of very curious appearance, of oval shape, the size of marbles; they were fatty substances, rather hardened, like suet, with a green tinge. The patient told me that for weeks he had been eating fat mutton, and had been very much employed mixing green paint. The symptoms now subsided; he had no return.

The extensive blueness in the gums was a very characteristic feature in this disease. I saw 120 cases, and I witnessed this peculiar change in most of them. There were very few exceptions. Those patients with the gums most tinged did not always suffer the most acute symptoms, but they continued more or less indisposed till the gums assumed their healthy aspect; but I do not consider any patients safe, if they have suffered from severe paroxysms, while this unnatural appearance remains, for many have followed their avocations for weeks, and have then been doomed to fresh, and perhaps more severe attacks. I ate the poisoned bread myself, but the symptoms went off very lightly. In convalescence I always enjoined strict attention to the bowels, very warm clothing, and a milk and light diet.

No case of paralysis of the arms has yet occurred. Some violent cases were followed by mild typhoid symptoms, others by slight jaundice, anasarca, and diarrhoea. One diseased old woman, subject to pyrosis, I think must have died from exhausting diarrhoea if she had not been well supplied with laudanum, brandy, and other stimulants.

Some are easily affected with small doses of lead, whilst others I have seen since the last few months have resisted its effects most wonderfully. I knew a man take half an ounce of Liquor Plumbi in mistake, without any ill effects.

I have endeavoured to give a faithful narrative of the cases, taken from the bed-sides of the patients, and it is gratifying to be able to state, that we have not lost a single patient, though all will admit that they never saw before such violent and long-continued cases. This differs from Andral's computation, who states that one death generally occurs in every hundred. This success is very satisfactory to the medical men, who attended the patients most diligently and zealously, and I feel much obliged to them for frequent discussions on their cases during treatment.

The miller was also a paper maker, and used acetate of lead for bleaching his paper.

Stourbridge, May 25, 1849.

FIBROUS TUMOUR OF THE UTERUS, &c.: CASE AND REMARKS.

By EDWARD BALLARD, M.D., East Retford,

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The following recital can scarcely be denominated a *clinical* illustration, but as it illustrates some interesting points in connection with the progress of a very common disease, I do not hesitate to submit it to the readers of the Journal.

CASE.

Abdominal Tumour; Fluctuation, &c.: Fibrous Tumour of Uterus; Perforation and Inflammation of the Peritoneum, &c.

About six years ago I was requested by Mr. Garland, of Islington, to examine the body of a patient of his, an old lady, who had for many years been the subject of an abdominal tumour. The only history of the case I could obtain, either then or subsequently, was that for a short time before her death the abdomen had been increasing unusually in bulk, and, without making any complaints which led him to suspect an inflammatory disease in that cavity, she had gradually sunk.

The body generally was stout; the abdomen was very much enlarged; and there was a very distinct fluctuation perceptible, with dulness on percussion everywhere but at the epigastrium; no solid tumour could be felt; there was much oedematous thickening of the abdominal walls in depending parts; and the legs were also swollen.

The abdomen was tapped, and about four gallons of an opaque, reddish-brown, turbid liquid was drawn off, specific gravity 1.018; it appeared to contain fine floating particles. As the cavity of the peritoneum became emptied, the abdominal tumour stated to have been present during life became perceptible to the hand, large and circumscribed, occupying a considerable part of the abdomen, hard over a great part of its extent, but in some parts yielding to pressure; it was capable of being lifted by insinuating the hands behind it. On opening the abdomen the tumour was found to be connected with the uterus, occupying the inlet of the pelvis, and projecting ten or twelve inches above it, and more towards the right side than the left; it had evidently formed in the fundus of the organ, since the broad ligaments and ovaries were in their natural position, the Fallopian tubes not laid along the sides of the uterus as when the entire body is enlarged. There were no morbid adhesions. The size of it was that of a large adult's head; the peritoneum which covered it was rough, corrugated, dense, and thickened, and attached to it were loose shreds of brownish-red lymph, especially on the anterior and superior parts. The right side of the tumour was hard, but the left presented a more globular protuberance, containing fluid. At the upper and lateral part of this softer portion was an opening, about the size of a large pea, through which a liquid might be pressed, similar to that in the general cavity of the peritoneum. The weight of the entire tumour was between four and five pounds; its solid portion consisted of fibrous matter. The cavity was about the size of a child's head; its contents were a liquid, such as was discovered in the peritoneum; and a large quantity of a reddish brown shreddy lymph attached to the wall, and lying loose in the interior. The wall measured three lines at its thinnest part; it was lined by a softer substance, of a red colour, and capable of removal by scraping with the scalpel, varying however in density and in thickness from a line to half an inch. This cavity was separated from the true uterine cavity by a tissue, of about an inch or more in thickness. The cervix uteri had disappeared, the vagina

terminating above in the opening into the cavity of the uterus, which was rounded, having completely lost the usual appearance of the os tincæ. The uterine cavity presented the appearance of a long narrow canal, stretching about three inches upwards, backwards, and towards the right side, lying thus behind and beneath the morbid cavity above described. Its lining membrane was reddened, and it contained a reddish, bloody, mucus.

The peritoneal covering of the anterior wall was mostly pale, and covered with a smooth even coating of lymph, well and firmly organized upon it, leaving here and there small spots of serous membrane uncoated. Opposite the tumour, however, the peritoneum was of a darker hue, and covered with the same sort of shreddy lymph as the tumour itself. The small intestines were glued together by lymph, but little organized; in some parts there were large bands of soft adhesions. Recent clear lymph was also perceptible in points, and smooth layers over the whole surface of the intestines. The peritoneal coat of the stomach and intestinal canal was of a dark purple hue. The liver was adherent to the diaphragm, and its upper surface roughened by the shreddy lymph before noticed. The peritoneal coat of the spleen was cartilaginous in patches, these sometimes attaining the thickness of a line. The diaphragm rose higher into the chest than usual. The lungs were pushed upwards and backwards, and occupied less than their usual space. Heart enlarged. Wall of left ventricle one inch and a quarter thick. Kidneys large, and coarse in structure.

REMARKS.—1. Fibrous tumours of the uterus are by no means uncommonly found after death in women who are carried off by all kinds of diseases. If small, and placed beneath the peritoneal surface, they may be productive of no inconvenience whatever, but if large they may produce much local uneasiness; or by pressing on neighbouring organs, as the bladder or rectum, disorder their function, and impede more or less the evacuation of the urine or fæces. It is not common for them to prove fatal, but the above case exhibits one mode in which they may become so. I have already (Case II.) illustrated one change which fibrous tumours of the uterus undergo in process of time, namely, their condensation, and more or less perfect calcareous degeneration. This, also, is one of the changes to which tubercle is subject; but as this matter is capable of a process of softening, so, too, is the fibrous tumour. It was in this manner that the cavity which I have described became formed. Whether originally due to inflammation or not, (and I should be disposed to regard the latter as most probable,) that process was evidently going on at the time of the patient's death, as evidenced by the large quantity of lymph which was discovered in the cavity. The disease had proved fatal by the extension of the softening process to the external surface, and perforation of the peritoneum.

2. Directing our attention to the peritoneum, it is observable that there appeared to have been no endeavour made at preventing the effusion of the contents of the morbid cavity by the formation of adhesions.

Where perforation of the wall of the stomach succeeds as the result of a *large* ulceration of the mucous surface, it is common for adhesions to occur to a neighbouring organ; but in the instance before us, the cause of perforation was probably not an inflammatory one, the opening through the membrane taking place by gangrene, from defective vascular supply, the substance below it undergoing death. Perhaps, also, there was present some amount of liquid effusion in the peritoneum previous to the perforation. The peritoneal membrane exhibited indications of recent and of former inflammatory action, the latter in the firmly organized coating of lymph which covered most of the parietal peritoneum, and the former in the ascitic effusion, vascular discoloration, and recent lymph. The one was probably the result of irritation of the large solid tumour, the latter clearly due to the perforation. The large amount of effused fluid may be accounted for by the congestive character of the inflammation. It was remarkable that there was no suspicion either of perforation of the peritoneum, or of peritonitis, excited in the mind of the medical attendant by the symptoms presented by the patient; no sudden occurrence of pain induced by the former, and no local pain and tenderness to indicate the latter. The age of the patient will readily account for this, since the obtuseness of sensibility of advanced years tends to render latent inflammatory disorders, which, in a younger person, would exhibit themselves by marked nervous phenomena.

3. I desire lastly to draw attention to the disappearance of the cervix uteri in connection with a tumour of the fundus of the organ. I have already noticed a similar occurrence where the body was greatly enlarged by being the seat of hypertrophy, fibrous tumour, and cancerous growth. In these two instances it was plainly due to the changes the organ had undergone; in others, however, the cervix is only partially destroyed, from adhesions occurring between it and the neighbouring part of the vaginal wall.

Hospital Reports.

QUEEN'S HOSPITAL, BIRMINGHAM.

CLINICAL REPORTS OF SURGICAL CASES UNDER THE TREATMENT OF PROFESSOR SANDS COX, F.R.S., SENIOR SURGEON TO THE HOSPITAL.

Reported by Mr. PETER HINCKES BIRD, late Resident
Medical Officer.

CASE XXII.

STRANGULATED INGUINAL HERNIA.

Joseph Sandbrook, aged 43, slater, admitted on December 25th, 1846, at 11 o'clock p.m., under the care of Professor Cox. He states that he has had a rupture in the right inguinal region for four years, which he could return. About four months ago he perceived a tumour in the left inguinal region, which