field of the high power of the microscope, would suggest that they had increased in number.

REMARKS BY DR. MANTLE.

There is no doubt that a cavernous angioma of the liver of the size of the one described is very rare indeed. In Frerich's well-known work on the liver,¹ he describes the condition as being generally found on the surface of the liver, the size of a hazel nut or walnut, and penetrating the organ as a wedge-shaped or globular tumour. He concludes his description of it by saying: "The pathological and clinical importance of the cavernous tumour is very slight. I know of no case in which it has given rise either to local or general derangements."

In Allbutt's *System*² Dr. Hale White, the writer of the article on tumours of the liver, dismisses angioma in these words: "Cavernous angioma of the liver is common, but produces no symptoms during life."

Osler³ says: "Occasionally in children angiomas have developed and produced large tumours."

Sims Woodhead⁴ writes of it thus: "This tumour is not very frequently met with in the human subject, but in the liver of the cat is of common occurrence."

Ziegler thinks the cavernous tumours begin to develop after middle age, when the cells begin to atrophy. This patient was only 33, and there were no signs of tissue degeneration anywhere else.

The photograph is taken from an excellent water-colour painting executed by Miss Wright, of Leeds. It only shows the tumour in a collapsed condition owing to the escape of blood, the amount of which was estimated at about 8 pints.

I have to express my thanks to Mr. Turner, the house-surgeon, for very carefully-taken notes of the case, and to Dr. Powell White for his valuable pathological report as to the nature of the tumour.

REFERENCES.

¹ *A Clinical Treatise on Diseases of the Liver*, vol. ii. ² Allbutt's *System of Medicine*, vol. iv. ³ *Practice of Medicine*. ⁴ *Practical Pathology*.

A CASE OF PROLAPSE OF THE BOWEL WITH LOSS OF CONTROL,

TREATED BY INJECTION OF PARAFFIN UNDER THE MUCOUS MEMBRANE.

By STEPHEN PAGET, F.R.C.S.,

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GERSUNY and other surgeons have obtained good results, in prolapse of the bowel, by the injection of paraffin under the prolapsed mucous membrane. The paraffin, once set, remains as a hard smooth nodule in the submucous tissue, holding up the prolapse, and acting as a valve to prevent any leakage from the bowel. It is essential for the success of the treatment that the paraffin should not stray outside the bowel, but should be deposited just under the mucous membrane, and that the prolapse should be reduced so soon as the paraffin has set. The following case, which was entrusted to me by Mr. Swinford Edwards, may serve to call attention to this very useful method.

The patient, 65 years old, was a tall, thin, rather feeble man, who eight years ago, in April, 1897, had undergone excision of the rectum for cancer. A few weeks after the operation, he began to be troubled with prolapse of the bowel and partial loss of control over its contents. He has worn a plug ever since to keep the prolapse up. The use of this support has prevented him from sitting comfortably, and has made him stoop in walking; and he says that he has never been comfortable by day, only at night, when he can do without his support. From time to time, even while he was wearing this plug, the prolapse would come down, and he would be soiled by the discharge of mucus. He had control over solid motions; only, after taking hot food or tea he would be compelled to go very quickly to the closet, or he would be soiled; and, if the bowels were at all relaxed, it was impossible for him to keep himself clean.

On January 8th, 1903, he was admitted to the West London Hospital; and Mr. Edwards very kindly let me have charge of him. The opening into the bowel lay at the bottom of a deep cup-shaped fossa; the walls of this fossa were soft and healthy, not rigid or cicatricial; the ring round the end of the bowel was lax, and easily admitted three fingers; and there was no feel of a sphincter. The prolapse was slight; only, if he walked about, or bore down gently, about two inches of healthy mucous membrane were everted. When he was in bed there was no prolapse.

On January 15th Dr. Shuter gave an anaesthetic; and, with the help of Mr. Speirs, my house-surgeon, I injected paraffin at several points into and around the prolapsed bowel. I have to confess that some of the paraffin went wide of the mark, and did no harm but no good; and that

the whole procedure, for want of experience, was not all that it ought to be. But I succeeded in raising the mucous membrane at two points, one lateral, the other posterior, so that two hard round hummocks or nodules, about 1 in. in diameter, and half or three-quarters of an inch in height, could be felt, like tumours growing in the submucous layer of the bowel; and these two swellings, one lying a little above the other, so narrowed the bowel that it would admit only one finger. The lower swelling lay just within the anal ring, and had the appearance of blocking it right across, but was easily pushed aside by the finger. Thus, by the two swellings together, the lower end of the bowel was held up, and made valvular. A morphine suppository was given, and the patient was put back to bed. He had no pain or tenesmus, only very trivial discomfort for a few hours. The bowels were kept quiet for five days with opium, and then acted of their own accord. He was allowed to walk about the ward on the tenth day.

The result of the treatment is very good. There is no prolapse, and no escape of the contents of the bowels. He has no difficulty in keeping himself clean; he walks erect, instead of stooping; and he is thankful to be rid of his rectal plug, after wearing it for seven and a-half years. Of course, sooner or later, another injection may be needed; but there is at present no reason to expect anything of the kind. Anyhow, it could easily be made under cocaine. So far as things have gone at present, he appears to have been cured, by a very simple method, of all the miserable discomfort that these cases suffer for years.

The points to be noted are that the paraffin must be injected immediately under the mucous membrane of the prolapse, not outside the bowel, but into the fold of everted mucous membrane; that numerous punctures must not be made, but only one or two, lest a vein should be wounded; that the prolapse, with the nodules of paraffin in its submucous layer, must be put back at once, and kept back; that the bowels must be kept inactive for several days after the operation; and that the patient must be kept in bed for ten or more days till the tissues are thoroughly contracted.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

A CASE OF PROLAPSUS UTERI TREATED SUCCESSFULLY BY INJECTION OF QUININE.

ONE of the subjects selected for discussion at the meeting of the British Medical Association last year was that of the operative treatment of prolapsus uteri. The different views expressed then by many operators make it apparent that there is no one direct route to success in the treatment of this troublesome condition. Inglis Parsons has for the last few years been practising with success his ingenious operation of injection of the broad ligaments with a solution of quinine sulphate. Having seen some of his results at the Chelsea Hospital for Women I determined to try this method in the case of a lady who recently consulted me for persistent prolapse.

The patient, aged 38, who looked strong and healthy, had had three children, the youngest of whom was 3 years old. She complained of the ordinary symptoms of prolapse, which prevented her from performing her usual household and social duties, and her life had become a burden.

History.—She had had no previous gynaecological trouble; her labours had been easy. About three or four months after her last confinement she began to notice a bearing-down sensation, which came on more severely after any exertion; there was no actual pain, and the discomfort was so slight that she did not consult a doctor till about a year ago, when the os began to protrude from the vulvar orifice. A variety of pessaries were then tried, but without much benefit, as they caused her discomfort and she was unable to retain them.

Treatment.—I first saw her about the middle of May, and found that the vaginal walls were very lax, that the uterus was enlarged (a sound passing $3\frac{1}{2}$ in.), and retroverted, and the cervix soft and hypertrophied. On straining there was marked procidentia. I also found that the left ovary was enlarged, tender, and prolapsed into the pouch of Douglas, and that this was a source of discomfort when a pessary was introduced. I advised injection of the broad ligaments with quinine. This I did on June 16th, injecting 50 minims of quinine sulphate solution (1 in 5) into each broad ligament, and, replacing the uterus, inserted a Napier's pessary. There were no bad symptoms beyond a slight buzzing in the head on the second