dulness in either flank, as well as a fixed area of dulness in the right iliac fossa which ran obliquely across the lower part of the abdomen, to terminate at the middle of Poupart's ligament on the opposite side.

There was a good deal of pain on micturition. Thoracic viscera healthy. No impairment of liver dulness. The whole aspect of the case strongly suggested peritonitis, secondary to perforation of the vermiform appendix, but the general condition was sufficiently good as to deem it inadvisable to operate at once. The next day, however, there was no material improvement, so exploration was decided upon.

He was anæsthetised, and an incision made in the middle line, immediately below the umbilicus. The peritoneal cavity being opened, it was observed that the underlying intestine was deeply injected and covered with exudation. No fluid escaped. The hand was then carefully introduced, when it was found that everywhere the coils of bowel were feebly adherent the one to the other, and more or less buried in plastic lymph. The hepatic region was not so thoroughly explored, but elsewhere the signs of general peritonitis were unmistakable. A second incision was then made in the right iliac fossa. The same condition of matting as existed in the middle line manifested itself here also, and it was not till the finger was gently passed down over the pelvic brim that an abscess cavity of considerable size was evacuated of much thick and offensive pus. No irrigation was employed, but a glass tube was introduced from the mid-line incision into the pelvic region, and another from that in the right iliac fossa. He was then put back to bed.

During the next fourteen days he remained in much the same condition. The wounds continued to drain well, and in a week's time rubber tubes were substituted, and shortened as occasion demanded. The pulse remained about 88, and there was no material rise of temperature. He was, however, a little sick from time to time, and diarrhoea was an occasional complication. A trial was made immediately after operation of antistreptococcic serum in doses of 10 c.cm. twice daily, but as no benefit appeared to accrue to this it was discontinued after six or seven days.

At the end of this fortnight the temperature rose to 100.2°, and for the first time a tender point was noticed about two inches to the left of the median incision. It was thought that a loculus of pus existed in this situation. Accordingly, an incision was made, and fully a pint of offensive pus let free, a drainage tube being inserted. In due course both this wound and the median incision closed, but on two subsequent occasions that existing in the right iliac fossa broke down, and discharged a varying amount of purulent material. The boy left the hospital, well, on October 7th.

REMARKS.—We are obliged to Dr. Ord for permission to publish the notes of the case, which we think well worthy of putting on record, since we had the opportunity of assuring ourselves that the peritonitis which existed was very nearly, if not quite, general, and that recovery only took place with the formation of loculated abscesses. It will be noted that no irrigation whatsoever was employed at the primary operation, since the peritoneal cavity was practically obliterated by plastic peritonitis. His constitutional state, throughout, was good, and seemed altogether out of proportion to the abdominal condition. To this we must ascribe the successful issue of the case, and inasmuch as such are almost uniformly fatal, the present result is highly encouraging.

A CASE IN WHICH CHOLECYSTECTOMY WAS FOLLOWED BY RECOVERY.¹

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[With Notes by L. M. BRETON, M.R.C.S., L.R.C.P.]

In August last I saw the patient, in consultation with Mr. Breton, and agreed with him that the only chance of her living, or dying in any degree of comfort, lay in operation. Accordingly I performed cholecystectomy on August 13th.

The following history and notes of the case have been

written by Mr. Breton, who kindly assisted me at the operation.

Previous History.—For twenty years the patient, whose age is 52, has been subject to recurring attacks of abdominal pain, coming on suddenly, and generally accompanied by vomiting. The intervals, which at first were long—sometimes three or four years—became shorter, until within the eighteen months before the operation she had as many as six such attacks. During the eighteen months she had never been free from a constant dull aching pain in the situation of the gall bladder. She stated that she has never been jaundiced. When called in to see her on June 30th, 1896, I found her suffering from intense abdominal pain; she had vomited twice, her skin was cold and moist, and the pulse small and rapid. The acuteness of the pain passed off in a few hours, and on the following two days twelve or more gall stones were passed, varying in size from that of nearly a hazel nut to a split pea. After a few days the patient got about the house as before, but complained very much of constant aching pain, and expressed her willingness to undergo any treatment which could hold out prospect of permanent relief. Thinking that the mischief was most probably confined to the gall bladder or cystic duct (from the fact that the attacks had never been followed by jaundice), I thought the case was one favourable for the operation of cholecystectomy.

OPERATION.

The ordinary incision having been made and the peritoneal cavity opened, the gall bladder was found to be filled with what appeared to be one large stone. There was no fluid in the bladder, which was in close contact with its contents. Bearing in mind the excellent results of inguinal colotomy, where a glass rod is used, and only a couple of deep sutures instead of the old and more elaborate stitching, I determined on trying a somewhat similar mode of operation in this case. Accordingly, the pear-shaped tumour was drawn forward through the abdominal wound and used as a wedge. I then passed two deep sutures, including the peritoneum, through the abdominal wall, the one above the other below the apex of the "pear." A few more stitches completed the first stage of the operation.

On August 17th I removed the stone and adherent bladder. Its weight is 5 drachms, and it measures 2½ ins. in length and 1½ in. in width. Some small pieces were broken off in extraction, and on clearing these away and passing a probe into the duct no other stone could be felt. It appears to me that in any case where the gall bladder is fully and firmly distended, like this one, this operation is much to be preferred to the more complicated one, with its innumerable sutures in the gall bladder, which are always difficult to pass. Mr. Breton tells me that his patient is now in good health and spirits, and able to take short walks, though she had two drawbacks during convalescence—the one cystitis, the other phlebitis in the left leg; both, however, yielded to treatment, and she now expresses herself as absolutely free from the old intolerable pain.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

THE PATHOLOGY OF RODENT ULCER.

At the recent meeting of the Pathological Society of London, the question of the origin of rodent ulcer was again brought forward, and in the course of discussion Mr. S. G. Shattock alluded to the suggestion I made some two years ago at a previous meeting that the source of this growth was in abortive lachrymal glands upon parts of the face corresponding with the sites in which these glands exist in many of the higher mammalia, for example, antelopes, deer, sheep, goats, etc. He objected to this view on the ground of the wide distribution of the lesion, but suggested that the origin was in foetal residues of abortive glands. Now, the lachrymal glands or face glands I drew attention to are in structure highly differentiated glands of an acinous or tubular type. In one species both types may exist in the same gland, in another but one type may occur. Their position is most frequently at the inner canthus of the eye, infraorbital or supra-maxillary, but also supraorbital, inframaxillary, and post-audicular.

Almost without exception does rodent ulcer affect one of these positions. Cases are said to occur in other regions of the body, but, if we exclude the groin, these cases are so rare that one feels there may be some doubt about their being

¹Part of a paper on Calculi, read before the Southampton Medical Society, November 3rd, 1896.