The above features lead the writer to conclude that the tumour was a mixed-cell tumour of the soft palate, with an exceptionally abundant blood supply, and containing a cyst of unusual size.

No attempt is made to discuss the etiology of this tumour, as there are numerous and excellent contributions by many authors available for consultation; and as McFarland⁶ says, "Whoever in the face of these excellent contributions undertakes to add to the literature might well be called upon to apologize."

REFERENCES.

- ¹ Von Gabourd (quoted by Sturgis): *Gaz. des Hôp. de Paris*, 1906, lxxvi, 1299; McGibbon and Beattie: *British Medical Journal*, 1928, i, 664.
² Diggle, F. H., and Dembrowski (quoted by Barnes, H. A.): Jackson and Coates *The Nose, Throat, and Ear and their Diseases*, 1929, 166.
³ Lynch, R. C.: *Arch. Otolaryngol.*, 1930, li, v, 618.
⁴ Eggers, H. C.: *Arch. Path.*, 1928, vi, 378.
⁵ Sonnenschein, R.: *Arch. Otolaryngol.*, 1930, li, ii, 137.
⁶ Sturgis, M. G.: *Surg., Gynecol. and Obstet.*, 1914, xviii, 456.
⁷ Fry, R. M.: *Brit. Journ. Surg.*, 1927, xv, 291.
⁸ McFarland, J.: *Amer. Journ. Med. Sci.*, 1926, clxii, 804.

DELAYED OPERATION FOR TRAUMATIC INTRA-CEREBRAL HAEMORRHAGE.

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 (With Special Plate.)

THE mortality after operations for traumatic intra-cerebral haemorrhage is sufficiently high that it may be worth while considering whether delayed operation is more likely to be beneficial in such cases.

The following particulars of a case of head injury I recently operated on will, I think, be of general interest. During a quarrel a man, aged 30, received a blow on the left side of the head with a bamboo stick, at about 7 p.m. on April 20th, 1930. He was brought to the hospital at 8.30 o'clock the following morning in an unconscious state. He had a large contusion over the left side of the forehead, involving the eyebrows, eyelids, and the temple. Both pupils were contracted and equal, and there was no haemorrhage or cerebro-spinal fluid from the ear, nose, or mouth. His pulse was 62, small in volume, respirations 20 and shallow, and he was having involuntary micturition and defaecation. He remained in this state till April 24th, when he recovered consciousness, but was unable to speak, and was completely paralysed on the right side (face and limbs). He was still having involuntary micturition and defaecation. His pulse was 68, respirations 18; pupils both reacting to light, but left a little sluggish, and deep reflexes completely abolished on the right side. He was advised an operation, which he refused. He continued to be in the same state, and in spite of careful nursing he developed a small bed sore over the sacrum. On May 6th he started getting evening rise of temperature, and he was complaining of persistent headache. On May 17th he consented to be operated on. When under chloroform a U-shaped flap with apex upwards was turned down from the temporal region; a longitudinal fissured fracture, running from the supraorbital margin upwards, backwards, and outwards across the frontal and parietal bones as far as the parieto-squamous suture, was seen. The skull was trephined over the middle of this and a disc of bone removed. The anterior branch of the middle meningeal artery was exposed under the trephine circle and was found not to be damaged. There was a little oozing of dark venous blood from the anterior edge of this opening, and the circle was enlarged in this direction, the underlying surface being digitally explored; a few clots were expressed from the antero-inferior angle of this opening. As there was not sufficient evidence of extradural pressure to account for his symptoms, the opening was further enlarged towards the postero-superior angle and the underlying surface explored with the fingers. There was no evidence of accumulated blood-clot in this area. The dura was then opened by a crucial incision (after ligating the middle meningeal artery, as it was in the way) and the cortex was exposed. The surface was dull and bulging through the opening in the dura. A

closed pair of artery forceps was thrust into the substance of the brain in the direction of the pre-central convolution, and on opening the blades a large quantity of altered blood-clot and degenerated and softened puriform brain matter was evacuated. The cavity was subsequently irrigated with saline, and at this stage the brain regained its colour and began to pulsate. The dura was then stitched up, and the wound was closed with a superficial gauze drain. He was put on regular doses of hexamine. His temperature came down to normal the next day, and when the gauze drain was removed a little pent-up blood-stained fluid was evacuated. On May 22nd slight finger movements were noticed on the right hand. His limbs were now supported on splints, the shoulder being kept abducted and the wrist dorsiflexed. On May 25th slight movements of the right leg were noticed. Sutures were removed on this day, and the wound was found to have healed by first intention. The patient by now had gained control over micturition and defaecation, and he was given daily massage to his paralysed limbs, morning and evening. On May 30th he spoke a few words. On June 8th he could walk with the help of a stick, although with jerky movements at his ankle, could move the fingers of his hand slightly, and was able to speak a few words; but he was absolutely unable to move his forearm or hand independent of support. On June 12th he was able to move his wrist and elbow, but his power was still very weak. On June 14th he was able to flex his elbow-joint voluntarily, and when the arm was raised up and supported his efforts to raise the arm above the level of the shoulder were noticed by slight contractions of the deltoid and spinati. On June 20th he was discharged from hospital, when he was able to walk well and speak, though slowly and with deliberation. He had completely recovered function in his lower limbs, and was able to use his upper limb with a slight weakness of the abductors and external rotators of the upper arm, and with inability to approximate his little and ring fingers. On August 1st he appeared in court, and argued his own case. His movements in the shoulder-joint are still restricted and weak. There is slight wasting of the muscles of the hypothenar eminence, and inability to oppose his ring and little fingers continues. His speech is slow, and there is a little hesitancy in it.

The photograph reproduced in the Plate shows the site of operation and demonstrates the patient's ability to raise the arm to the level of the shoulder, and also shows his inability to approximate the little and ring fingers.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

AN UNUSUAL CASE OF STIFF KNEE.

(With Special Plate.)

THE following case appears to be a unique example of "stiff knee," and there is, so far as I am aware, no record of a similar case in the literature of the subject. The rarity of the condition places it in the category of a museum specimen, rather than in the more valuable and more useful sphere of everyday work. Nevertheless it is worthy of being put on record, and therefore I venture to publish it as a radiological contribution to the study of stiff knee.

Rather less than a year ago I was asked to make an x-ray examination of a left knee-joint, which had become practically immobile in a slightly flexed position, and by the courtesy of the patient's doctor I was able to obtain the following history.

Mrs. H., aged 53, states that the earliest feeling of discomfort in her left knee was experienced about the beginning of the year 1926, and took the form of stiffness rather than of pain. Up to March, 1927, she was able to walk quite well, and to extend and flex the knee without any great discomfort beyond a feeling of stiffness at the knee-joint. In March, 1927, she underwent an operation for urethral caruncle, and she states that she was able to walk into the operating theatre in quite a normal manner, but on waking up in bed from the anaesthetic she experienced an acute pain in the knee. This was the first occasion on which really acute pain had occurred. She remained

**J. E. G. MCGIBBON: CYSTIC TUMOUR OF
THE SOFT PALATE.**

**D. K. SABHESAN: TRAUMATIC INTRA-CEREBRAL
HÆMORRHAGE.**

DAVID KYLE: PATELLA TRANSFIXED BY EXOSTOSIS FROM FEMUR.

FIG. 1.—Skiagram, actual size.

FIG. 2.—Showing relationship of bones.