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.

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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.