forms of muscular weakness. Each illness provides a solution of intolerable difficulty or a refuge from intolerable hardship. Unluckily for the hysteric, the subconscious solution or refuge is often highly troublesome and inconvenient. Hence the description of hysteria which I have just given—namely, pleasantly peaceful pessimism.

H.—Compulsive and Obsessional Neuroses

These are particularly severe and painful illnesses in which the patient labours under an imperious and overriding requirement to perform unnecessary and irrational acts, or to perform needless ritual or to think along ceaselessly recurring lines of thought. One of the

worst forms of compulsion neurosis is that in which the patient finds herself ceaselessly washing her hands. Milder forms of obsessional neurosis include sundry forms of explosive utterance or coprolalia, sundry odd habits, and mild forms of kleptomania. These forms of neurosis spring from hidden fears. The hand-washing neurosis, for instance, may spring from fear of contamination, real or metaphorical. Most of the fears concerned can be traced to fears about personal integrity.

The remaining classes (I and J) in the table are not strictly within the scope of this review. But members of these classes form a very large number of those commonly called neurotic or neurasthenic.

PULMONECTOMY

A PRELIMINARY REPORT ON TWO CASES IN WHICH AN ENTIRE LUNG HAS BEEN SUCCESSFULLY REMOVED

BY

GEORGE A. MASON, F.R.C.S.

SENIOR SURGICAL REGISTRAR, ROYAL VICTORIA INFIRMARY, NEWCASTLE-UPON-TYNE; THORACIC SURGEON, WOOLEY SANATORIUM, NORTHUMBERLAND

Total pulmonectomy, although occasionally attempted, was in no instance successful until 1931, when Nissen, working in Sauerbruch's clinic in Berlin, resected the entire left lung of a girl aged 12 years who was suffering from bronchiectasis secondary to a traumatic rupture of the left main bronchus.¹ In the following year Haight, working in Alexander's clinic in Michigan, repeated this success when he removed the entire left lung of a girl aged 13 years, in whom bronchiectasis had followed delayed removal of an aspirated foreign body.² The operation is probably more hazardous in cases of bronchiectasis than in neoplastic disease owing to the greater risk of sepsis; and although a few additional successful cases have been reported during the last two years in America—notably by Evarts Graham³ and Reinhoff⁴—these have been mostly for growths.

This is a brief preliminary report of two cases of unilateral bronchiectasis—one a girl and the other a boy—which have recovered after removal of an entire lung, the left and the right respectively. There was no degree of stenosis of the stem bronchus in either case, such as was present in those operated upon by Nissen and Haight. Mass ligatures were applied to the lung root in each case

to promote gangrene in the lung prior to its removal. This was the method employed by both Nissen and Haight, and appears to be the only one by which a bronchiectatic lung has been successfully removed.

First Case

N. W., a girl aged 13 years, was referred by Dr. Horsley Drummond. Since the age of 5 she had suffered from recurrent attacks of "pneumonia," each of which had been followed by profuse expectoration of foul sputum. In 1931, following such an attack, an empyema in connexion with the base of the left lung had been drained at another hospital. She was admitted to the Royal Victoria Infirmary, Newcastle-upon-Tyne, at Easter, 1934, suffering from a pneumonic attack. Subsequent lipiodol examination demonstrated bronchiectasis of the entire left lung. The sputum diminished and almost completely disappeared with general treatment, but marked pallor and clubbing of the fingers persisted. The chest wall was retracted on the left side and the sternum unduly prominent.

Operation: May 4th, 1934.—Anaesthesia was administered by Dr. W. J. Phillips. Preliminary basal narcosis with avertin (80 per cent. of the charted "Bayer" dose) was given, intratracheal insufflation of oxygen, warmed ether vapour, and a small quantity of nitrous oxide. A second intratracheal tube was also introduced to facilitate evacuation of pulmonary secretion. The patient was placed on her right side with a sandbag under the chest. A long incision was employed, extending from the spine behind to the sternum in front, and crossing the scapula about 3 cm. above its angle. The latissimus dorsi, etc., were divided in the line of the incision and the scapula retracted forwards and upwards. The fifth and sixth ribs were divided close to the spine, and their intercostal muscles divided throughout the length of the incision. These ribs were then widely separated with the help of a de Quervain retractor. The lung was completely adherent, but the two lobes were freed and mobilized with comparative ease. Two stout braided-silk ligatures

FIG. 1.

FIG. 2.

FIG. 3.

(Pearsall No. 22) were tightly applied to the pedicle of each lobe, and the phrenic nerve was divided above the root of the lung to facilitate subsequent obliteration of the cavity.

During manipulation of the hilus, and whilst the ligatures were being tightened, curious bodily jerks, apparently violent respiratory movements, occurred; in addition and simultaneously, the auricles were seen to distend the pericardium, whilst the aorta apparently ceased beating. These phenomena recurred at least fifteen or twenty times. Gauze tampons were wrapped round the lobes to prevent re-adhesion, and the wound was almost completely closed, except posteriorly for the tampons. Flavine was instilled daily.

The wound was reopened on the sixth day and the tampons changed. This was repeated on the eleventh day, but on this occasion the lobes were ablated with the help of a thermocautery and the wound left widely open throughout its entire length. Two or three days later the small remaining fragments of the pedicles in the ligatures sloughed off, and the cavity immediately began to diminish in size. There was slight pyrexia, and the pulse ran in the vicinity of 120 per minute for almost a fortnight after the sloughing lung was removed from the chest; but the thoracic cavity appeared clean and the general condition steadily improving. For two or three days after the operation there was some degree of oedema of the opposite lung, but this was easily controlled by atropine.

Progress.—Massage and appropriate exercises were carried out from an early stage in order to prevent the development of scoliosis. Having gained over a stone in weight, and with the general health greatly improved, the patient was allowed to return home on September 30th. She has attended as an out-patient at frequent intervals since then. She is now free from cough and expectoration. The cavity has been largely obliterated by flattening of the chest wall and elevation of the paralysed diaphragm. It is now only the size of a walnut, and is epithelialized; on its floor are two bronchial fistulae, which are becoming very slowly but progressively smaller, and hence are unlikely to require any further plastic procedure (Figs. 1, 2, and 3).

Second Case

J. W., a youth aged 18 years, was referred by Professor W. E. Hume. When 5 years old a small stone became impacted in the right bronchus and was not coughed up until two years later. Since then there has been a constant and copious expectoration of foul sputum. The patient had been in a sanatorium at one period, but tubercle bacilli were never detected in his sputum. Recently, marked signs of toxic absorption became evident—clubbing of the fingers, night sweats, and loss of weight. Eight or ten ounces of foul sputum were being coughed up daily after admission to the Royal Victoria Infirmary, Newcastle-upon-Tyne. A lipiodol examination revealed the presence of such a gross degree of bronchiectasis that only scattered pools of lipiodol were seen in the right lung. The heart and trachea were much displaced to the right side. The right phrenic nerve was evulsed in September, 1934, as a preliminary to pulmonectomy. The sputum subsequently diminished in amount to two ounces per day.

Operation: October 18th, 1934.—Anaesthesia similar to that in the first case was again given by Dr. W. J. Phillips. The incision was also the same. The right side of the chest was opened. Despite the radiological appearances the right lung was not adherent, except by a few bands at the apex and by a dense symphysis to the paralysed and elevated diaphragm. The lung was small and shrunken, and as it was difficult to demonstrate the interlobar fissure, only one stout braided-silk ligature (Pearsall No. 22) was tightly applied to the whole hilus after mobilization. No obvious reflex phenomena were observed, but the blood pressure (as recorded in the arm) at this stage having fallen to 30 mm. Hg, the operation was rapidly terminated, as in the first case. The condition rapidly improved after the patient had returned to bed, but a persistent pulmonary oedema developed, which required the repeated administration of atropine during the subsequent fortnight. The wound being reopened, under light anaesthesia, on the seventh and again on the thirteenth day, the tampons were changed. It was hoped that the lung, which was now very much shrunken, would slough off, but as it failed to do so, it was removed with the galvanocautery thirty days after the operation.

Progress.—The wound and the cavity have diminished in size with amazing rapidity, the diaphragm having risen steadily, and the mediastinum having moved across in a striking manner. The cavity itself is now—three months after the operation—only about one-fifth or one-sixth of its original size, and, although it is not impossible, it appears highly improbable that a thoracoplasty will be required to obliterate it completely. There are at present three small bronchial fistulae, through which a certain amount of flavine-stained discharge is aspirated from the cavity and expectorated, but this only amounts to approximately half an ounce per day. The general condition is steadily improving, the boy having a good appetite and sleeping well. It is hoped, with confidence, that he will soon be able to go to a convalescent home.

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Clinical Memoranda

Recurrence of Large Fibroid from Cervical Stump after Supravaginal Hysterectomy

Any recurrence of a fibroid growth from a seedling in the cervical stump after supravaginal hysterectomy must be a rarity; still more so one so enormous as almost to fill the abdominal cavity.

On March 13th, 1926, I removed a large multinodular fibroid and a left-sided cystic ovary from a woman aged 35, leaving the right ovary and tube and the usual cervical stump. Eight years later, on April 12th, 1934, I was asked by Dr. Ryan of Worthing to see the patient again. She had complained of "hardness of the stomach" for three years, frequency of micturition for two years, and an increasing abdominal tumour for about a year. The bowels were constipated. There had been complete amenorrhoea and no vaginal discharge since her operation. She had lost 2 stone in weight within twelve months; she looked ill, and was feeling tired and unable to carry on her duties.

On examination there was an enormous tumour reaching from the symphysis to the ribs, giving the impression of being cystic in parts and firm and solid in others. It was dull all over to percussion, and the dullness extended into the left flank, while the right flank gave a tympanitic note. The dullness and tympanitis did not shift with a change of position. Per rectum the pelvis was filled with a smooth swelling, apparently continuous with that above, and not giving the impression of being fixed.

I thought, in view of the marked loss of weight, that the growth was probably an adenocarcinoma arising from the remaining right ovary, and although the outlook seemed poor I advised an exploratory operation. This was carried out on April 19th. An incision from the symphysis to the xiphisternum was necessary to deliver the tumour, which proved to be a fibroid with an extension downwards that filled and was moulded to the cavity of the pelvis. The sigmoid and pelvic colon were tightly stretched across the left lateral and posterior walls of the tumour below for about eight inches, like tiny, thin, flattened ribbons, half an inch wide only, and so attenuated that it seemed almost impossible for faeces to have passed through them. The peritoneum above them was incised and stripped downwards and inwards along with the ribbon of the bowel, adhesions to the bladder in front were separated, the pelvic portion was delivered, and finally the whole tumour was divided from its attachment to the left side of a small cervical stump. The right ovary, which was cystic, the right tube, and the appendix were removed; the sigmoid and pelvic colon were sutured to the peritoneum on the left side, and a glove drain put down to the space behind them, which was inclined to coze.

The tumour, immediately after removal, weighed 12½ lb., and measured 13 inches in length and 9 inches transversely at its greatest diameter. Microscopically it proved to be a simple fibroid. The patient made a good recovery.

Hove.

H. N. FLETCHER.