the same part of the left lung; these patches stood out a little from the surface, and were airless, friable, and sank in water, each was surrounded by a dark ring of engorgement, which merged into the healthy lung, and there was recent pleurisy over the pneumonic areas. All the other organs were examined, and showed considerable engorgement, but no special lesion was observed. The cervical, the axillary, and the lumbar lymphatic glands were slightly enlarged; the left iliac slightly enlarged, red, and soft; all the other glands, including the bronchial, looked absolutely normal.

Bacteriological Examination.—Cultures on agar-agar were made from the pneumonic lung and spleen, and ultimately a pure growth of the plague bacillus was obtained from each. Under the microscope the pneumonic patches in both stages showed an immense number of plague bacilli, and the rest of the lung showed a large number; the fluid in the trachea also showed very many; the spleen and blood showed a few; the left supra-trochlea and the left inguinal glands showed a fair number; and all the other glands extremely few.

This, then, was a case of plague, in which during life the symptoms pointed to disease of the lungs, and in which there were no evidences of glandular enlargement, whilst after death there was clear proof of enormous growth of plague bacilli in the lungs and of only very slight growth in the lymphatic glands. Up to the present I have made twelve *post-mortem* examinations on such cases, all presenting appearances similar to the above, and it is noteworthy that all the patients were brought to hospital supposed to be suffering from cough and fever, and their friends were quite unaware of the nature of the disease.

With regard to the clinical symptoms of these cases, the late Dr. M. died of this form of plague, and a few notes of his illness are subjoined:

On January 2nd, being in his usual health, he was seized with a rigor; fever came on, with nausea, vomiting, bad headache, and a tired, aching feeling in his limbs; his temperature soon rose to 103.4° , but his tongue remained clean and moist and his skin was not at all dry.

On January 3rd he had passed a bad night and felt worse, and the symptoms persisted through the day, temperature averaging 104° , pulse 110, respirations 23; in the afternoon he felt some pain at the lower part of the left axilla, just under the anterior fold, but there was no glandular enlargement or pain in the glands anywhere.

On January 4th had slept badly and felt worse, temperature 104.6° , pulse 114, respirations 25; tongue still moist, with a little fur behind, but no sordes about the lips or teeth. During the night he began to cough, and brought up some watery sero-mucous fluid slightly blood-tinged; the pain in the left axilla persisted, and at this spot the fine crepitations of early pneumonia could be heard; they could also be heard just below the left clavicle, but the rest of the lungs and other organs appeared to be normal, as did the lymphatic glands. The symptoms, however, were not like ordinary pneumonia, for the onset was different, the condition of the tongue and mouth different, there was no dyspnoea or pneumonic disproportion of pulse and respiration, and the sputum was not at all like rusty sputum, for it was loose and free, coming up with the slightest cough; it was watery, looking more like serum than mucus, and it was slightly pink, not rusty-yellow at all; also there was the striking fact that the patient's general condition was far worse than could be explained by the small amount of lung disease present; so I examined the sputum under the microscope, and found it full of bacilli, looking like those of plague, and cultures were made from it from which a pure growth of the plague bacillus was obtained.

During January 4th and 5th the patient became worse and worse; his expectoration continued profuse; temperature about 104° ; his respirations increased to 35 and 45, and the pulse to 120 and 135; the tongue became rather dry and furred, and he died on January 6th.

There is also the case of the nurse who attended on him, for she, unfortunately, died of the same form of plague; in brief, she became ill on the evening of January 7th, and showed symptoms of pneumonia on January 8th; she became rapidly worse, and died on the 10th; but her sputum was not nearly so profuse as in the former case, and exhaustion came on much earlier. She also had no glandular enlargement or pain whatever, and bacteriologically her sputum was exactly as described above.

This form of plague is highly infectious, and probably takes a large share in the spread of the disease; for in these cases the patients' sputum is practically a virulent pure culture of the plague bacillus, and as there is reason to believe that many of the cases are not recognised as plague at all, pre-

cautions are not taken by the patients' friends and the dangerous nature of the disease is not appreciated. I have no means of knowing how frequent this variety of plague has been in the present epidemic, but there is some evidence to show that a considerable number of cases have occurred.

Moreover, it seems likely that a ship's passenger suffering from this form of plague might escape detection by sanitary officers, and might be permitted to land at his destination as though he were the subject of simple pneumonia; and so a centre of infection for the spread of plague would be established.

With regard to the literature on this subject, I have not been able to find a published description of this variety of plague; but an allusion to it is made in the accounts of the Pali epidemic of 1836, and it is stated that the Astrakhan outbreak of 1877 was first regarded as croupous pneumonia or as typhus complicated by pneumonia; from the reports on the Hong Kong epidemic it appears that plague pneumonia did not occur there. There is just this to add: the usual definition of plague in works on medicine is—"A specific fever, attended by bubo of the inguinal or other glands;" but it seems that such a form of words does not include all varieties of the disease.

A CASE OF DISLOCATION OF PERONEI TENDONS TREATED BY OPERATION.

By G. MUNRO SMITH, M.R.C.S.ENG.,
Assistant Surgeon, Bristol Royal Infirmary.

It is stated that the peroneus brevis is more frequently dislocated than the peroneus longus, but in the following case both tendons were out of place. Although there was a rent

Dissection of peronei at external malleolus; at P is shown the area of periosteum which was dissected back and fastened to the fascia behind the tendons, the sheath is not shown. A, fibula; B, peroneus longus; C, tendo Achillis; D, fascia; E, peroneus brevis; F, fat; G, skin of heel.

in the sheath, it was the stretching of the latter which was the chief lesion. The groove behind the tibia was very

shallow, and covered with smooth fascia, to which the sheath was adherent.

L. B., aged 50, a labourer, attended as an out-patient at the Bristol Royal Infirmary, complaining of a dull aching pain in the right ankle with occasional sharp twinges whilst at work. On examination it was found that he had well-marked dislocation of the peronei tendons over the external malleolus. The tendons could easily be reduced, but the groove for their reception was shallow, and they soon sprang from their bed again. Rest and fixation did little good, so an operation was determined on.

In February, 1896, I made a long incision behind the fibula, and found both the longus and brevis tendons had slipped from their common sheath, which was torn and stretched. I sewed up the rent and stitched the sheath to the fibrous tissue behind its groove. After the wound was healed the patient was kept at rest for some weeks, and then allowed to get about in plaster-of-paris, and afterwards with a leather support. He returned to work, and was decidedly improved for a time, but the old pain returned, and last November he again came to me anxious to have something further done.

On November 30th I carried out the following operation. I exposed the sheath for about 6 inches, stitched up a rent about 2 inches long, and constricted the redundant tissue by catgut ligatures. I then peeled off from the malleolus an oblong piece of periosteum (marked in the Fig. at p), leaving it attached by one margin to the bone, and sewed it securely to the fascia behind the sheath, so that the piece of periosteum arched over the peronei tendons. I then put in three sutures into the sheath, and fastened it to some firm fascia behind the groove. The wound was sutured and dressed in the usual manner. When the incision was healed the leg was put up in plaster-of-paris for some weeks, and he then wore the same leather pad as before. He has now been at work for six weeks, and has felt no pain. The tendons appear to be firmly fixed in their groove.

The late Dr. J. R. Wood recommended tenotomy with fixation by plaster-of-paris in these dislocations, and M. Mollière has reported cases in which he has divided the tendon of the peroneus longus as it passes under the cuboid, and then thrust the tenotome into the sheath "to excite inflammation;" but although the usefulness of the foot does not seem to have been impaired by cutting the peroneus longus, yet this could not succeed in the above case, as both tendons were out of place. The result has so far been quite successful, but more time must elapse before a final verdict can be given.

SUCCESSFUL REMOVAL OF A CYSTIC ABDOMINAL TUMOUR FROM A CHILD AGED 7 MONTHS.

By JOHN CAMPBELL, M.A., M.D., F.R.C.S.ENG.,

Surgeon to the Samaritan Hospital for Women, Belfast, and Assistant Surgeon to the Belfast Maternity Hospital.

A FEMALE child, aged 7 months, was sent to me by Dr. Creery, of Coleraine, and Dr. Martin, of Portrush, on July 8th, 1896. I am indebted to Dr. Creery for the history of the case, and for the photograph after operation.

History.—The labour was difficult, forceps being applied high up. The child thrived well, and was apparently healthy at the age of 3 months, but about a month later the mother noticed swelling of the abdomen, which gradually increased. Periodical attacks of violent colicky pain also occurred.

Condition on July 8th.—The general nutrition was good. The respirations were shallow and embarrassed. The abdomen was greatly distended by a lobulated tumour, which was more prominent on the left side, and felt hard in its upper half, but soft and fluctuating below. There was dullness on percussion all over the abdomen except in the right hypochondriac region, which was resonant.

Operation.—On July 10th chloroform was given by Dr. McKinney and the accompanying photograph taken by Dr. Cecil Shaw. A median incision was then made from midway between the ensiform process and navel to midway between the navel and symphysis pubis. This exposed a large tumour lying behind the posterior parietal peritoneum and pushing the intestines into the right hypochondrium. The cystic portion having been tapped, the whole mass was enucleated from the subperitoneal tissue. No bleeding of consequence occurred and no ligatures were needed. The tumour had no pedicle, but was more firmly attached deep in the left side of the pelvis than elsewhere. It lay in front of the left kidney, which was situated at the level of the iliac crest and was freely movable. The peritoneal covering of the tumour was attached to the edges of the lower end of the abdominal wound and the cavity was packed with gauze. The upper end of the wound was closed by two layers of

suture, silk being used for the peritoneum and silkworm gut for the skin and aponeurosis. The operation was well borne, except for a few seconds during the extraction of the tumour, when the pulse became bad, apparently owing to pressure on the cardiac area of the diaphragm.

Fig. 1.—Before operation.

Subsequent History.—Two hours after operation the child took milk and barley water, and was thenceforward fed regularly every two hours. Fifteen-minim doses of whisky were given every half hour for the first three hours. The child slept well. She vomited slightly on one occasion only. On the sixth day the gauze packing was removed, and the bowels acted spontaneously. On the eleventh day the silkworm gut stitches were removed. The wound was then healed except where the drain had been. At the end of a fortnight the child went home. Three months later the silk stitches began to come away. On December 16th, five months after operation, I saw the child in excellent health, though all the silk had not separated. One photograph was taken on July 10th, just before the operation, and the other about four months afterwards, in November, 1896.

Fig. 2. After operation.

Structure of Tumour.—The tumour was composed of a cyst containing about 10 ounces of clear yellow fluid, and of a solid portion, in which a mass of cartilage and a piece of bone lay embedded. It weighed 3 lbs. when fresh. There was nothing to indicate the organ from which it originated. Dr. Lorrain Smith was so kind as to examine it for me.

REMARKS.

This appears to be the youngest child from which a cystic abdominal tumour has ever been successfully removed. The only case which approaches it in point of youth is that operated on by Roehmer, of Berlin, in 1883, at the age of 20 months. The present case is, therefore, 13 months younger than the Berlin one.