Such instances as the foregoing seem to me to prove the hereditability of the disease. It is obviously impossible in most of them that the malady could have been acquired from a common source of infection, and no fortuitous circumstances will explain such concurrences.

A remarkable feature about many cases of inherited cancer is that like normal structure it is homotopic in its transmission; that is, it attacks the corresponding organ in each of the related individuals. This is especially noticeable in Sibley's case, where the mother and her 5 daughters all had cancer of the left breast.

Although this form of transmission often defaults, it is, nevertheless, noteworthy that on the average—taking all the seats of inherited cancer into consideration—homotopic transmission preponderates. Thus my analysis of the family history of 136 women with mammary cancer shows that of the 48 seats of inherited cancer the breast was the part affected in 19.

EXTRAUTERINE PREGNANCY: FIVE MONTHS FETUS: PLACENTA IMPLANTED ON ANTERIOR ABDOMINAL WALL: OPERATION: RECOVERY.

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History.—A. K., aged 28, and married three years and a half, had had no child and no miscarriage. She began to menstruate at the age of 17, and the discharge thereafter recurred regularly until March, 1898, during which month and the four succeeding months (April, May, June, and July) it did not appear. A hæmorrhagic discharge from the vagina was observed on August 8th and 9th, from August 24th until August 31st, and again from September 5th until September 24th, when the fœtus and placenta were removed by abdominal section. Menstruation had always been accompanied by pain, and in March, when the menstrual discharge should have made its appearance, pain similar to that usually experienced during menstruation, but more severe, was then complained of. Little or no pain was complained of during April, May, June, July, or August. On September 2nd patient was suddenly seized with severe pain in the left iliac region, but she has been, comparatively speaking, free of pain since this date. Almost immediately after the menstrual period was missed in March patient began to be sick in the morning, and this symptom persisted until the end of April only. During March and April pain was experienced in the hypogastrium during micturition. The abdomen has increased in size since April.

Physical Signs.—The abdomen below the level of the umbilicus is prominent; the left half is markedly more prominent than the right. Palpation reveals the presence of a somewhat pyriform tumour, which extends from the left anterior superior spine of the ilium to within 2 inches of the same anatomical mark on the right side. The larger end of the tumour is located in the left abdomen, and its upper border here reaches to the level of the umbilicus, whilst the upper border on the right side falls short of this level by 2 inches. The left portion of the tumour is smooth and appears to be solid, whilst the right half is slightly irregular and appears to be cystic. No sounds are heard on auscultating the tumour. Colostrum is obtained readily from both breasts. The cervix uteri is located far back towards the hollow of the sacrum; it is not enlarged and the os is not open. The vaginal roof anteriorly and on the left side is pushed down by a swelling which is a portion of the abdominal tumour. The body of the uterus is incorporated with the abdomino-pelvic tumour posteriorly. The pulse is 72 a minute and the temperature normal.

Operation.—The abdominal wall was incised mesially from $1\frac{1}{2}$ in. below the umbilicus to within 1 in. of the pubes. The upper portion of this incision opened the peritoneal cavity to the extent of about 1 in. The tumour was carefully incised below the peritoneal reflection. It was then observed that the placenta was implanted on the anterior abdominal wall and extended some inches to the right and left of the abdominal incision. I separated the placenta extensively from the abdominal wall, but as I failed to reach satisfactorily the

free margin of the placenta and feared I might injure the bladder by persisting, I broke through the placenta at a spot opposite the abdominal incision and delivered the fœtus, head first, through this breach. The remaining portion of the placenta was thereafter separated and removed. The fœtus, 5 months old, which had probably been dead 6 or 7 weeks, had been lodged in the substance of the left broad ligament, and had separated the bladder from the uterus. The cavity in the broad ligament was plugged with cyanide gauze, which was removed twenty-four hours after the operation. Convalescence proceeded uninterruptedly.

Remarks.—It is highly probable that by rupture of the Fallopian tube the ovum escaped into the substance of the broad ligament during the fourth week after conception, or at least some days before the placenta had begun to be differentiated. No hæmorrhage from the uterus occurred until the fœtus was dead and no decidual shreds were ever observed. No spurious labour pains were experienced, and in none of the full-time extrauterine pregnancies which have come under my care have pains of a labour-like character been complained of.¹ Although the fœtus had been dead 6 or 7 weeks before it was removed there was no evidence of any constitutional disturbance, the pulse and temperature even were normal. Morning sickness was a troublesome symptom for about 7 weeks, and was noted first soon after the menstrual period was missed in March. The implantation of the placenta on the anterior abdominal wall centrally proved a troublesome complication at the time of operation.

REFERENCE.

¹ See A Study of Four Cases of Full-time Extrauterine Pregnancy. *Edin. Med. Journal*, August, 1898.

MEMORANDA:

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

THE TREATMENT OF ECZEMA.

FROM time to time one sees in the BRITISH MEDICAL JOURNAL and in other papers references to special treatment of eczema. In the EPITOME of November 12th, for instance, occurs a paragraph on the treatment of chronic eczema by iodine. The time seems opportune for me to emphasise what is practically the essence of treatment for this disease.

Antiseptic Remedies.—Silver nitrate I discarded for iodine nearly ten years ago, but for the time I used it I must speak favourably of its efficacy. The solution of iodine which I adopted and have since used is one of 100 gr. of the metal dissolved in 1 fluid ounce of spirit, with potassium iodide and ether. This solution may be used in most stages of the disease, even when the skin is much fissured and inflamed, especially if its application is preceded by brushing the part to be treated with a solution of cocaine hydrochlorate (4 per cent.). Thickening of the skin I soften by strapping with "infirmity strapping" previous to applying the iodine, but this proceeding is not often necessary. More often I apply the iodine solution and over the painted part apply the strapping. By this means an iodine vapour bath is ensured. Copper sulphate is a good remedy when used over small areas, such as the fingers. After smoothing the fingers with soap and pumice-stone, I rub on the blue-stone. The immediate effect is painful, but the resulting cure is rapid. When eczema has almost recovered there are often foci of inflammation left, which seem to reinfect the recovering surface. These must be cauterised, and for that purpose I prefer strong carbolic acid lightly applied.

Exclusion of Air.—When the skin is healing is the time to dust over the surface with calomel or cover over with some air-excluding medium. For the horny eczema which occurs readily on the hands and forearm a frequent application of common paraffin oil is very useful. It is to be washed off by means of soap and warm water shortly after each application. On some large surfaces I have begun with a spray of ethyl chloride, followed by painting with collodion flexile. By excluding air some cases have recovered without further application.