of a few teeth, which are connected with their neighbours by sharp points or hooks. In the case I record below the patient had been for many years in the habit of wearing three artificial incisors attached to a plate which had been broken some months previously, and which from motives of economy she had neglected to get repaired.

History.—E. R., aged 33, who was not in the habit of removing her teeth at night, woke up early in the morning of October 30th, 1897, with a very sore throat, and found that she had lost her teeth. As she was subject to occasional epileptic attacks she concluded, "as she felt so bad," that she had had one during the night and had swallowed her teeth. She sent for her doctor, who advised her to take nothing but gruel, but she found that swallowing was so painful that she took "hardly anything." Thirty-six hours afterwards her breath began to get short, and this gradually increased for the next twenty-four hours, when she applied at the hospital for admission.

State on Admission.—The patient was a healthy looking woman with a distinctly anxious expression accompanied by slight cyanosis. There was marked stridor, respirations 28, pulse 110, no cough. Laryngoscopic examination showed nothing abnormal. There was distinct diminution of resonance at both pulmonary bases for about three finger-breadths and the breath sounds over this area were very feeble. Elevation of the ribs was fair, but there was little expansion. On examining her throat externally she complained of marked tenderness, much increased by pressure, about one inch below and to the left of the cricoid, at which point there was a distinct fulness to be felt on deep pressure. A bougie passed $7\frac{1}{2}$ inches when it was distinctly stopped. The veins of the neck were abnormally full.

Operation.—As there seemed but little doubt that her teeth were firmly impacted in the œsophagus, and were causing laryngeal obstruction, she was advised that an œsophagotomy was necessary and to this she readily consented. She was accordingly put under chloroform, and I proceeded, assisted by Dr. Holman Weekes, to make an incision about $3\frac{1}{2}$ inches in length, along the anterior border of the left sterno-mastoid muscle, commencing about half inch above the upper border of the thyroid cartilage. The common carotid sheath was then gradually exposed. The sterno-mastoid muscles having been drawn outwards together with the large vessels, and the omohyoid muscle hooked down, the trachea and œsophagus were defined and the former having been pulled over to the right and all venous oozing, which on account of the interference with respiration was of a rather free character, stopped, the foreign body could be easily felt about three-quarters of an inch below the cricoid, bulging towards the posterior surface. A sharp point which had almost penetrated the œsophageal wall could be detected and a vertical incision of about an inch having been made over it, the plate was easily extracted. At the moment of extraction the venous bleeding was well marked, but firm pressure being applied for a few minutes it gradually, as respiration became freer, ceased. The point had almost ulcerated through the œsophageal wall, which was quite rotten, and about a teaspoonful of pus escaped when it was incised, and therefore no attempt at stitching up the gullet wall was made. A drainage tube was inserted from the opening in the œsophagus to the lower end of the wound, what was then stitched up.

After-History.—The patient soon recovered from the shock of the operation and expressed herself very grateful for the relief she experienced. She was encouraged to sit up in bed as much as possible, but no attempt at fixing her head was made. She was fed entirely by means of suppositories and nutrient enemata, and she seemed to be doing so well and suffered so little from thirst that no attempt at feeding her by the mouth was made until the sixth day, when she was given a little milk, the greater part of which, however, ran through the tube in her neck. During the first few days the discharge was of a rather free character, but after the fifth day it gradually decreased, and the tube, which from this time was shortened every other day, was eventually removed on the fourteenth day. The wound above the tube healed by first intention, the stitches, twelve in number, being removed on the ninth day. The patient seemed so comfortable and her strength was so well maintained that no further attempt to feed her by the mouth was made until the seventeenth day, when she was found to swallow fluids comfortably, and she has experienced no difficulty or discomfort during deglutition from that time. The wound was soundly healed on the twenty-third day, and she was discharged from hospital four days later.

Description of Plate.—The plate was of an irregular quadrilateral shape and measured $1\frac{1}{4}$ inch from before backwards and about $\frac{3}{4}$ inch from side to side. It carried three incisors, and attached to the inner of these was a sharp gold spike by which it was connected to the neighbouring tooth. It was obviously this spike which, by penetrating the œsophageal wall, had prevented its further passage to the stomach.

PRIMARY TUMOUR OF RIGHT AURICLE OF HEART, RUPTURE OF INFERIOR VENA CAVA.

By NATHAN RAW, M.D., B.S., F.R.C.S. EDIN.,
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PRIMARY tumours are exceedingly rare in the heart. According to Berthensen the structure in 30 published cases of primary tumours of the heart was as follows: Sarcoma 9 (pure sarcoma 5, fibrosarcoma 3, myxosarcoma 1), myxoma 7 (pure myxoma 4, fibromyxoma 3), fibroma 6, syphilitic tumours 2, cancer 3, lipoma 2, cyst 1. Pawlowski only succeeded in collecting 3 cases of fibroma of the heart. The patient from whom this interesting tumour was taken was a charwoman, aged 43, admitted under my care into the Mill Road Infirmary on January 11th, 1898.

HISTORY.

She first complained of pain in the chest, with dyspnoea on exertion, and had to sit up in bed at night $3\frac{1}{2}$ years before admission. This continued without intermission, although she was able to do a little work until 2 months before admission, when she was seized suddenly with great pain in the right chest, which prevented her breathing for a time. She has been addicted to alcohol for some years. There was no history of syphilis.

CONDITION ON ADMISSION.

She was a stout, muscular, well-nourished woman, although she said she had lost flesh lately. She had an anxious expression, could not lie down in bed, and had great dyspnoea of a spasmodic character. There was moderate ascites and œdema of the lower extremities; the most notable feature was the enormous enlargement of the superficial veins of the thighs, abdomen, and thorax, which formed two columns on either side of the middle line of the abdomen. They were very tortuous, but the current of blood in them was towards the heart. This condition of veins at once suggested the probability of the inferior vena cava being occluded at some part of its course near the heart with anastomoses between the superficial epigastric and long thoracic and internal mammary and intercostal veins. The right side of the chest was almost immobile and completely dull to percussion both back and front, with absence of breath sounds, and all the symptoms of effusion. The left lung was normal. The heart was displaced outwards considerably. Its action was quite regular, and there was a soft blowing systolic murmur heard at the base and conducted up the sternum for 2 inches and outwards into the axilla and back. The liver was pushed downwards, forming a rounded prominent tumour in the epigastrium, the lower edge was rough and nodular, and extended to within 1 inch of the umbilicus; the abdominal cavity contained a fair quantity of fluid.

AFTER-HISTORY.

The right pleural cavity was aspirated and 61 oz. of what appeared to be pure blood withdrawn. This gave the patient considerable relief and her dyspnoea subsided, allowing her to lie down in bed. There was a slight attempt at expansion of the lung and the dullness disappeared to some extent, but it soon became absolute again, and as we evidently had a hæmothorax to deal with I did not think it desirable to aspirate again. The temperature ranged between 99° and 101° . The pulse was 100 and the respirations 24.

The chief points of clinical interest in this case then were: The great dyspnoea and inability to lie down in bed, much more pronounced during the night; the complete filling of the right pleural cavity with blood, the enormous distension of the superficial veins of the abdomen, thorax, and lower extremities, the general œdema with ascites, and the displacement of the heart and liver, which was enlarged and nodular. The kidneys were apparently healthy, as the urine was normal. The diagnosis was difficult, but after a careful consideration of the points mentioned I was of opinion that she had a new growth in the lung or mediastinum with probably secondary deposits in the liver, and that the growth in the chest was pressing on the inferior vena cava before or at its entrance into the auricle. The diagnosis however in many points proved to be wrong. The progress of the case was short and uneventful. There was latterly great pain on pressure over the precordia, the dyspnoea increased, and she died on February 16th from syncope.

Necropsy.—At the necropsy, twelve hours after death, the body was enormously distended with gas, the parts chiefly affected being the neck, the upper part of chest, the stomach, and the liver. The extremities did not contain gas; when liberated it was not offensive. The blood was carefully examined and stained, when enormous numbers of the bacillus *aërogenes capsulatus* were found, thus accounting for the rapid gas formation after death. The bacilli were in larger numbers in the blood from the liver, but could be obtained from the blood of any part. On opening the chest the right pleural cavity was found to be quite full and distended with dark-coloured fluid blood, with here and there a few clots, the amount being between 6 and 7 pints. The heart was displaced outwards. The right lung was collapsed, and pressed against the vertebral column towards the apex of the cavity.

The left lung was enlarged and emphysematous in front, deeply congested at the base. The abdominal cavity contained 2 pints of blood-stained serum; the liver was much enlarged, and extended nearly down to the umbilicus. It was nodular, and presented the typical appearances of cirrhosis. On palpating the liver it was found soft and yielding, and distended with gas; a cross-section showed numerous distended veins. The kidneys, spleen, and brain were normal. A point of great interest was the great enlargement of the lumbar veins, while the inferior vena cava was almost empty in the greater part of its course, and contained a large organised thrombus in its upper third, almost completely occluding its lumen.

After removal of the blood from the right pleural cavity, the heart was examined before removal from the chest, and a distinct rent was seen in the inferior vena cava just before its entrance into the auricle and above the diaphragm. The heart, liver, and lungs were removed together. A large, hard tumour, measuring $3\frac{1}{4}$ inches in its longitudinal and 3 inches in its transverse diameter, occupied the right auricle and distended it greatly. It was firmly adherent to the wall of the auricle at its upper half and free below. At the inner side of the tumour was a thin calcareous plate. The growth directly extended down the course of the inferior vena cava as a dense hard mass $1\frac{1}{2}$ inch thick, quite nodular, and terminating on the under surface of the liver as distinct and separate hard nodular masses as large as walnuts. These separate growths had no direct connection with the primary growth in the auricle. The tumour was hard and difficult to cut, and quite solid. Histologically it was a section composed almost entirely of fibrous tissue, the cells of which were very unevenly distributed. The cells were elongated or spindle-shaped throughout the section, but in places, especially near the margins of the growth, there were numerous clusters of round cells. The general appearance of the sections was that of pure fibroma, but the macroscopic characters suggested a distinct metastasis in the form of separate growths on the surface of the liver. This, together with the rich distribution of small round cells, as seen in the sections, suggested a fibrosarcoma.

The sections of the secondary growths showed precisely the same appearances as the primary tumour. The wall of the auricle was stretched to such an extent in places as to be only the thickness of paper, and was with difficulty stripped from the growth. The whole of the body was carefully searched, but no other evidence of new growth could be found.

Peter Neu, in a dissertation to the University of Bonn on sarcomata of the heart, has collected 14 cases, 5 of which were primary and 9 secondary. Of the primary cases 3 were in the right auricle, the other 2 being in the septum ventriculorum.

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MEMORANDA:

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

CASE OF EXCISION OF A LARGE TUBERCULOUS MESENTERIC ABSCESS.

On August 12th of this year, C. M., a boy aged 4 years, was brought to me by his mother, at the request of Dr. Montgomery, because of an abdominal tumour. The history given was that until two years ago he was quite healthy, and throve

well. At that time he suffered from an attack of jaundice. This passed off, but he remained very weak in the limbs, and heartless. Last summer, however, he improved very much in health, and was now stronger and better than he had been for some time. A week before coming to see me there was noticed for the first time a "hard lump in the belly." It apparently gave the boy no inconvenience, and was quite painless. His appetite was good, his bowels were regular, and he slept well. The family history was satisfactory.

The patient was a pale but well-nourished boy, and his general appearance was healthy. The chest and heart sounds were normal, and the urine was free from urine and sugar. On examination of the abdomen it appeared unduly prominent towards its lower part, the prominence being best seen when the patient was standing erect. On palpation a smooth, globular, elastic swelling could be felt lying in the middle line in the umbilical region. It felt about the size of a cocoa nut, and occupied an area immediately below the umbilicus. It was anchored down at its deepest part, but could be moved from side to side. A catheter passed into the bladder made no alteration in the size of the tumour.

I advised an exploratory laparotomy, which was done on August 20th. The abdomen was opened in the middle line below the umbilicus. On cutting through the peritoneum the tumour appeared as a smooth, glistening, bluish grey structure, with numerous small vessels ramifying over its surface. The abdominal incision was then extended upwards and downwards (to 4 inches in length). While proceeding to separate some adherent omentum from the surface of the "tumour," a gush of pus took place from it. The rent from which the pus was escaping was grasped with forceps, and as it was evidently a tuberculous abscess that had to be dealt with, I decided to remove the abscess wall entire. This I accomplished after considerable difficulty, owing to adhesions between it and the neighbouring coils of intestine. It had apparently originated in one of the mesenteric glands, and in this region I had to use scissors freely to get it clipped away. Some neighbouring mesenteric glands were found enlarged, but were not further dealt with. The abdominal cavity having been carefully cleansed, the wound was closed without any drain.

There was considerable shock after the operation, but this soon passed off. The wound healed by first intention, and the boy is now (September 23rd) well and running about. It will be interesting to watch the future progress of the case as regards the effect of the abdominal section on the remaining enlarged glands.

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GEORGE THOMAS BEATSON, M.D.

PERINEPHRIC ABSCESS, WITH COMA.

Mrs. M., a well-developed and well-nourished woman, married but no children, consulted me on September 3rd, 1897, complaining of a dull aching pain in the right lumbar region of two days' duration, which she described as due to rheumatism. There was elevation of temperature (101.2°), and a pulse of 110. From this time the pain continued, and the temperature, which gradually rose, fluctuated between 102° and 104° . The patient had an enlarged spleen, and twelve months previously had passed a large quantity of blood *per rectum*. She had had not felt pain in the lower part of the abdomen or in the region of Poupart's ligament. There was no history of injury and no urinary symptoms. Examination over the seat of pain revealed the absence of oedema, tumour, and redness, and there was no flexion of thigh at the hip-joint.

Two days after I was called in the patient gradually became comatose, and remained so for five days, when she appeared to be sinking. There were no optic changes.

On the sixth day, after seeing her, when she was in a very low way, with a feeble flickering pulse which could not be counted, and a temperature of 104.2° , I decided to operate, and made an incision over the outer border of the right quadratus lumbus muscle, and then, passing a large aspirating trocar deeply, I discovered pus. On enlarging my incision I evacuated two pints of stinking green pus, which, on microscopic examination, was not found to contain any bony debris.

I drained the abscess cavity, and in the course of the next two days quite 2 pints of similar pus were evacuated. From this time the temperature slowly fell, but fluctuated between 100° and 102° until the 16th, when it became normal and