The application failed to give relief, and when he presented himself at the hospital I advised him to have the ulnar artery tied.

On August 27th he was chloroformed, and the left ulnar ligatured above the wrist. Immediately after this the "beating" in the sac ceased. The hand and forearm were bandaged on a straight splint, and in the afternoon the young man was allowed to go home.

September 10th. The patient was seen to-day by me, when I found the wound above the wrist had healed. There was felt under the skin a hardish nodule, presumably the clotted contents of the aneurysm. The swelling had gone down, and all discomfort in the part had ceased.

I am quite satisfied that extirpation of the aneurysm as performed by Griffiths is the better operation. Yet, with care, I believe W. G.'s hand will give him no further trouble. The great advantage of dissecting out the sac lies in the fact that the future of such cases need give one no anxiety.

The wonder is that palmar aneurysms are so uncommon, because every engine driver and fireman uses the flat of his hand to start some stiff handle or lever of his locomotive. The blow often does produce a "dirling" sensation in the fingers supplied by the ulnar nerve, but, luckily, rupture of the intima coat of the artery does not often occur.

In conclusion, I may say I had it in my mind to tie the superficial volar along with the ulnar, but when I considered that the superficial arch was alone involved, and that the sac would be filled with firm clot ere the volar had had time to widen, I trusted to the above operation to effect a cure. I think it has succeeded, for W. G.'s hand will be fit for work very soon.

A CASE OF CERVICAL RIBS.

(With a Special Skiagraphic Illustration.)

By HERBERT ALDERSON, M.B., M.R.C.S.

CERVICAL ribs being rarely met with in the anatomical subject, and less often in the living body, a brief account of the following case with the radiograph here reproduced will, I believe, be of considerable interest.

A young lady, aged 21, consulted me this summer concerning a swelling in the right side of her neck. She complained of a little pain over the swelling, and was anxious to know if the protuberance would grow larger and thus cause a disfigurement; beyond this slight pain, which was not constant, and anxiety as to an increase of size, the swelling caused no inconvenience whatever.

The protuberance was believed to have been present some time, but it was only the last few weeks or so that the patient had taken any notice of it. The patient is a well built girl, accustomed to golfing and other athletic exercises, which are in no way interfered with by her extra rib.

On examination I perceived a slight swelling in the right anterior triangle of the neck, $2\frac{1}{2}$ inches above the clavicle, contiguous to the anterior border of the sterno-mastoid muscle. The protuberance was felt to be very hard, obviously bony, immovable, quite superficial, and over it the skin moved freely; there was no tenderness, a small artery was noticed coursing over the swelling. It appeared fusiform in shape, about the size of a brazil nut minus the shell, traced upwards or downwards it was lost in the deeper structures of the neck.

The left side of the neck appeared in every way normal and nothing could be determined by examination of the neck posteriorly.

The right subclavian artery appears to differ in no way from its fellow on the left; the pulsation of both radials is of equal volume.

The slight pain was easily accounted for by an irritation of the skin over the bony protuberance, caused by friction from a starched linen collar pretty constantly worn.

Supernumerary cervical ribs are frequently classified according to whether they possess a shaft, or merely a head, neck, and tubercle without a shaft. The radiograph reproduced on another page was taken for me by Dr. F. H. Low, and demonstrates the existence of a rib of each class, that on the left side being of the rudimentary class, having only head, neck, and

tubercle, articulating with the transverse process of the seventh cervical, but no shaft. Articulating with the right transverse process of the seventh cervical vertebra, a particularly good example of the full-grown supernumerary rib can be seen; the shaft will be noticed to pass under the clavicle to the first intercostal space, and probably joins the second rib by a cartilaginous union, an arrangement which I have not previously seen recorded. The radiograph also demonstrates a break in the continuity of the shaft of the cervical rib, with apparently the formation of a false joint, and it is this point which corresponds with the protuberance in the neck.

The patient gives a history of sundry mishaps when quite young, including a broken thigh and collar bone, which might also include a fractured supernumerary rib, or the rib and the collar bone might be synonymous.

The natural obliquity of the ribs is also well shown, the sterno-clavicular articulation and the first rib anteriorly being on a level with the fourth rib posteriorly.

The literature of supernumerary ribs, although not extensive, spreads over a considerable period of time. I find that in the *Edinburgh Medical and Surgical Journal*, vol. 40, Dr. Dymock records a case, with a drawing of supernumerary cervical ribs, met with accidentally in an anatomical subject during the year 1830. Dr. Dymock mentions that Galen, Fallopius, Winslow and others have seen such cases; but have not recorded details, an example not followed by M. Hunauld, who published an excellent paper on the subject in the *Mémoires de l'Académie Royale des Sciences* in 1740.

Professor Gruber, who collected all known cases from 1740 to the year 1809, found 76 examples of cervical ribs occurring in 45 individuals, since which time a few cases at considerable intervals have been recorded. In the *Edinburgh Medical and Surgical Journal* for 1892 a case is recorded where removal was necessary to relieve pain in the neck and arm on movement, and formication and numbness in the hand. The rib was successfully excised by Dr. George Fischer (Hanover) with complete relief to symptoms.

In the *Boston Medical and Surgical Journal* for 1896, Dr. J. Collins Warren records a case which gave rise to symptoms, pain about the middle of the clavicle passing down the arm, completely relieved by disarticulation, and removal of the rib piecemeal nearly up to its point of origin from the seventh cervical vertebra.

Supernumerary cervical ribs are probably more numerous than the literature of the subject would lead one to suppose. Many cases without doubt pass unnoticed, giving rise to no physical sign nor to any symptom, and insufficient dissection may in some cases cause them to remain unnoticed in the anatomical subject.

THE PATHOLOGY OF GENU VALGUM.

(With a Special Skiagraphic Illustration.)

By J. B. FOOTNER, F.R.C.S.,

Honorary Surgeon, Tunbridge Wells General Hospital.

IN the *BRITISH MEDICAL JOURNAL* of May 29th, 1897, there is a short but interesting communication from Mr. Charles A. Morton on the pathology of genu valgum. He there states that a skiagraph of a case of this deformity failed to show elongation of the internal condyle of the femur, but demonstrated, on the other hand, the presence of a very marked curvature in the shafts of the tibia and fibula.

The skiagraphs reproduced on another page of a severe case of genu valgum in a child aged 3 years tend to confirm his statement. It will be seen that there is some curving of the tibia and fibula, but that there is also considerable elongation of the inner tuberosity of the former bone.

One skiagraph (Fig. 1) shows the condition before operation. The other (Fig. 2) shows that the elongation of the inner tuberosity of the tibia has almost completely disappeared after operation.

I preferred division of the femur rather than the tibia, because the former is in my opinion a much more simple operation, and no important blood vessels or nerves are likely to be interfered with. In dividing the tibia, possibly some injury might be done to the anterior or posterior tibial vessels or nerves. It might also be more difficult to maintain the short

Fig. 1.—Before operation.

Fig. 2.—After operation.

Skiagrams showing condition of bones of knee in genu valgum

TO ILLUSTRATE MR. FOOTNER'S PAPER (page 1638).

upper fragment of the tibia in accurate position. The after-result of division of the femur in this case was good.

I have to thank Dr. Chapman, House-Surgeon of the General Hospital here, for the skiagraphs.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

ANTERIOR DISLOCATION OF FOOT.

A PAINTER fell from the roof of a two-storeyed house on August 5th, 1897, and the feet struck the ground first. I found the right foot displaced forward and inverted. The surface of the astragalus forming the articulation with the tibia was prominent, and lay against and in front of the tibia, and the external malleolus projected. There was no fracture. Reduction was easy under chloroform by traction on the foot and eversion by the right hand, and pressure on the prominent astragalus by the left thumb.

The patient remained in bed with lateral splints and foot-pieces for six days, when his ankle was put in a plaster case, and he was allowed to get about on it. Though the external lateral ligament must have been extensively if not completely ruptured very little swelling followed. The plaster case was removed after being worn seventeen days. The joint was found painless, and with normal mobility. There was, however, a slight increase in circumference, which had not disappeared when I saw him last, seven days after. It was so slight that he would not pay any attention to it, as he said he felt the ankle as strong to walk on as the other.

I see Erichsen¹ says the above accident is so rare as seldom to have been witnessed, and Treves² says that in the few reported cases one or both malleoli were broken.

C. L. MARTIN, M.R.C.S., L.R.C.P.Lond.

Umtali, Rhodesia, South Africa.

A CASE OF SPURIOUS ABORTION.

THE patient was a multipara (six children), the youngest being 2½ years old. Menstruation was perfectly regular until the end of March, 1897, and she calculated from this time that she was pregnant. As time went on there was a perceptible swelling of the abdomen. On July 8th, 1897, I was called on account of hæmorrhage having set in. This discharge was similar to that described by Dr. Eden in the case of Dr. Dakin, that is, a brownish discharge streaked with blood. The symptoms during the amenorrhœa were slight—slight morning sickness and only slight alterations in the appearance of the breasts. As they had been slight also in past pregnancies, they were of little diagnostic value. The uterus on bimanual examination was firm and enlarged, the fundus being felt just above the rim of the pelvis. The ovaries and tubes were apparently normal. The case appeared to be a case of threatened abortion at thirteen or fourteen weeks.

After six days, in which the patient was kept in bed and the uterine muscles kept as quiet as possible, a cast, not so large as those described by Dr. Eden, was passed. It was 2½ inches long and 1 inch broad. Its outer surface was rough, but there was no apparent placental site or any chorionic structure. On examination microscopically it was found to be decidual tissue, and so far as I was able to see, no tissue of any other character except blood vessels. The patient made an uninterrupted recovery; bleeding ceased on the day following the expulsion of the cast. No pain was experienced during the whole time.

In considering the case, my first idea was of a fertilised ovum which in some way had perished; my second was, whether the fact that the patient was anxious not to be pregnant (which was in reality the case) had anything to do with it.

It would be interesting to know what the desires of the three cases cited by Dr. Eden were with reference to their being pregnant or not. Knowing the influence these conditions have in cases of pseudocyesis, it is within the bounds of

reason that it may be a cause or aid in spurious abortion.

Birkenhead.

J. HERBERT DIXON, M.B., C.M. Edin.

DISLOCATION OF THE UNGUAL PHALANX.

THE above dislocation is apparently so rare that Erichsen, in the eighth edition of his *Surgery*, says: "I do not think that simple dislocation of the ungual phalanx from the second is possible," and I can only find the record of one case in medical literature. An account of such a dislocation may not be without interest: A young man, a compositor, came to me on October 31st, stating that while playing cricket and standing at slip, in attempting to catch a ball, he was struck by it straight on the end of the second finger of the right hand, the fingers at the time being extended. The terminal portion of the finger was extended while the metacarpal phalanx was somewhat flexed. On examination, the base of the ungual phalanx was both seen and felt resting upon the dorsal surface of the head of the second phalanx. Slight traction upon the terminal phalanx and a little pressure on its base at once restored the bone to position.

Grahamstown, Cape Colony.

JAMES T. BAYS, M.D. Lond.

WALCHER'S POSITION IN OBSTETRICS.

THE following case, in which this position was useful, resembles that recorded by Dr. Mitchell in the *BRITISH MEDICAL JOURNAL* of July 3rd, 1897, and some of those previously described by me in the *JOURNAL* of October 31st, 1896. The patient was aged about 30, and had had four previous pregnancies. The first and second labours ended in craniotomy; the third labour was induced at the seventh month, but the child was dead when extracted. At the fourth labour the head was crushed during extraction with forceps, so that the patient had never had a living child. When she was in labour for the fifth time at full term her attendant remembered the utility of Walcher's posture, and sent for me as soon as dilatation was complete. She refused to have chloroform, but consented to lie on her back, her legs hanging down over the edge of the bed, her feet not touching the floor. Axis traction forceps were applied, and a living child was delivered after a stiff pull. The head was much moulded, but not injured, and in a few days it recovered its shape. Its measurements were then of very fair size, namely—Diameters: O.M., 5½ inches; O.F., 5 inches; S.O.B., 4 inches; B.P., 3½ inches; B.T., 3 inches. Circumferences: O.M., 15 inches; O.F., 14½ inches; S.O.B., 13½ inches. The child was 18 inches in length at birth, and has done well. The pelvic measurements of the mother are as follows: Interspino-diameter, 10 inches; intercrural, 9½ inches; intertrochanteric, 12 inches; external conjugate, 5½ inches; diagonal conjugate, 3 inches. The pelvis is therefore very flat, and the true conjugate must be about ¾ inch less than the diagonal, or 3½ inches less than the external conjugate—namely, about 2½ inches, or 1½ inch less than normal. I might have turned and delivered in Walcher's position, but preferred the forceps. I am convinced, however, that apart from the use of this position, the head in question could not have passed uninjured through the pelvis in question without symphysiotomy.

Manchester.

W. E. FOTHERGILL, M.D.

CASE OF RIGIDITY OF THE OS UTERI TREATED BY HOT BATHS.

I WAS called one evening to attend a primipara, aged 40, who had been in labour for thirty hours. I found her in bed, having very severe bearing-down pains both in the back and abdomen. I was told that the waters had all drained away in the morning, and that she had been having very severe pains for three hours. On vaginal examination I found the head presenting and the vagina very small. The cervix was hard and rigid, and the os completely closed, so much so that I was quite unable to pass a sound into the cervical canal. I ordered warm douches and gave chloroform. I unfortunately had no chloral with me, so was unable to try the effect of that drug. The chloroform had no effect. The pains became more frequent and more severe, the whole uterus being forced down with each pain, without any dilatation of the cervix. The patient showed signs of rapid exhaustion, and I had almost determined to make lateral incisions into the

¹ *Science and Art of Surgery*, 8th Edition

² *Surgical Anatomy*, 2nd Edition.