

Half an inch below the margin of the liver. The perforation was closed with eight or nine Lembert sutures of silk, the left kidney pouch was carefully dried out, and the omentum and transverse colon were cleansed and replaced. For 60 hours after the operation nothing was given by the mouth. Nutrient and saline enemata relieved the thirst. Fluid diet was then commenced with two-drachm doses half-hourly of milk-and-water and gradually increased. Light farinaceous (Benger's) food was first given on the 25th and after that date she gradually advanced to ordinary rations. On the 22nd for a few hours there were severe pain and collapse. There was some foul suppuration around the skin sutures for which chinisol fomentations were used. The sutures were removed on the ninth and tenth days. The patient left her bed on Jan. 1st and returned to duty on Jan. 18th. She is now in excellent general health and has not had indigestion since the operation.

Remarks by Mr. LUCY.—The foregoing case is of interest as showing the value of early accurate diagnosis and the effect on the post-operative progress of withholding strictly everything by the mouth when perforation is once diagnosed. The history of precedent dyspepsia, a tender epigastrium, and occasional vomiting, together with the sudden onset of pain and collapse, the rapid thoracic respiration, tympany over the whole liver area, but marked dullness in the left hypochondriac and lumbar regions, all made up a clinical picture of sudden gastric perforation. Cœliotomy was performed about 17 hours after perforation and the ultimate good result was largely due to the withholding of all oral feeding by Dr. Bowes and Dr. H. B. Wilkinson. The absence of hæmatemesis here (as in all perforating cases that I have so far seen) is noteworthy.

Medical Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

Tropical Abscess of the Liver.

THE following concludes our report of the meeting of this society held on May 13th (*vide* THE LANCET, May 17th, p. 1397).

Dr. PATRICK MANSON, in discussing Mr. RICKMAN J. GODLEE'S paper on Tropical Abscess of the Liver (which is published at p. 1452 of our present issue), said that the operation he had suggested—namely, plunging in a trocar and inserting a drainage-tube through it, was only suitable for ordinary use or in tropical countries where experienced surgeons were not so plentiful. It was a simpler operation. He would like to ask why it was that abscesses in the upper part of the liver extended the liver dullness upwards instead of lowering the liver as a whole. He doubted if the escape of a little pus into the peritoneum in these cases was attended by very great danger.

Dr. A. CROMBIE remarked that he had been treating cases of hepatic abscess for 30 years. It was the practice in India to use Dieulafoy's aspirator and in small abscesses this was sufficient and the patient recovered. Even in larger abscesses one or two such operations were sufficient. In one case he had aspirated 14 times and the case resulted in recovery. He thought that all suitable cases should be treated in this way, at any rate in the first instance. In all his cases he had never found it necessary to stitch the liver to the wall before opening the abscess. He quite agreed with Dr. Manson that no damage resulted, as a rule, from the leakage of pus into the peritoneum.

Mr. JAMES CANTLIE had used Dr. Manson's trocar in 34 cases in all and thought that its convenience was very great; very often the surroundings of such cases were very unfavourable. The danger of hæmorrhage from a hepatic vein was also obviated in this way. The drainage-tube should be an indiarubber one.

Dr. W. G. ROCKWOOD had operated on upwards of 100 cases in 25 years. He had employed the method suggested by Dr. Manson many times. In his earlier cases he aspirated. He sometimes found it necessary to aspirate a second or third time. Lately it had been his practice to excise a portion of the rib.

Mr. GODLEE, in reply, said he was bound to confess that he had not seen any very serious consequences from the

escape of the pus into the peritoneum, but on one occasion the patient had some pain which might have been produced in this way when the liver was not stitched to the abdominal wall. As regards aspiration this suggestion had been made in cases of empyema, but sooner or later they always needed a more complete operation.

PATHOLOGICAL SOCIETY OF LONDON.

Infective Lesions of the Tongue, Stomach, and Intestines in Addison's Anæmia (Pernicious Anæmia).—Joint Lesions in Hæmophilia.—Congenital Atresia of the Small Intestine.—Fibrinous Cast of the Gall-bladder.—Hæmorrhage into the Adrenal Bodies.—Disseminated Carcinoma simulating Tubercle.—Annual General Meeting.

A MEETING of this society was held on May 20th, Mr. W. WATSON CHEYNE, C.B., the President, being in the chair.

Dr. WILLIAM HUNTER made a communication on the Infective Lesions of the Tongue, Stomach, and Intestines found in Addison's Anæmia (Pernicious Anæmia). This paper (which was illustrated by a lantern demonstration) was an extension of the researches previously recorded.¹ The present results were based upon 25 cases of pernicious anæmia which had come under his (Dr. Hunter's) observation during the past two years. In pernicious anæmia (the disease described by Addison in 1855) there was a hæmolysis which was not found in the numerous other varieties of anæmia described by various authors and which were attributed by them to a great variety of causes, such as poverty, ulcer of the stomach, ankylostomiasis, hæmorrhages, &c. Sepsis alone was incapable of giving rise to true pernicious anæmia, for in septic anæmia there was no evidence of hæmolysis in the liver. The evidence on which Dr. Hunter's conclusions had been based was of three kinds—(1) the prevalence of oral sepsis (gingivitis, decayed teeth, &c.) in connexion with the disease; (2) the existence in these cases of a subacute infective gastritis as one result of long-continued oral sepsis and mucoid vomit containing streptococcus longus; and (3) the occasional prevalence of infective lesions in the mucosa of the alimentary canal, probably having a similar origin. The present communication was based on the bacteriological and histological examination of the 25 cases recently observed. Necropsies had been performed on seven of these, from which 1145 sections had been made and some 250 cultures had been made. A peculiar form of glossitis had been found in every one of the 25 cases. Special observations had been made on the tongue, clinical and anatomical. There was great thinning of the mucosa which in places was quite wanting, so that the lymphatics of the tongue were practically in direct continuity with the buccal cavity. It was this thinning of the mucosa which produced the glossy condition of the surface of the tongue which Dr. Hunter regarded as quite peculiar to the disease. He had obtained pure cultures of streptococcus longus from the lymphatics of the tongue. These had been injected into mice and killed them in six or seven days. The only other disease in which anything resembling this condition of tongue was psilosis, but Dr. Hunter was not sufficiently familiar with the latter disease to speak definitely. In the stomach he had found an inflammatory condition of the mucosa extending down almost to the submucosa. The epithelium was thrown off in large quantity as mucoid vomit and in the final stage complete atrophy of the gastric mucosa occurred. Marked lesions in the intestines had also been found. The mucoid vomit which was vomited in the morning contained pure cultures of streptococcus longus. The conclusion which Dr. Hunter had arrived at was that there was a double infective process: (1) a specific infection, of which the chief evidence was a glossitis; and (2) a septic infection of the mouth, stomach, and intestine, of which the chief evidences during life were varying degrees of "oral sepsis" and "septic gastritis," the latter recognisable during life by the vomit and various symptoms of oral gastric and intestinal disturbance, and after death the conditions of gastritis, gastric atrophy, intestinal atrophy, erosions, or ulcers now and again found in the disease.

Mr. A. LUCAS (Birmingham) exhibited an Unusual Variety of Joint Lesion in a case of Hæmophilia. The patient was a boy, aged 10½ years, who had been an out-patient under the care of Mr. Lucas for about four years, suffering

¹ THE LANCET, Jan. 27th (p. 221) and Feb. 3rd (p. 296) and 10th (p. 371), 1900.

from hæmophilia and who was accidentally drowned whilst at play. He had had repeated hæmorrhages into the knee-joints, more frequently into the right joint. There was much enlargement of this joint, the synovial membrane was thickened, and the ends of the bones also appeared to be enlarged. There were no adhesions; the synovial membrane was thickened and the fringes were hypertrophied and stained from the repeated hæmorrhages. The cartilages were slightly lipped at their free margins as in osteo-arthritis. The articular surfaces showed many irregular pits where in places the cartilage had entirely disappeared. This condition was most marked where there had been pressure of the cartilaginous surfaces, but there appeared to be no rubbing away of the cartilage.

Mr. LUCAS also communicated a case of Congenital Atresia of the Small Intestine which had occurred in a male child, aged three days, who was admitted into the Birmingham General Hospital with symptoms of intestinal obstruction including fæcal vomiting.

Dr. H. D. ROLLESTON showed a Fibrinous Cast of the Gall-bladder removed during Cholecystotomy by Mr. Herbert Allingham from a woman, aged 52 years. The gall-bladder was much enlarged and adherent to adjacent parts. It contained a large single gall-stone of the size of a walnut which was enveloped in a fibrinous cast. The cast was easily separable from the walls of the gall-bladder and resembled a dysmenorrhœic cast of the uterus. Histologically the membrane was composed of a fibrinous network inclosing crystals and bile pigment. The case was an example of fibrinous or membranous cholecystitis. This lesion was not analogous to that of mucous colitis where the intestinal casts were composed of coagulated mucus.

Dr. CLIVE RIVIERE exhibited four specimens of Hæmorrhage into the Suprarenal Capsules from cases occurring at the Shadwell Children's Hospital. The cases were characterised clinically by vomiting, diarrhœa, a purpuric eruption, and a high temperature, and ran their course to a fatal termination in from 12 to 48 hours. The condition of the suprarenals was different from that of circumscribed hæmorrhage since there was a diffuse infiltration with blood. Besides the suprarenal lesion in these cases there was swelling of Peyer's patches and mesenteric glands. It was suggested that the cause might be food toxins or a toxæmia due to a bacterial infection of the intestine. The former seemed unlikely from the insidious course of the early symptoms. The latter explained the condition most satisfactorily.

Dr. F. J. SMITH exhibited specimens from a case of Disseminated Carcinoma simulating Tubercle.

The annual general meeting was held at the conclusion of the ordinary meeting. The report of the council was read and adopted. The re-arrangement of the society's meetings had led to a satisfactory increase in the attendance of members. A general index of the Transactions had been issued. Owing to the expense of printing the Transactions it would be desirable to adopt some means of retrenchment in the society's expenditure.—Votes of thanks were proposed and carried to the retiring President, Vice-Presidents, members of council, and secretaries.

The following officers and council were duly elected for the year 1902-3:—President: the Right Hon. the Lord Lister. Vice-Presidents: Mr. R. J. Godlee, Dr. W. D. Halliburton, Dr. E. Klein, and Dr. F. W. Pavy. Treasurer: Dr. Sidney Coupland. General secretary: Mr. S. G. Shattock. Sectional secretaries: Dr. H. Morley Fletcher, Mr. A. G. R. Foulerton, Dr. T. Grigor Brodie, and Dr. A. E. Garrod. Council: Dr. R. Crawford, Dr. J. Fawcett, Dr. L. Freyberger, Dr. N. Dalton, Dr. G. F. Still, Dr. T. W. P. Lawrence, Dr. S. H. Habershon, Dr. F. W. Andrewes, Dr. W. Bulloch, Dr. John McFadyean, Dr. Allan Macfadyen, Mr. H. G. Plimmer, Dr. R. T. Hewlett, Dr. W. S. Lazarus-Barlow, Dr. J. R. Bradford, Dr. E. H. Starling, Mr. C. A. Ballance, Dr. F. G. Hopkins, Dr. V. Harley, and Dr. S. G. Hédin.

OBSTETRICAL SOCIETY OF LONDON.

Fibroid Tumour of the Ovary.—Lymphangitis Mammæ.—Exhibition of Specimens.

A MEETING of this society was held on May 7th, Dr PETER HORROCKS, the President, being in the chair.

Dr. JOHN S. FAIRBAIRN read a paper on Five Specimens of Fibroid Tumour of the Ovary, with Observations on their

Pathological Anatomy. Attention was first directed to the descriptions of these growths as given in the text-books and monographs on the subject. The general statement was that these tumours were formed by hyperplasia of the whole stroma, so that the organ was converted into a hard tumour retaining more or less the original shape of the ovary. Five specimens, varying in size from a small growth of the size of a hen's egg up to a large tumour of over four pounds in weight, were described in detail. In all of them the new growth had arisen within the ovary and affected only a portion of the stroma, leaving a considerable part of the organ as a separate and easily recognisable structure. The microscopic appearances were also noted and a short clinical history of the cases from which they were obtained was added. After looking through a large number of recorded cases of fibroma and fibro-myoma of the ovary, some 15 or 16 were selected as similar to those described in the paper and a short abstract of them was given. When such specimens had been shown at societies they had given rise to some discussion from the unusual persistence of a portion of the ovary. The number of instances quoted, together with the five specimens under review, was sufficient to show that the descriptions usually given were misleading. While the difficulty of detecting unstriped muscle cells among fibrous tissue cells was acknowledged, the evidence of a comparative examination of sections from these tumours appeared to be in favour of their being considered fibromata. The sections provided a very good opportunity of contrasting the minute structure of the growth with the ovarian stroma from which they had originated; the results of such a study were adduced in favour of considering these firm hard growths of the ovary as simple fibromata and not as fibro-sarcomata. The question of these tumours arising from a chronic oöphoritis was discussed very briefly and the importance of the tunica albuginea in forming a strong covering to ovarian growths was pointed out. In conclusion, the fibromata of the ovary were divided into three classes for purposes of description. 1. The ovary was entirely replaced by the new formation. This occurred in small as well as large growths and therefore did not depend on the size to which the growth had attained. 2. A local growth of the stroma leaving part of the ovary unaffected, except by compression. The growth tended to remain within the capsule of the ovary. 3. Pedunculated fibromata like subperitoneal fibroids of the uterus. These might either have originated in the stroma and later been extruded or they might be growths of the tunica albuginea.—Mr. ALBAN H. G. DORAN maintained that the three specimens which he exhibited that evening in relation to Dr. Fairbairn's important paper implied that fibroma and myoma of the ovary were distinct diseases. The section of the large fibroma showed perfect wavy white fibre, as did the section of the little solitary fibroma not half an inch in diameter. The myoma, unlike the two fibromas, was closely related to the ovarian ligament, which included muscular tissue derived from the uterus. On section it showed plain muscle cells, precisely as seen in a section of a myoma of the uterus. Oedematous fibroids were once taken for sarcomas of the ovary; subtracting these suspected malignant growths from the malignant solid tumours of the ovary they would probably find that carcinoma of the ovary was much more common than sarcoma, as Martin had demonstrated, whilst fibroma, innocent even when looking malignant, was by no means rare. There were plenty exhibited that night. Mr. Doran noted how the tube and mesosalpinx often underwent little or no hypertrophy in fibroma, so that when the tumour was large it was rather difficult to get at the pedicle.—Mr. J. BLAND-SUTTON congratulated Dr. Fairbairn on establishing the fact that the encapsulation of the tumour could be relied upon as a generic and distinguishing feature. When the fibroid was of moderate size, as in the smallest specimen of his series, the disproportion between the ovary and the tumour was not so marked; but when the mass had a circumference of 10 or even 30 centimetres, or more, then the small bud-like remnant of the ovary at the uterine end of the tumour appeared to be very incongruous. The leading features of these tumours could be summarised thus: encapsulation, ovoid shape, intense hardness, and the whorled disposition of the tissue as displayed on the cut surface. These were a group of signs presented by no other tumour of the ovary and their clinical value was equal to their simplicity. There was an important feature by which ovarian fibroids were distinguished from similar tumours in the uterus. It was well-established that uterine fibroids did