets or anything characteristic could be seen; unfortunately the part of the cyst wall removed was not at once examined to see if it presented the laminated appearance of an hydatid cyst wall. Fluid somewhat similar to this is also found in so-called cysts of the broad ligament.

The following is the history of the case. A. B., aged 44, married twenty-five years, and never pregnant, attended at the Out-patient Department of the Hospital for Women, May 18th, 1882, and was seen by Dr. Mansell Moullin, who found the abdomen distended by a tumour which presented all the characteristic marks of an unilocular ovarian cyst. The patient had noticed the abdomen enlarging for two years. She was admitted under my care June 22nd. With the exception of one brother having died of consumption, her family history presented no marked features. The only illnesses to which the patient referred were one which she called inflammation of the bowels twenty-five years ago, and a second six years ago, when she had "bilious fever" and a second attack of inflammation of the bowels. Her present illness began two years ago, when she noticed a lump in her abdomen, about as large as a good sized orange, about the level of the navel; it appeared to move from side to side with the movements of the body; it gradually enlarged, and as it did so it became less movable; it had grown more rapidly during the last six months. She had had no pain till recently, and that only "a bearing down;" no trouble or difficulty with micturition; the bowels were constipated. She was regular every four weeks, but scantily. On examination, the abdomen was distended, and especially on the left side, where there was dullness on percussion far back; on the right side there was resonance up to the line of the insertion of the rectus muscle. Fluctuation could be distinctly felt all over the front of the abdomen in every direction; in the middle line, dullness extended six inches above the umbilicus. The abdominal measurements were, at umbilical level 38 inches, 3 inches above umbilicus 36 inches, 3 inches below umbilicus 38 inches. The distance from the ensiform cartilage to the umbilicus was 9 inches, from the umbilicus to the pubes 8½ inches: from the umbilicus to the iliac crest, on each side, 10 inches. The vaginal examination showed that the cervix was drawn over to the left side, the fundus lying towards the right foramen ovale; the sound passed 2½ inches; the uterus was movable: nothing of the cyst could be felt by internal examination. The case was diagnosed as an unilocular ovarian cyst, and on July 13th she was operated upon. An