lowed by terrific and uncontrollable hæmorrhage from the regions of Douglas's pouch, cæcum, and intestines. This hæmorrhage came from tufts of placenta which were attached to those regions, nor did this hæmorrhage cease until every vestige of placenta was removed.

The condition of our patient was now beyond hope. A rapid toilet of the peritoneum was made, the silk ligature round the stump tightened, and the *écraseur* removed. The abdominal wall was sewn up. The patient lived about half an hour. Transfusion was tried without success.

REMARKS.—The woodcut, from a drawing by Mr. P. Paget, will serve some idea of the relative positions of both the intra- and extrauterine foetus. There can be no doubt that the supposed sarcomatous mass felt by the vagina was the vertex of the extrauterine foetus, and a portion of the placenta belonging to it. Hæmorrhage from the placenta probably began before the operation; it would be due to either the examination or to the uterine contractions, possibly both. I may say that I have failed to find on record any such case as this, and it certainly seems that such a one should not pass without notice. I should also venture to state that one could hardly look for recovery under such terrible conditions, but that the right course was taken there can be no manner of doubt.

PERSISTENCE OF THE THYREO-GLOSSAL DUCT.

By CHARLES A. MORTON, F.R.C.S.,
Surgeon to the Bristol General Infirmary.

THE evening after the meeting of the Royal Medical and Chirurgical Society on April 10th I reported the following case to the Bristol Medico-Chirurgical Society, which may be of interest in connection with those reported at the London meeting.¹

A young man, aged 19, consulted Dr. Baron in January last for a swelling over the larynx and some slight expectoration of mucus, which was thought to be connected with it. Dr. Baron examined his throat and larynx, and, finding nothing abnormal, sent him to me for the external swelling. This first appeared when he was 3 years old, and was then "lanced," and glairy fluid evacuated. It had closed and then been "lanced" repeatedly. During the last two years it had been closed, but for three weeks a swelling had been forming, and the skin had become red and thin over it. There was a round, fluctuating soft swelling, the size of a walnut, just above the pomum Adami in the middle line, with a small scar in the skin over it. It moved freely with the larynx on swallowing. I regarded the cyst as a tubulo-dermoid formed in connection with a persistent thyreoglossal duct, and proposed to remove it, but would not promise complete extirpation of the disease, as I thought it might be impossible to dissect out any deeply lying portion of the duct extending upwards through the tongue, especially as I was told that on one occasion a medical man had passed a probe for 1 or 2 inches towards the pharynx.

The next day (January 10th) I dissected out the cyst. It lay over the thyro-hyoid membrane and hyoid bone, and contained a clear jelly with streaks of pus in it. The next day a drachm of jelly came away from the wound. It then quickly healed, but broke down at one corner and again discharged jelly, but only for a few days, and now for the last two months it has been healed. When I found the contents jelly I was inclined to regard my diagnosis as an error, forgetting that these cysts are unlike lingual dermoids arising in the lingual part of the duct, which contain sebaceous material. Although no cord was found at the time of removal extending upwards, the history of the case and the discharge of jelly after the removal of the cyst—no part of the wall of which was left behind—I think, make the diagnosis certain. Probably there was a duct extending some little distance upwards not seen at the operation, which discharged for a short time after, and has now been obliterated by cicatricial contraction.

The history of my case was almost exactly the same as that of the patient, aged 20, referred to by Mr. Durham in a clinical lecture published in the *Clinical Journal* of January, 1894, and very like the first of Mr. Raymond Johnson's cases in the *Transactions of the Pathological Society*.

¹ See "British Medical Journal" April 11th, p. 801.

REPORTS

ON

MEDICAL & SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF GREAT BRITAIN, IRELAND, AND THE COLONIES.

INFIRMARY FOR CHILDREN, LIVERPOOL.

ON EMPYEMA IN CHILDHOOD.

(By J. P. WIGHTMAN, M.R.C.S., L.R.C.P.Lond., late Senior House-Surgeon to the Infirmary.)

As interesting statistics on the above subject may be obtained from the records kept at a children's hospital, I have thought it worth while to bring forward a few points collected from the notes and records kept for the past ten years at the Infirmary for Children, Liverpool. For permission to make use of the above notes I am indebted to the kindness of Drs. P. Davidson and N. P. Marsh, Honorary Physicians, and Mr. R. W. Murray, Honorary Surgeon to the infirmary.

During the ten years 1884-1893 there were admitted to the institution 145 cases of empyema occurring in children from the age of 12 years down to infancy. Of these, 124 cases remained as in-patients until the termination of their illness; 35 were over and 89 under 6 years; 77 cases are marked as cured, 18 relieved, and there were 29 deaths.

MORTALITY.

The death-rate from infancy to the age of 3 years is a very high one, and averages about 50 per cent. From 3 years old to the age of 7 the death-rate diminishes markedly, being 15 to 16 per cent. There were no fatal terminations in the 20 cases occurring in children from the age of 7 to 12. A point to be remembered in looking at the number of deaths is the unfortunate frequency with which cases of empyema are brought to a children's hospital, and that then, and not till then, a correct diagnosis is made, the probable reason being that the physical signs have not been properly investigated previously.

Age.	Cured.	Relieved.	Died.	Total.
Under 12 months ...	1	—	2	3
Between 1 and 2 years...	7	1	7	15
" 2 " 3 " ...	8	1	9	18
" 3 " 4 " ...	13	2	3	18
" 4 " 5 " ...	12	3	3	18
" 5 " 6 " ...	11	3	3	17
" 6 " 7 " ...	10	3	2	15
" 7 " 8 " ...	3	1	—	4
" 8 " 9 " ...	5	—	—	5
" 9 " 10 " ...	1	1	—	2
" 10 " 11 " ...	4	1	—	5
" 11 " 12 " ...	2	2	—	4
	77	18	29	124
7 cases contracted scarlet fever ...	...	...	...	7
14 cases taken out by parents or result uncertain ...	...	...	...	14
	Total	...	...	145

The complications of empyema were usually acute inflammations of adjoining serous membranes, for example, pleurisy, pericarditis, peritonitis, this inflammation being almost always suppurative.

On going through the notes and *post-mortem* books with reference to the 29 cases of death, it was found that there were 6 cases of double empyema; 9 cases in which suppurative pericarditis, and 4 in which suppurative peritonitis occurred; 2 in which an empyema ruptured into the lung. Out of the 29 cases of death, fatal syncope occurred 4 times, 3 of these having as complication suppurative pericarditis. There are notes of one case of double empyema and one of empyema complicated by suppurative pericarditis, both of which recovered.