sterin or bile pigments. They, however, served to prove the presence of gall stone to the patient's mind, and, in conjunction with a specially severe attack of pain, secured her consent to an operation. This was done on August 16th, 1895. On exposing the gall bladder by the usual incision it was plain that I had to do with an unusual conditions of things. The whole extent of the bladder presented to both touch and sight the character of a parchment-like skin tightly stretched over one stone. On opening the bladder this proved to be the case; and the stone, of which an illustration is appended, was with tedious and careful dissection cleared from the bladder wall, to which it was intimately adhering throughout its extent.

The narrow buffer-like end was distending the cystic duct. At A B there is a shallow groove going completely round the neck and terminating in a gap sufficient to allow the passage of bile. To this is to be attributed no doubt the fact that throughout the whole case there had been no jaundice. The largeness of the incision in the gall bladder precluding any attempt to anastomose with the intestine, its edges were secured to the parietal wound. Although the operation was a long one, having occupied fifty-five minutes from commencing to give chloroform to replacing the patient in bed, she suffered remarkably little from shock, had no considerable pain, and was cheerful and bright. Twenty-two hours after the operation, however, she suddenly complained of feeling sick, went into a state of syncope, and died in about two minutes.

The points that appear worthy of remark are the size of the stone (2½ inches), the length of time it must have taken to accrete, the total absence of jaundice, the fallacy of the treatment by olive oil, and the death from syncope when everything was looking so favourable to recovery.

ORBITAL TUMOUR: THIRTY YEARS' GROWTH; HISTORY OF INJURY!

By J. BROOKE RIDLEY, M.D. EDIN.,
Woking, Surrey.

B. A., 46 years of age, a strong healthy man, wheelwright by trade, states that thirty years ago he was struck over the left eye by a wheel falling whilst he was mending it; the result was a severe black eye, but no external wound or injury to the globe itself. About a year after the accident he discovered that his sight was going fast in the left eye, and a few months later he became aware of something growing in the orbit. This has slowly increased since, though he says that little advance has been made during the past seven years. The present state of the growth is well shown in the photograph. The orbit is filled by a firm, resisting, and somewhat elastic tumour, occupying mostly a unilateral position on the nasal side of the eye, causing marked proptosis, with downward and outward displacement, con-

gestion of the affected area, with dilated vessels due to pressure on the ophthalmic vein, but no œdema of the skin or subcutaneous tissues. The free edge of the growth is distinctly apparent at the inner margin of the orbit, but does not appear to invade either the bones or eye. No pulsation, *bruit*, or thrill is to be detected on palpation or auscultation. There is no pain or constitutional disturbance, only slight discomfort from epiphora and headache due to pressure on the duct and supraorbital nerve; the headache varies much in intensity, being absent for days at times.

The external appearance of the eye is normal; mobility is good, though somewhat impeded by the growth. The eyelid shuts easily over the globe; tension is normal; the pupil is the same size as that of the right, and responds well to light. The fundus oculi shows dilated tortuous veins and optic atrophy. He is only able to distinguish light with the left eye. The skin is freely movable, there being no adhesions, enlarged glands, or signs of any inflammatory action or invasion from neighbouring sinuses or fossæ, and no change is observed on compressing the carotid artery.

As regards the nature of the growth, it is evidently not a bony, vascular, or malignant one; but beyond this it would be difficult to speak with certainty, as in the majority of cases of this description no positive diagnosis can be arrived at until an operation is performed. This he refuses to allow.

AN UNUSUAL CASE OF RUPTURED INTESTINE.

By J. ANDERSON SMITH, M.D. LOND.,
Honorary Medical Officer Kilburn and St. John's Wood Dispensary.

FROM its rarity and from the obscurity as to its exact causation, the following case seems worthy of record:

A lady aged 58, who had suffered frequently from constipation, sometimes going seven or eight days without any action of the bowels, was suddenly seized whilst out walking with severe pains of a bearing-down character, commencing in the back and coming round to the front, not radiating into the groins and thighs. The bowels had been open that morning and regularly for the last week. She was in excellent health when the pain seized her. She was able to get home—only a short distance—and I saw her about an hour after the onset

of the pain. She was then lying on a couch, with her legs extended, and complaining of severe pains in the abdomen. There was great tenderness, especially over the right hypochondrium and epigastrium. The whole abdomen appeared somewhat distended, and was hyperresonant, the liver dullness not extending below the ribs. Nothing could be felt on palpation. There was no hernia, and no history of injury or strain. She thought she had had attacks of gallstone colic on previous occasions, but the history was not clear. The tongue was clean, there was no dyspnoea, no collapse, and the pulse was full and beating 64 per minute. The face was flushed and perspiring. There was some slight bile-stained vomiting.

I prescribed a carminative mixture, and ordered turpentine stupes. This treatment appeared to have given her much relief, for she was able to have her midday lunch, and talk cheerfully and rationally to a neighbour who came in to see her. The urine was high-coloured, but contained no blood.

I was sent for again at 5.30 P.M., and found the patient practically moribund. She was intensely cyanosed, breathing very shallowly, and with a pulse that could hardly be felt at the wrist. She was perfectly conscious, and said she was in little pain then. There was a doubtful history of straining at stool an hour or two previously, but she was too ill to give any reliable account of what had happened since lunch. The abdomen was more distended, and much less tender. Evidently there was rupture of some internal organ. She died about 6 P.M. the same day.

At the *post-mortem* examination, made next day with the assistance of Dr. Macevoy, who had kindly seen the case with me on the previous afternoon, the peritoneal cavity was found to be filled with a large mass of pultaceous olive green faeces which had escaped from a transverse rupture in the ileum. There was no peritonitis. The colon was enormously dilated and thinned in parts, as also the lower part of the ileum. There were faeces in the bowel below the seat of rupture as well as above. A good deal of blood-stained mucus was noticed in the lower part of the colon. There were no bands, no intussusception, no volvulus, no appendicitis, and no evidence of gall stones. The gall bladder was healthy, the liver a little fatty. The rupture was about 1 inch long, and occurred in the transverse diameter of the ileum about 6 inches from the ileo-cæcal valve. Where the gut had ruptured there was an oedematous purple patch about the size of a halfpenny. There were no ulcers in any other part of the bowel, and no enlargement of the lymphoid follicles nor evidence of new growth.

The case at first suggested ruptured gall bladder from gall stones, but the *post-mortem* examination gives no support to that hypothesis. Her age was against intussusception, and the duration was extremely short for volvulus. Is it possible that the mere weight of faeces in a dilated and thinned bowel could have caused some temporary kink in the gut, nipping a small piece of it, which piece finally gave way under the effort of strain during defecation?

CASE ILLUSTRATING A NEW METHOD OF TENDON SUTURE.

By H. LITTLEWOOD, F.R.C.S.ENG.,

Senior Assistant Surgeon to the Leeds General Infirmary.

F. P., aged 36 years, a joiner, was admitted to the Leeds Infirmary on August 6th, 1895, with a traumatic aneurysm of the right radial artery at the back of the wrist. There was also evidence that the three tendons of the extensor muscles of the thumb were divided about the same position.

The following history was given: A month before admission, whilst refitting a shop window a piece of plate glass fell across the back of his wrist, causing a wound. He was taken to a hospital, when the tendons were sutured and the wounds dressed. The wound was quite healed on admission to the infirmary.

Operation.—On August 10th, under ether, an incision was made over the aneurysm; this was completely dissected out, and the radial artery above and below the sac ligatured. The incision was prolonged and the skin reflected up, so as to ex-

pose the divided ends of the tendons. The three extensor tendons were found divided and separated for at least 2 inches; some silk sutures were found attached to the ends. It was now found impossible to bring the cut ends into apposition, so the following method was adopted:

A transverse incision was made half-way across each tendon about $1\frac{1}{2}$ inch from the divided ends (*a*); from this point the

a Point of division for splitting tendon. *b* Tendon split to within a short distance of divided ends. *c* Position of suture.

tendons were split to within a short distance of their divided ends (*b*), the parts reflected down, and the free ends sutured by means of fine silk (*c*). In this way the interval was bridged over without any tension on the newly united parts. Having stopped all bleeding, the wound was sutured with silkworm gut, and the hand and forearm bandaged with a firm uniform wool dressing, the thumb being placed in the extended position.

The dressing remained on nearly a month, the patient being treated as an out-patient after the first week. On removing the dressing all the wound had healed with the exception of a granulating surface about three-quarters of an inch in length. This was rather a long time in healing, but did so in about a month.

The patient was shown at the meeting of the Leeds and West Riding Medico-Chirurgical Society on November 29th, 1895. The wound was then soundly healed; the movements of the extensor longus and extensor brevis pollicis were good, but that of the extensor ossis metacarpi was weak.

The plan adopted in this case appears to offer in certain cases some advantages over other methods of tendon suture where the divided ends are separated for such a distance, and if it is successful when the tendons are so slender as those of the extensors of the thumb, it should be so in other cases where one has stouter tendons to deal with. The tendons must be manipulated with the greatest care, and of course the asepsis must be perfect. I attach great importance to the permanent dressing of wool, applied with a fair amount of uniform pressure.

I have to thank Mr. J. R. Lambert, the dresser, for the notes of the case, and for his care in dressing the patient during the time he attended in the out-patient department.

CASE OF DISSECTING ANEURYSM OF AORTA: RUPTURE INTO PERICARDIUM.

By H. S. ELWORTHY, F.R.C.S.,

Late Assistant Medical Officer, Northumberland House Asylum.

THE case is that of R. H., aged 51, warehouseman, married, who became insane in 1889. In September, 1890, he began to complain of vague pains in the abdomen, and in November had a fit followed by temporary paraplegia, and pains and cramps in the abdomen. He was very lazy in habits, lying