occurred between the ages of 10 and 20 years, and in 10 cases the attack was the first. These patients were generally admitted in *extremis*, with a history of from three to eight days' illness. The abdomen was opened in 8 cases, and in the others the diagnosis was verified or made at the necropsy.

In conclusion, taking all the cases together, the usual symptoms were fairly constant. In 3 cases pain and swelling were more marked on the left side, and in 8 cases pain was complained of during micturition. Concretions were recorded in 12 instances (5 in Class c), and in 1 case the appendix came away as a slough three days after an abscess was opened. A faecal fistula resulted in 3 cases, and a ventral hernia in 2.

CASE OF GALL STONES: CHOLECYSTOTOMY.

HOOR-GLASS CONTRACTION OF THE GALL BLADDER.

By HUGH COLLIGAN DONALD, M.B., C.M.,
F.R.C.S. EDIN.,
Surgeon to the Paisley General Infirmary.

MY reason for reporting the following case is that I believe many cases of hour-glass contraction of the gall bladder have not been recorded, although on reading Mr. Mayo Robson's recent and most instructive work on *Diseases of the Gall Bladder and Bile Ducts* I find that under the heading of Hour-Glass Contraction of the Gall Bladder he remarks: "Hour-glass-shaped gall bladder is probably not uncommon, for though I have found only one specimen in the museums, and that at Middlesex, I have myself operated on two cases in which the distal part of the gall bladder contained calculi, and was connected with the gall bladder proper by a narrow neck. While in one case I thought this deformity might be due to the contraction of an ulcer, in the other, the mucous membrane being smooth, the deformity was apparently congenital."

Mrs. H., aged 40, housewife, was admitted to hospital under my care on November 8th, 1897, with the following history: Two nights previously she was seized with a sharp spasm of pain in the right hypochondrium, radiating towards the umbilicus, and passing round to the right shoulder. It lasted two hours, increased in severity, and ultimately subsided with an attack of vomiting. She stated that nine years ago she had a similar attack to that described, which was followed by a second three weeks or a month later, but for the following five years she was free from pain or sickness of any kind, and up to the onset of the present illness only remembered having had one similar attack of spasm. On admission, the patient was slightly jaundiced, emaciated, and weak; the urine contained bile, and the motions were pale in character. Beyond tenderness on palpation over the region of the gall bladder, no other physical sign was elicited. The patient was under observation in the ward for ten days before operation, and during that time she had from two to three spasms of pain per day, followed by vomiting, some of these slight, others very severe, but with each successive attack the symptoms tended to become worse than its predecessor. I should have preferred to have delayed operation till these attacks of pain had subsided for a few days, but as there was no evidence of this occurring, and the patient was rapidly losing ground, I operated on November 12th, assisted by my colleague Dr. Gibb. The details of the operation were carried out on the lines described in the book already mentioned, by Mr. Mayo Robson, whom I had the great privilege of assisting in many of his gall-bladder operations during the period I acted as his private assistant. The gall bladder was found to be thickened and contracted, being firmly adherent to and tucked up to the under surface of the liver. It was distinctly hour-glass in character, and contained a thick, clear, and glairy mucus. Two calculi were removed from the proximal part of the gall bladder, which was separated from the distal by a narrow neck, the calibre of which would admit a long probe such as used in exploring the ducts. The distal portion and neck were excised, and the proximal part brought and anchored to the aponeurosis. The wound healed by first intention, and the gall bladder was drained by means of a rubber tube, which was removed three weeks after operation. During the first three or four

days after operation mucus was freely discharged, followed for two days by an admixture of mucus and pus, and latterly by pure bile. The opening into the gall bladder was completely healed six weeks after operation, and the patient was dismissed on the 8th, free from pain, improved in colour, and gaining weight and strength.

I cannot advance an opinion as to whether this condition of gall bladder was congenital or due to ulceration.

For notes on the history of this case I am indebted to Dr. Mackay, House-Surgeon.

TWO UNUSUAL CASES OF FOREIGN BODIES REMOVED BY THE AID OF THE ROENTGEN RAYS.

By R. BOLTON McCausland, SEN. MOD., M.D.T.C.D.,
F.R.C.S.I.,
Surgeon to Stevens's Hospital, etc.

SINCE the introduction of radiography into surgery many advances have been made in its application, but a great deal still remains to be worked out and perfected. I have not as yet been able to try any of the methods put forward by various authors, such as that of Dr. Davidson¹ or Dr. Harrison,² for localising and defining exactly the size of a foreign body, and at what depth it lies from the surface. From reports in the journals of a few successful cases, some of these methods seem to fulfil two conditions absolutely essential:

(a) To be able to plan the incision, so that with the least damage to the parts the object may be removed.

(b) To be able to say at what distance from the surface a substance lies—for example, whether in a joint or outside of it.

(c) A third essential would be to my mind rapidity in the method employed.

As I was the first surgeon in Ireland (on March 23rd, 1896, at Stevens's Hospital) to remove from a patient a foreign body, the presence of which was clearly shown in a radiograph taken for me at that time by Professor Barrett, Royal College of Science, Dublin, the subject of radiography has always had an attraction for me, and I have used it very extensively for many purposes.

Two cases have lately been under my care in hospital, and as they presented some points of special interest, I may be pardoned for briefly relating them.

CASE 1.—E. W., an epileptic from a convent in the south-west of Ireland was admitted to Stevens's Hospital on January 27th, 1898. She stated she had a fall (a fit?) a month previous to admission, with sewing in her hand, and that a needle had entered near the wrist of the right arm. On admittance the hand and forearm were swelled, the latter red-den and eczematous; and it presented five marks of incisions, previous attempts to find the needle, three of which were not closed and suppurating. Looked at with the barium platino-cyanide screen the needle was plainly seen in its entire length above the inflamed part of the forearm, about an inch below the elbow-joint, lying in front obliquely on the radius, but also a little over the interosseous membrane and ulna. It could be distinctly felt in one spot deep on the outside of the forearm, and could have been removed, but the girl would not allow it then.

She was prepared for operation next day (January 28th); but when the dressings were removed no needle could be felt with the most careful manipulation, so she was allowed back to the ward to recover from the anæsthetic. She was put on potassium iodide and ammonium bromide, but had some fits that day and the next, and on January 30th she was brought to the room to be radiographed. Unfortunately, owing to excitement, she had a fit before the radiograph was finished. She was removed to the ward again, and the plate when developed showed plainly that the needle had shifted from its original position and was now lying at the junction of the lower and middle thirds of the forearm.

By February 4th the fits had been got under control and the forearm was in a healthy condition; it was disinfected, and the girl was carried in a chair and the arm examined as before with the screen, the needle being now seen occupying an intermediate position to the two former ones. With a blue pencil, while the screen was being used, the line of the needle was easily drawn on the skin of the forearm, on back and front. She was at once anæsthetised, and the needle was without much difficulty removed by an incision 2 inches long from the outside of the forearm from underneath the supinator longus and extensor carpi radialis longior and brevior. Esmarch's bandage was not applied, fearing that it might move the needle; one vessel was twisted and the wound put up dry. The girl left hospital in ten days' time. The wound was soundly healed; the forearm was free from eczema and she had full use of the hand and arm. The needle was complete and measured 2½ inches long. It was blackened, as is always the case.

The special points of interest in this case seem to be: (1) The large size of the needle entire in length, which on

three different occasions, at intervals of a few days, distinctly shifted its position, once evidently from the washing and preparation of the arm for operation. (2) The number of operations prior to coming under my care. (3) The ease with which the needle was seen with the screen and accurately localised with a coloured pencil. (4) The satisfactory result of the operation as to use of hand and arm.

CASE II.—M. W., a servant, was admitted to Steevens's Hospital on Feb. 6th. She had fallen down stairs and hurt her knee some weeks previously. The knee was somewhat swollen, and a distinct irregularity was felt to the inner side of the patella which I was so sure was a needle or pin that I did not radiograph her. Under an anæsthetic I easily removed the pointed end of a needle, $\frac{1}{16}$ inch long, and put the leg on a splint. The girl was surprised when she saw the needle, being unaware that anything

CASE II.—Rough sketch of original radiograph.

had run into her knee. The wound healed at once, and when she was allowed up and had been walking about a few days, she still complained of pain and "a pricking feel," but more to the lower and outer part of the patella (same, left leg). I then radiographed the knee (15 minutes' exposure), and a foreign substance immediately showed when the plate was developed. Of course I thought the needle broke on penetration, and that I had left the eye end behind in the joint, though the radiograph did not give the appearance of a blunt end. Again, under an anæsthetic, with some difficulty, I removed a small portion of needle (see Fig.)—another pointed end. I treated the leg as before. The wound healed in a week; no fever, and the girl left hospital March 7th, with full use and movement of her leg, surprised at having had two parts of separate needles in her knee without knowing of the existence of either, and without any sign externally of the penetration of either.

REMARKS.

In the first operation I did not open the capsule of the joint, but the needle, from its position and length, must have been partly in the joint. In the second operation, which was much more difficult, I did open the capsule, but closed it under a constant stream of sterilised water, one stitch (silk-worm gut, removed the sixth day) having taken up the capsule. The wound was put up perfectly dry, a most important point I try to obtain in all operations, great and small.

REFERENCES.

BRITISH MEDICAL JOURNAL, January 1st, 1898, p. 10. ²*Ibid.*, February 12th, 1898, p. 431.

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

MEASLES IN AN INFANT: POSSIBLE INFECTION AT BIRTH.

On January 29th I attended Mrs. K., a healthy primipara, and delivered her of a well-nourished healthy female child. The puerperium was uneventful, and the mother nursed the child. The baby remained well till February 7th, the tenth day from birth, when it began to be indisposed and to sneeze; on February 10th, the thirteenth day after delivery, a well-developed eruption of measles covered all the body, the eyes were congested, the eyelids swollen, and the tongue covered with a thick fur; there was little cough. The eruption faded on the fifth or sixth day, and the infant made a good recovery, being kept in a warm atmosphere impregnated with steam.

There are two points of interest in connection with the case: first the extreme youth of the patient, and secondly, the fact that a case like this determines the incubation and invasion periods of measles with some exactness. The child sickened on the tenth day of its extrauterine existence, and had premonitory symptoms for three days longer before the eruption appeared. Hensch in his latest edition (*Vorlesungen u. Kinderkrankheiten*, 1897) gives ten days for incubation, and three to four for invasion; Osler (1897) practically agrees with this, while Ashby and Wright point out that if inoculated the disease may need only seven to eight days for incubation.

The only apparent explanation of the attack is that I conveyed the infection; inoculation through the severed umbilical cord could hardly have taken place, as my hands were washed repeatedly in corrosive sublimate lotion during the delivery.

Glasgow.

CARSTAIRS DOUGLAS, M.D., B.Sc.

AMMONIUM CHLORIDE IN THE TREATMENT OF TROPICAL DYSENTERY.

I HAVE had a goodly number of cases of acute tropical dysentery at the Police Hospital, Colombo, and also in private practice, which yielded very satisfactory results by the administration of ammonium chloride. I remember the first case I treated with this drug; I was surprised at the rapid disappearance of blood from the stools, and the freedom from abdominal pain. Since then I have always adopted this method of treatment with very good results. The salt was given in drachm doses every four hours, and the patient placed on milk and arrowroot diet. In the majority of cases blood was absent from the stools on the third or fourth day. In two cases, however, I had to resort to other remedies, which consisted in small doses of the extracts of opium and cannabis indica dissolved in about a wine glass of bee's honey and mixed with about a quarter of a fresh bael fruit, which is eaten at a time. The result is a rapid disappearance of blood from the stools. One case, a boy aged 92 years, was given his ordinary diet of rice and plantain curry on the third day after this treatment.

I agree with Dr. Wyatt Smith that ipecacuanha is "useless" in the treatment of tropical dysentery, but I differ from his opinion that opium is "positively poisonous." In my opinion opium should never be given in the early stages of tropical dysentery; its beneficial effects are only seen in the last stages when combined with cannabis indica, and when other drugs have failed.

While Dr. Wyatt Smith claims to place sulphate of magnesia as "practically a specific" in tropical dysentery, I must offer to place chloride of ammonium on the same list.

JOHN W. S. ATTYGALLE, M.B., C.M. Aberdeen.

Colombo, Ceylon.

THE next meeting of the Congress für innere Medicin will be held at Carlsbad. A proposal, brought forward at the recent meeting at Wiesbaden, that the meetings should be held at Wiesbaden and Carlsbad in alternate years, was negatived.