middle line and down into the left iliac fossa. She complained of pain in the left iliac region and frequent micturition, accompanied by a bearing down pain. The tumour was slightly mobile, and was dull in the flank as well as elsewhere. The urine was normal. The diagnosis lay between hydronephrosis and an intra-abdominal cyst. Chromocystoscopy was resorted to, when both ureters were seen to be expelling coloured jets of equal intensity and equal frequency. The renal origin of the tumour was, therefore, negative, and the abdomen opened to the outer side of the left rectus muscle. It turned out to be a mesenteric cyst—one of the rarest of abdominal tumours. The contents consisted of the usual milky fluid. It was drained, and three months later, when the cavity had shrunk and it appeared that it would not close if left to itself, it was successfully dissected out. The cyst had taken its covering from the left layer of the mesentery, and had compressed the descending colon into the loin, thereby preventing gas from accumulating in that viscus and accounting for the absence of resonance in the flank.

I will not weary you by detailing any more of the many instances in which I have found chromocystoscopy of use in my practice during the last few years, for I think I have offered ample evidence in support of the proposition with which I started—namely, that the method is deserving of more extended recognition and general application than is the case at present. Indeed, I would go further, and urge that it should be included in the routine course of examination of all renal cases before operation, and of all abdominal tumours where there is the smallest possibility of their renal origin.

CYSTIC DISEASE OF KIDNEYS WITH PYURIA AND HAEMORRHAGES.

BY

T. CARWARDINE, M.S., and G. P. BLETCHLY, M.B.,
BRISTOL. NAILSWORTH.

The following is an interesting summary of a case of cystic disease of the kidneys, in which a correct diagnosis was arrived at during life, although no tumour could be felt. In an analysis of 62 such cases by Lejars, a correct diagnosis was made during life in only 5 of them, and a tumour was present in only 18.¹ The case also has some bearing on the relationship of malaria to the disease. "Michalowicz considers that malaria contributes in a distinct manner to cystic degeneration both of the liver and kidneys."²

Whenever pyuria occurs in association with the general symptoms and signs of chronic interstitial nephritis, there is a probability of cystic kidneys; particularly if any other congenital malformation be present.

C., three months before his death at the age of 11, was seen in consultation with Dr. Bletchly, who has kindly furnished most of the particulars.

His mother had malaria before he was born, and though seeming all right at birth, he had "malaria" within six weeks, with temperature reaching 106° and extreme emaciation, but rapidly got well under treatment by quinine and change of air. At 5 months he had inflammation of the bowels and lung. He was subsequently in India till the age of 4, and it was found that he had an undescended testicle. At the age of 5 the undescended testicle was removed by Mr. E., and the wound finally healed after two or three months.

At the age of 6 it was noticed that his urine was offensive from time to time, and during these attacks his vision was bad and he was fidgety and irritable. At 8 he could not see properly, being apparently very near-sighted. He consulted Mr. B., who referred to bacilli in the urine.

At 9 his eyes were examined by Mr. C., who reported: Fundus suggestive of albuminuric retinitis; one or two haemorrhages in left eye; left optic post-neuritis; suggestions of old trouble and recent also; fields of vision narrowed in both eyes, more so in the left; signs like albuminuric retinitis, but equivocal. His urine was then examined on two occasions, and on each it contained numerous pus cells and sluggish motile bacilli, but no casts, blood cells, or renal epithelium.

At 9½ years he was seen by Mr. M., who examined him under an anaesthetic; found the bladder normal, the kidneys not enlarged, and diagnosed pyelitis. The urine was then acid, with a trace of pus, red blood cells, many bacteria (not tubercle bacilli), and a small number of hyaline casts. He then had measles, and returned to school six months ago looking well.

Two months ago he appeared to have slipped from the steps of a swimming bath, and was at the time thought to have meningitis. His urine had been very bad previously. He had no "fit," but is said to have drawn both arms up, screwed his face, and to have fallen off; then he scrambled and fell off again, and later shook his arms up and down. He was very ill afterwards; once fell out of bed, had severe right frontal headache for some time; there was no sickness or delirium,

but temporary retention of urine. Paralysis was noticed ten days after the fall, gradually diminishing.

Up to this time the pyuria and the central nervous condition had not been referred to a common cause, the former having been rather attributed to infection of the bladder from the sinus remaining after removal of the undescending testis.

Three months before death there was slight albuminuria; the heart's apex was external to the nipple line, and the pulse of high tension. There were paresis and slight wasting of the left face, arm, and leg. The knee-jerks were increased, more so on the left; and Babinski's sign was present on the left side. We thought the condition due to cerebral haemorrhage, and argued that the only possible common cause for this and the pyuria would be congenital cystic kidneys, although the kidneys could not be felt. There supervened orthopnoea, sickness, slight haematemesis, cardiac dilatation with enlarged liver and pulmonary congestion, scanty urine, and he eventually died in syncope.

Post-mortem Examination (Dr. Bletchly).—No meningitis; right convolutions somewhat flattened. Evidence of old haemorrhage into the right lateral ventricle. No abscess or sinus in connexion with the scar of operation for undescended testis. No cysts in liver. Right kidney: Very small, only capsule and a little fibrous tissue in the lower half; and the upper part was very small, with capsule adherent, and a few cysts on the surface containing clear fluid; ureter small but patent. Left kidney: Larger than normal; a few small cysts on surface, extending into the cortex; capsule adherent; cortex ¼ in. thick; kidney substance very hard; a little pus in the renal pelvis; ureter patent. No other sign of pus; bladder walls thickened.

REFERENCES.

- ¹ H. Morris, *Surgical Diseases of the Kidney and Ureter*, 1901, i, 558, 652.
- ² *Ibid.*, p. 656.

A CASE OF TORSION OF THE GREAT OMENTUM AND HABITUAL PARTIAL REDUCTION EN MASSE.

BY

EDRED M. CORNER, and LEONARD GRANT,
M.C., F.R.C.S. M.D.,

CONSULTING SURGEON,
PASSMORE EDWARDS HOSPITAL,
BOWES PARK, N.

SURGEON,
PASSMORE EDWARDS HOSPITAL,
BOWES PARK, N.

By collecting all the records of omentum torsion in some papers published with Dr. Pinches in 1905 and 1906,¹ it was found to be in reality by no means such a rare occurrence as had been thought, the real reason for its apparent rareness being that it was very easily overlooked. Having had a typical case under our care lately in the Passmore Edwards Hospital, Wood Green, we have decided to publish it, so as yet again to draw attention to the subject of torsion of the omentum and the type of case in which it will be found most frequently. In 1905 Dr. Pinches and one of us stated that "torsion should be looked for carefully in all epiploceles of old standing, especially when painful, irreducible, subject to attacks of pain, or strangulated."

Torsion of the omentum most frequently occurs in association with an inguinal hernia of old standing, which contains only omentum. This is the class of case in which, not only is it most frequent, but when it is most easily overlooked. There is a clinical feature which is useful to direct the surgeon's attention to the possibility of torsion when operating on an omental hernia associated with symptoms of subacute strangulation—namely, if the neck of omentum be easily moved within the inguinal canal, which is consequently loose and not strangulating the omentum. Therefore, when the cause for the symptoms is not found in the strangulation of the hernia, let torsion of the contents of the sac be carefully looked for.

The patient was a man, B., aged 54, who had had a left inguinal hernia for forty years. For thirty years he had worn a truss, and for the last seven years had been unable to reduce all the contents within the abdomen. He had had occasional pain in the hernia, but never anything so severe as the attack to be described. On June 5th, 1908, he went to bed in his ordinary health, and was awakened early in the morning with severe pain in the hernia, which had become greatly increased in size. There was no sickness, and the bowels were inactive, though flatus was passed. For thirty-six hours he lay in bed with the pelvis well raised and hot applications to the part, which became gradually reduced to its normal size, a portion remaining irreducible. He was seen by Dr. Grant on the night of June 7th, when the pain had very largely diminished, the temperature was normal, and the pulse quiet.

Five days later he was anaesthetized by Dr. Fergusson in the hospital. He was a short stout man, and under the anaesthetic

the omentum was still irreducible. Before anaesthesia was complete it was found that there was a distinct and tender rounded swelling in the lower part of the hernia, just above the testicle, which could be felt to contain two or three hard tender masses of different size.

An incision was made over the swelling and extending up on to the abdomen, and the upper loculus of the sac (c in figure) opened. The contents within it were normal omentum, more of which could be easily withdrawn from the abdomen through the neck (B), which was not strangulating the omentum. Though it was possible to withdraw omentum from the abdomen through the neck B, it was impossible to withdraw it through the neck D from the loculus E. In consequence the incision in the sac had to be enlarged with scissors and the neck D divided. On withdrawing the omentum from the loculus E, it was seen to be smooth, swollen, not adherent, and twisted once on itself, untwisting as it was released. Interlocking ligatures were placed on the stalk of the omentum which had been in the neck B, and the distal part removed. The sac was then freed, divided, and the proximal end closed. The inguinal canal was sutured with silk after the manner ascribed to Fergusson. The skin wound was closed with silkworm gut. The wound healed by first intention; later on an abscess containing fat globules discharged from the depths of the wound, and a mass could be felt in the abdomen, which was probably the inflamed end of the ligatured omentum, epiploitis.

A few years ago we operated on a somewhat similar case of painful irreducible epiplocele, but at the operation observed no torsion. It is of interest that the authors should have some difference of opinion as to the presence or absence of torsion at the point B in the illustration. There is no doubt about that at D. But this shows how easy it is to miss or be uncertain about the smaller degrees of torsion.

Dr. A. B. Howitt and one of us have recently published two elaborate papers¹ upon the subject of the reduction *en masse* of herniae. Amongst other things, we urged that if by reduction *en masse* was meant the reduction of the hernia with its sac, its occurrence, partial or complete, was frequent enough in the habitual reduction by the patient of omentum, large bowel, and other herniae. The hernia recorded in the present communication had been only partially reducible for seven years. It had been seen when partially reduced, and it could be ascertained that the loculus E alone was completely irreducible. True, it took some time to reduce loculus C. But it could be done. Reference to the figure shows that the portion B—D was reducible *en masse*, sac and all. Therefore we would urge that the loculus E was probably the original sac of the hernia, that D was its neck, and that the loculus C and its neck B were acquired later. A proposition which might shed clinical light upon the suggestion that all herniae have preformed sacs.

REFERENCES.

¹ *American Journal of Medical Science*, 1905, cxxx, pp. 314-329; *St. Thomas's Hospital Reports*, 1904, xxxiii, pp. 435-475; *Medical and Chirurgical Transactions*, 1905, lxxxviii; *Transactions of the Clinical Society*, 1905, xxxix, pp. 21-25. ² *Annals of Surgery*, April, 1908, pp. 573-587; *St. Thomas's Hospital Reports*, xxxv, 1906, pp. 439-458.

By way of marking the completion of the improvements at the Seamen's Hospital, Greenwich, its chairman and committee were "At home" on October 28th. The improvements have been of the sanitary arrangements and minor structural alterations calculated to facilitate the efficiency and ease with which the work of the institution is performed. Towards the cost King Edward's Hospital Fund for London subscribed £2,000.

CANCER IN TRAVANCORE, SOUTH INDIA.*

A SUMMARY OF 1,700 CASES.

By WILLIAM C. BENTALL, L.R.C.P. AND S.E.,

SURGEON TO THE FIFTEEN HOSPITALS OF THE SOUTH TRAVANCORE MEDICAL MISSION OF THE LONDON MISSIONARY SOCIETY.

WHEN I first came to Travancore six years ago I was struck with the fact that nearly every second person I met had a tumour the size of a plum in the one cheek or the other, but on closer acquaintance with the people I found this to be a removable quantity, and I well remember making bold to ask a man what that swelling was, and he, taking it as a rebuke, retired to the edge of the verandah and ejected the quid of betel! But I have since found that, erroneous though my first judgement was, there is a close connexion between the pseudo-tumour and the malignant, and for a few years I have felt that the great frequency of cancer, especially of the buccal cavity, arising apparently from definite secondary causes, should be an indication for the line of investigation for primary causes. Feeling this, I wrote to Dr. Bashford, of the Imperial Cancer Research Fund, for suggestions as to lines of investigation and record, and in the report he sent me I was surprised to find that in the India Table for 1905 only 5 cases of cancer of the buccal mucous membrane were recorded, and of upper jaw 5 only, and lower jaw 31. My own report for that year for our Central Hospital at Neyoor showed 28 cases of buccal mucous membrane cancer.

I have gathered up from our fifteen mission hospitals (under the auspices of the London Missionary Society) and also from thirty-four Government hospitals, by the kind help of the Acting Durbar Physician, Dr. H. Campbell Perkins, the malignant cases seen during the last five years, numbering in all 1,700.

Geographical Incidence.

In the extreme north, in Cashmere, Dr. Neve, in charge of the Church Missionary Society Hospital, reports 100 cancer cases amongst 20,000 new cases annually, that is, 0.5 per cent. At Miraj, in the Bombay Presidency, Dr. Wanless, of the American Presbyterian Hospital, reports 41 cancer cases out of 13,666 new cases annually, a percentage of 0.3; and at Jumalamadagu, in the Cuddapah District, Drs. Campbell and Thomson, in charge of the London Mission Hospital, give 54 cancer cases in 6,870, which is just below 1 per cent. In South Travancore, out of 385,833 new cases in our own hospitals in five years, I find 702 cases of malignancy, which gives a percentage of a little below 0.2 per cent. as the cancer incidence. But in our central hospital at Neyoor it works out to nearly 1 per cent., which, perhaps, is due to a certain notoriety we have attained for operating on such things. I notice also in the returns kindly supplied to me by Dr. Campbell Perkins that the hospitals on the hills amongst the planters' coolies show a very much lower cancer-rate than those on the plains. In India, of course, we cannot satisfactorily tabulate death-rates from cancer, so as to enable us to compare with those of Britain, but the above figures may make a basis of comparison.

Age and Sex Incidence.

The most striking feature in Table I is the fact that the age of maximum occurrence of cancer in Travancore is about 20 years younger than in Great Britain—a difference most prominently marked in females in Travancore, where the highest figure is reached between the ages of 36 and 45. I do not think that this suggests that the menopause occurs younger in Travancore, for although I have not tabular figures at hand, I have gathered the distinct impression in my work that the menopause here comes on rather later, between 45 and 50.

To make the comparisons more striking I have constructed a percentage table (Table II) for Travancore and English age-incidence, the former based on my 1,700 cases, the latter on the report of the Imperial Cancer Research Fund for 1905.

* A paper read before the South Indian and Madras Branch of the British Medical Association at Madras, October 25th, 1907.

Diagram of the hernia sac. A is the abdominal end of the sac through which the omentum is entering. B is the neck of the sac where the omentum has become thinned and stalk-like, on which the ligatures were placed. C is the upper loculus which was opened first at the operation. D is the constriction in the sac separating the upper loculus, C, from the lower loculus, E, which contained the twisted omentum. It is probable that D is the point to which the hernia sac was reducible *en masse*, B being irreducible.