the existence of cheesy rhinitis as an independent affection. Among specialists, Cozzolino³ was the first authority who called attention to the affection, and he has since elaborated his observations, although in all he has only met with three cases. In the last of these he made a careful examination of the caseous matter, and found (1) fatty material with crystals of margaric and stearic; (2) epithelial cells; (3) circular black bodies (*aspergillus niger*); (4) white corpuscles; (5) microbes. Cozzolino now proposes to apply the term "cholesteatomatous rhinitis" to the affection. Beausoleil⁴ briefly refers to two cases he has met with; according to the short description, I gather that in both there were polypoid projections from the middle turbinated body, and in one the diagnosis pointed to empyema of the antrum, these examples thus proving a very marked parallel to the cases I have recorded here.

In addition to these observations, Strazza⁵ and Neumann⁶ have recorded cases in both of which masses of cheesy *débris* were found. In both a complete cure seems to have followed removal of the caseous material. In Strazza's case microscopic examination showed the foreign substance to be composed of epithelial cells undergoing fatty degeneration, and white corpuscles which stained with osmic acid. Neumann states that he found the substance removed by him to consist altogether of cholestearin.

I am unwilling, gentlemen, to take up more time than I can help. Besides, I do not know that any great value attaches to speculation and hypothesis. My cases—at least the first two—certainly correspond in their clinical features with the affection as it is described by the majority of the authors quoted. Neumann's case certainly seems unique if, indeed, the mass consisted of cholestearin only.

I may add that I think the history of my cases negatives the idea of any foreign body having been introduced, nor was any such substance detected.

RECURRENT AND SEVERE HÆMORRHAGE AFTER THE OPERATION FOR CLEFT PALATE.

By D'ARCY POWER, M.A.Oxon., F.R.C.S.Eng.,

Surgeon to the Victoria Hospital for Children; Demonstrator of Surgery at St. Bartholomew's Hospital.

It is always worth while to place on record any unusual event occurring in connection with a common operation, for it is by such means that our knowledge is advanced and the operation itself is thereby rendered safer. As a rule matters go so smoothly after the operation for cleft palate, that our only anxiety is to learn whether any portion of the cleft remains ununited. Serious hæmorrhage does occur occasionally, as in Mr. Howard Marsh's case recorded in the *Transactions of the Clinical Society*, vol. xi, p. 71. This happened before the rise of aseptic surgery, and the bleeding was controlled by the rough but effectual remedy of driving a splinter of match into the posterior palatine canal.

The case which recently occurred under my own care was the following:

R. H. T., a boy, aged 3 years, was admitted into the Victoria Hospital for Children on March 13th, 1894, with a harelip which did not extend into the nose, and a complete cleft of both the hard and the soft palate on the left side. The palate was closed throughout its whole extent on March 19th, the edges being brought together with sutures of horsehair and silver wire, after separation of the soft parts through antero-posterior incisions about a third of an inch from the edges of the cleft. There was free bleeding at the time of the operation, but it was not excessive. There is a note on March 23rd stating that the boy is behaving well. He lies quietly in bed and does not attempt to talk. On March 28th, nine days after the operation, the notes record that "the child got his hand into his mouth and picked at its silver sutures, setting up a troublesome hæmorrhage." This was not at first apparent because the blood was swallowed. The child became collapsed and blood then flowed from his mouth, and at the same time he vomited about six ounces of it. His nose and mouth were syringed with very hot water and the bleeding at once stopped. The boy gradually rallied.

The bleeding recurred on April 1st, the thirteenth day after the opera-

tion, and again in the evening, when a considerable quantity of blood was again vomited. The bleeding on this occasion came from the nose. Mr. Fantin, the house-surgeon, at once removed all the sutures, and plugged the anterior and posterior nares. The pulse was so rapid and feeble that it was considered wise to inject two pints of salt solution at a temperature of 100° F. into a vena coming of the brachial artery, as the superficial veins of the arm were too small to receive the cannula. There was no subsequent bleeding, and the patient was sent to the Convalescent Home at Broadstairs on April 11th. He was seen again on May 13th, when the note states that he was in good condition, and that the hard palate is completely united except for a small portion anteriorly; the soft palate has failed to unite. A small subsequent operation has completed the union of both the hard and the soft palates, and the hare-lip was at the same time repaired.

This case presents many points of interest, and it will be sufficient here to indicate them. The bleeding was unusual, on account of its severity and from its occurrence so long after the operation. It came undoubtedly from one of the larger branches of the posterior or descending palatine artery. These branches are very irregularly distributed. In this instance one of the branches presumably ran along the edge of the cleft, and was included in one of the horsehair sutures. This appears to be proved, in the first place, by the fact that the bleeding ceased at once and for ever after these sutures had been removed, whilst so long as they were in place it recurred; and, in the second place, because it commenced nine days after the operation, that is, at the time when recurrent hæmorrhage used to be most frequent after the application of a septic ligature to an artery in its continuity. Hæmorrhage at this stage is rarely or never seen now that aseptic methods are employed.

The bleeding, no doubt, stopped spontaneously on each occasion when the child's heart began to fail. The presence of the sutures, however, was sufficient to start the bleeding afresh when the circulation became restored. It was, therefore, only after their removal that a permanent arrest could be anticipated. It is more likely that this supposition is correct than it is to assume that the bleeding was due to a wound of the artery at the time of the operation, for if such had been the case there would almost certainly have been some hæmorrhage immediately after the operation. The practical point which the case appears to bring out is that it would be well to remove the sutures before resorting to more severe methods for the arrest of this form of hæmorrhage after the operation for cleft palate.

NOTE ON INVERSION AND TAXIS IN INTESTINAL OBSTRUCTION.

By ARTHUR SARGENT, M.R.C.S.Eng.,

Surgeon-Major H.M. 3rd Regiment Bombay Light Infantry.

THE two following cases occurred within a few days of each other, and are so typical of what may sometimes be done by means of taxis, inversion of the patient, and large enemata that I deemed them worthy of record.

CASE 1.—On May 3rd, 1894, I was called to see Sepoy B. P., aged 20. He was a strong muscular man, and gave the following history. He was in his usual health the day previous, being engaged on a working party parade. At about 4 P.M. he lifted a heavy weight, and drank some water fifteen minutes afterwards, from which time he was seized with great pain in the abdomen. He remained at his work till 7 P.M., and reported himself sick at the 3rd Regiment Bombay Infantry hospital at 8 P.M. His case was looked upon as one of ordinary colic. The resident medical subordinate treated him with castor oil and opium internally, and with mustard and fomentations externally. He vomited at 9 P.M., and as he showed no signs of improving I was sent for at 2 A.M. I found him very restless, with good pulse and warm extremities. There was an accumulation of wind in the left hypochondriac region. I gave him 20 minims of laudanum and an enema of an ounce of castor oil and turpentine in a pint of hot water; the enema returned, but only a little scybala came away. He did not sleep at all during the night, and at 7 A.M. I gave him 20 minims of laudanum, and a quarter of an hour afterwards 10 grains of calomel. He vomited at 11 A.M., a quarter of an hour after taking some gruel. As there was no action of the bowels by 1 P.M. I considered the diagnosis of acute obstruction confirmed. His pulse was 130, temperature normal, extremities warm, tongue moist but furred. I passed the stomach pump tube 21 inches up the rectum, at the same time slowly injecting hot water up to 6 pints; this appeared to afford great relief, but no scybala came away when the injection returned.

At 2 P.M. I inverted the patient in the usual way; that is, I made a strong man sit on the foot of the bed and take a leg of the patient over each shoulder and rise. I then kneaded the abdomen with my hands, and particularly the accumulation of wind in the left hypochondriac region. There was some gurgling and the whole abdomen became soft and the tumour disappeared. The operation took about a minute, and the patient said he felt much easier. I gave him 20 minims of laudanum—the third dose he had had in twelve hours. An hour after the inversion

³ *Bol. delle Malattie dell' Orecchio*, etc., 1884. *Annales des Maladies de l'Oreille*, etc., 1889, p. 645.

⁴ *Revue de Laryngologie*, etc., April 15th, 1893.

⁵ *Bol. delle Malattie dell' Orecchio*, ix. *Annales des Mal. de l'Oreille*, etc., xvii, 1891.

⁶ *Virchow's Archiv*, v, 132.

he took some gruel without vomiting, and fell asleep for two hours and awoke free from pain. He had a motion at 10 P.M., and three more during the night, and was discharged to duty eight days afterwards.

A. P., a strong, muscular, healthy-looking Brahmin priest, aged 35, was brought to the Dorabjee Pestomjee Charitable Dispensary, Mhow, on May 19th, 1894. He was collapsed and pulseless, but his extremities were warm, and he spoke with a fairly strong voice. He had been ill four days, with great abdominal pain and stercoraceous vomiting. He had been given purges without effect. He had a swelling of flatus in the right iliac region and his breathing was hurried. I looked upon him as dying, and that if anything could be done to save him it was necessary to do it at once. I inverted him as I had done the former patient and kneaded the abdomen, especially where the local swelling caused by flatus was, but the operation gave no relief. I then slowly and continuously passed the stomach pump 22 inches up the rectum, injecting hot water the while. When I had injected 8 pints without any returning the patient began to vomit stercoraceous fluid freely. I had no doubt this was the fluid I was injecting and that his obstruction was removed. I now tried to bring back his pulse by means of alcoholic stimulants, but he died of exhaustion about an hour afterwards.

Within the last six months I was present at a consultation called upon a case of intestinal obstruction in a young English soldier to decide if the abdomen should be opened. It was determined, however, before proceeding with laparotomy to pass the long tube and give copious enemata. The result was quite successful and the patient was saved a severe operation. This case was diagnosed as one of impacted faeces combined with paralysis of intestine from local inflammation.

If any apology is necessary for publishing the above simple cases, it is that I was induced to do so by reading in one of the most classical textbooks, written by one of the first of living surgeons, that he dismisses the subject of the use of enemata in acute intestinal obstruction thus: "Enemata are useless, and usually injurious, in cases of acute obstruction." I think I may reasonably ask, without, I hope, appearing to pit my opinion against so great an authority, Does not this statement require qualifying? The author quoted admits the use of the long tube in chronic obstruction; and I have no doubt if I had seen the second case recorded some twenty-four hours earlier, before collapse had set in, that his life would have been saved.

Regarding the inversion of patients accompanied by taxis, unless there is some obvious contraindication, such as great obesity accompanied by weak heart or peritonitis, I think it should be resorted to, and doubtless the administration of chloroform helps, but administering the last-named agent too often means a delay of two or three hours or more, especially if the patient be in a private house; valuable time may thus be lost. In my first case, taxis without chloroform apparently was all that was needed; and in the second case the patient, when first seen, was pulseless, so chloroform was contraindicated.

Finally, I consider, in the absence of strong contraindication, these two remedies should be given a fair trial, because in the event of the case terminating fatally, it is always a satisfaction to the deceased's relatives to know that no possible treatment had been overlooked, as the ignorant gossip and the educated read and hear of all possible treatments often months after their relative's death.

REPORTS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF LONDON.

WILLIAM PAVY, M.D., F.R.S., President, in the Chair.

Tuesday, November 20th, 1894.

MALIGNANT DISEASE OF THE LARYNX.

MR. STEPHEN PAGET recounted the case of a man, aged 64, in whom an ulcerated new growth was seen with the laryngoscope and felt with the finger. Relief was afforded by tracheotomy, but no further operation was deemed advisable. After death the upper end of the oesophagus was found filled with a tumour attached to the arytenoid, but extralaryngeal in origin. He thought the microscopic sections indicated it to be a giant-celled sarcoma, though these were unsatisfactory in character. Of 23 cases of sarcoma of the larynx, collected by Mr. Butlin, only 3 were, as this was, "extrinsic."

Mr. S. G. SHATTOCK had seen a growth of equal size, which Dr. Felix Semon had removed, and which was a

squamous-celled carcinoma, as he (the speaker) thought that Mr. Paget's also most probably was.

ACUTE SEPTIC EPIPHYSITIS.

MR. STEPHEN PAGET exhibited the parts removed by operation from a boy, who fractured his lower jaw in a fall; suppuration ensued, and then swelling of the left thigh and effusion into the knee-joint; pus formed about the lower end of the femur. The course of the case was afterwards one of chronic pyæmia. The leg not healing, amputation was performed three weeks after the accident. Abscesses formed in the left suprascapular region and elsewhere, and death occurred nine weeks after the injury. After death pus was found in the pleural cavity and pyæmic abscesses in the lungs. There did not appear to have been any injury inflicted upon the bone itself, the suppuration arising secondarily from the suppurating fracture of the jaw.

MR. GOLDING BIRD criticised the use of the term "acute epiphysitis;" he thought this should be used only in those cases where the inflammation of the epiphysis was primary and due to injury; in Mr. Paget's case the epiphysitis was rather part of a pyæmic series of phenomena.

PRIMARY MALIGNANT DISEASE OF THE GLANDS OF THE GROIN, ETC.

MR. C. A. MORTON recorded the case of a man who presented at first enlargement of the inguinal glands of both sides. This swelling subsided, but at the same time the skin over the right side became red, and seven months later the mass had again increased and was breaking down; the spleen presented no enlargement, and there was no leukaemia. Partial removal of the breaking down mass was practised, the growth being found to have widely infiltrated the surrounding structures. After death the enlargement on the left side did not infiltrate, whilst on the right it extended far along the iliac vessels. The point of interest was that, in addition to this, there were several growths in the subcutaneous tissue of the abdominal wall and in the lungs. Histologically the primary glandular formations presented the structure of lymphatic gland, though certain of the cells were larger, and there was no reticular stroma; in the other tumour, however, there was spindle-celled tissue. The author thought the case one in which sarcoma had followed upon an inflammation of the lymphatic glands.

DR. H. D. ROLLESTON suggested the possibility of the disease being a chronic form of glanders.

DR. HERBERT SNOW did not believe that a primary malignant disease of lymphatic glands ever commenced simultaneously in two sets; he did not think there was any real connection between the condition of the glands and the spindle-celled sarcomata elsewhere.

MR. A. A. BOWLBY remarked that malignant disease did not necessarily arise in a single gland. In some of the cases of so-called Hodgkin's disease in which new formations were found in the spleen and liver as well as in lymphatic glands the histology was not that of simple glandular tissue but of sarcoma in addition, and this he held to be true of all cases of fatal disseminated lymphadenoma; so it was in Mr. Morton's case.

DR. SIMS WOODHEAD observed that much confusion at present existed on the nomenclature of this subject. Some cases of what was described as lymphadenoma were due to specific infections; in the horse the name had been used in the case of rapid tuberculosis affecting the lymphatic glands; the same was true of chronic glanders, and Mr. Morton's case might really be one of the last, for the secondary growths differed so widely from the first.

DR. NEWTON PITT remarked that, taking a considerable number of cases of lymphadenoma, there was little variation in the cells of the different growths. If the tumours fungated, as might happen, into a bronchus, he should regard them as sarcomatous, and no longer strictly belonging to the class of lymphadenoma.

MR. MORTON, in reply, stated that the patient was a bricklayer, and there was no history pointing to glanders, and he thought the subsidence of the glandular enlargement was at variance with such a view.

EPITHELIOMATOUS CYST OF NECK.

MR. A. A. BOWLBY showed such a cyst, removed after death