

PART IV.  
MEDICAL MISCELLANY

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*Reports, Transactions, and Scientific Intelligence.*

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ROYAL ACADEMY OF MEDICINE IN IRELAND.

President—SAMUEL GORDON, M.D., F.R.C.P.I.

General Secretary—W. THOMSON, M.D.

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SECTION OF SURGERY.

President—H. G. CROLY, President of the Royal College of Surgeons  
in Ireland.

Sectional Secretary—MR. W. THORNLEY STOKER.

*Friday, December 12, 1890.*

The PRESIDENT in the Chair.

*The late Mr. Anthony H. Corley, Past President.*

The PRESIDENT—Before we go on with the regular business of the meeting, I am sure you will think that it is only my duty to say a word with regard to the great loss which this College has sustained by the removal from amongst us of one who was respected and admired by everybody in the profession—our late lamented friend, Dr. Anthony Corley. It is only a month since he was here in good spirits, if not in good health. None of us had any idea that he was then in such a condition as might have led to his removal at any moment. It is unnecessary for me to do more than say that he filled almost every position since he commenced the profession—first an industrious student in the Ledwich School; then a teacher in the Carmichael School; next a surgeon to two important hospitals—first Jervis-street and afterwards the Richmond Hospital. In this College he was successively a Professor, a Councillor, a Vice-President, and President. He won everything that the profession could give him in connection with the College of which he was so distinguished a member. I now submit for your approval the following resolution:—“That the Surgical Section of the Royal Academy of Medicine in Ireland, of which the late Professor Corley was so active

and distinguished a member, begs to convey to his widow and family its sense of the loss which surgical science and the public have sustained by his early and most lamented death, and its deep sympathy with their bereavement."

The resolution was adopted, and

The Secretary was requested to forward a copy of it to Mrs. Corley.

*Treatment of Lupus by Koch's Method.*

MR. THORNLEY STOKER exhibited two patients in whom lupus had been treated by Koch's method.

MR. KENDAL FRANKS, in view of the great importance and interest attached to tubercular disease, inquired as to the original condition of the patients and the mode of treatment, including the number of inoculations.

MR. THORNLEY STOKER—The two cases exhibited were the only two I was at liberty to bring, as the others are undergoing febrile reaction and could not be removed from bed. One of those shown, a female child, is an old-standing case of lupus of some years' duration, involving the upper lip and opening of the nose, the cheeks, chin, and eyelids, and penetrating into the subcutaneous areolar tissue. On the 6th of December I gave an injection of 2 mgrms. of lymph. It produced a moderate constitutional reaction, the temperature rising to between 101° and 102°. At the same time there was severe local reaction. Most of the face, previously in a pale cicatricial condition, swelled and became livid red, assuming very much the appearance observed when erysipelas attacks the face, and vesication of the greater part of the diseased surface took place. The child did not suffer great constitutional disturbance, and the reaction subsided in 24 hours. The portion of the diseased surface that was superficial remains of a red colour, but all the ulcerating process seems to have ceased and the vesicles have scabbed. Tomorrow morning I will give twice the strength of injection she had before—namely, 4 mgrms. of lymph. The other case is very remarkable as affording an example of a moderate dose of the lymph producing marked local reaction, and no constitutional reaction whatever. The patient, a man aged twenty-five, has had lupus since he was a child. It has not produced destructive ulceration of the skin, but spread in a cicatricial fashion underneath the cuticle. The first dose injected was one of 2 mgrms. As the result, in 8 hours the whole of the lupus patch became red and blistered, and a circumferential areola of about three-quarters of an inch became inflamed. The local reaction subsided in 24 hours. Next day he had a double dose—4 mgrms. There was a marked local reaction, but it was less than the first. Again, there was no constitutional reaction whatever—no sickness, no rise of temperature, no headache. Yesterday he got 6 mgrms., when slight constitutional reaction

took place, the temperature rising to about 100°, and he had a local reaction equal in degree to that following the second injection. The lupus patches are now dried up. I have given the injections either between the scapulæ, or below the inferior angle of one scapula or the other.

*Operative Treatment of Sympathetic Ophthalmia.*

MR. STORY read a paper upon operations on eyes blinded by sympathetic ophthalmitis, and gave the details of several cases operated on by various methods. His conclusions were that during active sympathetic inflammation no operation should be performed, and that after the subsidence of the inflammation the best operation is that proposed by the late Mr. Critchett, in which the lens capsule is divided by two cutting needles. If glaucoma occurs during active sympathy, and an operation is absolutely necessary, he would incise the cornea or sclerotic, but not do an iridectomy. Mr. Critchett's operation is better than iridectomy or extraction of the lens, because no hæmorrhage is produced, and less occasion is given for a fresh outbreak of inflammation. It has the great additional advantage of not making an opening in the globe through which a fluid vitreous may escape, as has been observed by Mr. Story, even when performing a simple iridectomy in an eye blinded by sympathetic ophthalmitis.

MR. MAXWELL suggested the use of Mr. Redmond's electric needle in such operations.

The PRESIDENT mentioned with approval the late Dr. Arthur Jacob's operation of immediate enucleation for injury from shot, and suggested that either that operation or emptying the contents of the socket would do away with the necessity of having to interfere with the sympathetically affected eye, while leaving a good pad for an artificial eye.

MR. STORY, in reply, said his object was to call attention to the operation described in his paper, though the result could not be regarded as very satisfactory. No doubt, had the injured eye been removed in time, as suggested by the President, there would not have been any occasion for an operation on the sympathising eye. He approved of Mr. Redmond's ingenious instrument, which he intended to use.

*Transfusion and Intra-venous Injection of Milk and Saline Fluid.*

DR. MELDON read a paper on transfusion of blood and the intra-venous injection of milk and saline fluid. Having reviewed the history of transfusion, he expressed his opinion that the evil results which have at times caused this operation to fall into disrepute have been occasioned by the employment of dissimilar blood. The author then narrated several successful cases of direct transfusion, as also one case saved by the injection of carbonate of ammonia and water. This paper

concluded with a *résumé* of the history of intra-venous injections of milk, which operation Dr. Meldon has performed thirty-two times with good results, yet he strongly advocated direct transfusion, whenever it was possible, in preference to any other variety of the operation.

MR. FRANKS suggested that a  $\frac{3}{4}$  per cent. salt solution would have answered the purpose for injection instead of carbonate of ammonia.

SIR WILLIAM STOKES recalled an instance in which the late Dr. Robert M'Donnell carried out transfusion with happy results, in the case of the wife of an eminent lawyer. She was dying of hæmorrhage and her husband supplied the blood.

MR. THORNLEY STOKER pointed out that transfusion or intra-venous injection was used for two different purposes. In one set of cases blood was introduced into the veins to supplement the failing power of nature and avert death from hæmorrhage, most frequently *post partum*. But in the other class of cases saline solution was introduced for the relief of a loaded right heart or for thickened blood, a melancholy example of which they had had in the case of their late brother, Dr. Corley, who was suffering, as the result of diabetic toxæmia, from failing brain, failing heart and pulmonary circulation. In Dr. Corley's case the effect of the injection was to produce temporary relief without ultimate benefit. Such operations in the second class of cases had not been proved to produce any permanent result. No doubt, a fillip was given to the failing powers of life, and the patient gained some temporary comfort, but as to ultimate good being done, it was a matter that required to be proved. But the injection of blood and nutritive fluid like milk in the case of persons dying of hæmorrhage was an operation on an entirely different basis. One lesson to be drawn from Dr. Meldon's paper was that Providence was unequal in the distribution of his gifts, for in his own large hospital practice he had never had an opportunity of introducing fluid into the veins of patients, while Dr. Meldon had no less than thirty-two opportunities of practising that operation.

The PRESIDENT, with reference to one of Dr. Meldon's cases, asked whether introducing the hand into an empty uterus, if hæmorrhage was not going on was not—in a case of collapse—a most dangerous proceeding? The late Alfred M'Clintock taught that if the placenta was retained with any symptom of collapse it was dangerous to introduce the hand into the empty uterus to remove it. He had himself been taught caution in an interesting case in which he was about to perform (with the late Dr. Robert M'Donnell's instrument) transfusion to save a woman's life. Her husband said he was willing to give some of his blood for the purpose; but having taken the precaution of examining him, the man proved to have valvular disease of the heart. In like manner, he should make sure that the kidneys were not diseased.

DR. CRANNY said he had had experience of three cases of transfusion done by the late Dr. Robert M'Donnell for *post partum* hæmorrhage. In two of them the result was perfectly successful, but the third patient died. There was an immediate increase in the volume of the pulse, and the general condition of the patient was so improved as to be noteworthy. It was a well recognised principle that when there was bleeding from the uterus, and either a portion of the placenta or clots remaining inside, the uterus should be emptied; but if there was collapse at the moment, the medical attendant should wait till the collapse was over. There would be no hæmorrhage during the momentary collapse, but if a piece of placenta were left in the uterus it would bleed.

DR. MELDON, in reply, said he had injected saline fluid once, and on that occasion he had no time to obtain any other than what he carried to make the milk injection alkaline—namely, a 10 gr. powder of carbonate of ammonia. He used Dr. M'Donnell's transfusion apparatus; but for the direct transfusion he had Aveling's, substituting Dr. Robert M'Donnell's cannula for the ordinary one supplied. At each contraction of the ball he assumed that about half an ounce was injected. As regards Mr. Stoker's experience, his own intra-venous injections of milk were done in consumptive cases and cases of anæmia. With regard to the case of the removal of the placenta, the patient was tossing about when the attempt was made to remove the clots and check the hæmorrhage. The collapse came on while he was removing the placenta.

The Section adjourned.

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## SECTION OF MEDICINE.

President—J. M. FINNY, M.D.; President of the Royal College of Physicians of Ireland.

Sectional Secretary—A. N. MONTGOMERY, M.R.C.P.

*Friday, December 19, 1890.*

The PRESIDENT in the Chair.

### *Case of Left Hemiplegia with Aphasia.*

DR. BEATTY exhibited a young girl, an example of left hemiplegia with aphasia. There was complete loss of taste and smell on the left side, and left hemianopsia was present and symmetrical.

DR. C. J. NIXON remarked that left hemiplegia was usually explained by a double lesion in the common situation; but the fact of the patient being left-handed explained all the phenomena that existed, assuming there was a single lesion. In place of the left hemisphere administering

to the phenomena of speech, in this instance it was the right hemisphere that acted.

DR. BEATTY, in reply, located the lesion in the angle and posterior segment of the internal capsule on the right side.

#### *A Case of Scleroderma.*

DR. NIXON read the notes of a case of unilateral scleroderma. [It will be found at page 97.]

DR. TWEEDY said it was well known that if those cases did not proceed to atrophy, they underwent spontaneous evolution, and the thickness of the skin eventually disappeared.

DR. BEATTY mentioned that eight years ago he had had a case of morphea, the patient, whom he saw for a couple of months, being a girl. She suffered from tooth-ache and neuralgia in the branches of the fifth nerve. In the linear patches there was often neuralgic pain, but in the oval patches none. Atrophy had taken place. In the lower lips were two grooves extending on the inner side of the lip down to the alveolus.

The PRESIDENT said he had never seen a case similar to that of the boy exhibited, but he had seen one of general scleroderma of the whole body, and beyond interfering with the free movement of the joints and the action of the muscles, there were no contractions or deformities.

DR. C. J. NIXON, in reply, said no doubt the history of cases of scleroderma showed a tendency to spontaneous evolution. There were generally two stages of the disease—first, infiltration, of an inflammatory nature; and secondly, atrophy. The scleroderma became gradually absorbed by a natural process independently or in spite of the use of drugs, which were of little avail in its treatment.

#### *Cystinuria.*

DR. WALTER G. SMITH read a paper upon Cystinuria. The condition is a rare one, and scarcely 70 cases are upon record.

A boy, aged eight years, was reported by his mother to have passed urine of a fragrant, orris-root odour, and depositing a greenish sediment. The boy's health was excellent in all respects, and there were no symptoms of urinary irritation. Out of six occasions upon which the child's urine was examined, once only was cystin found. The crystals were identified by their form, solubility in ammonia, and insolubility in acetic acid. The true formula of cystin is  $(C_3H_6NSO_2)_2$ . Dr. Smith discussed in some detail our present knowledge of the physiology and pathology of cystin. The following summary may be given:—

1. Cystin, or a cystin-like body, occurs in small amount in human urine as a normal product of proteid metabolism.
2. No relationship exists between uric acid and cystin.

3. Associated with cystinuria, pathologically, is the occurrence, in the urine and fæces, of certain ptomaines, belonging to the class of diamines, viz. :—

(a) Penta-methylene diamine (Cadaverin),  $C_5H_{14}N_2$ .

(b) Tetra-methylene-diamine (Putrescin),  $C_4H_{12}N_2$ .

4. Normal urine and fæces never contain diamines, nor do they occur in cystin calculi.

5. The formation of diamines is due to the agency of specific bacteria in the intestine.

6. The exact nature of the correlation between cystinuria and diaminuria has not yet been determined.

7. Cystinuria may persist for years without apparent injury to the health of the patient.

8. The therapeutical indication is to disinfect the contents of the bowel.

DR. SMITH exhibited some microscopic slides showing the characteristic crystals of cystin.

The Section adjourned.

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## SECTION OF OBSTETRICS.

President—S. R. MASON, M.B., F.R.C.S.I.

Sectional Secretary—ANDREW J. HORNE, F.R.C.P.I.

*Friday, January 2, 1891.*

The PRESIDENT in the Chair.

### *Exhibitions.*

MR. M'ARDLE exhibited—1. *Sub-peritoneal Fibroid*.—This tumour was removed from a patient aged thirty-two years. The peculiar points about this case are—1st, the only evidence she had of the tumour was the feeling of something falling about in the abdomen; 2nd, the first external evidence of the trouble was swelling due to peritoneal fluid; 3rd, the tumour was becoming gangrenous at one part, and the remainder, as well as the peritoneum, I found highly inflamed. Notwithstanding the extent of the peritonitis, the patient made an uninterrupted recovery.

2. *Ruptured Ovarian Cyst*.—This specimen I removed from a lady aged twenty-four years. The history of the case shows that in April last she consulted Dr. Malone, of Limerick. He discovered a tumour somewhat larger than an orange, and wisely recommended removal. His advice was not followed, and in June she got sudden and very severe abdominal pain and tenderness, with persistent vomiting. When she recovered the tumour could not be felt. Her health did not improve,

and I saw her for the first time in July, when she was so ill that I sent her to Bray for six weeks. Here improvement took place, and in October I performed laparotomy, removing from 8 to 10 pints of gray gelatinous material and this small cyst, the inner surface of which is covered with calcareous matter, and at one spot a mass of this substance standing out in the cavity. The questions I would ask in reference to this case are—1st, Was calcareous degeneration the cause of rupture? 2nd, How was the great amount of gelatinous fluid developed? 3rd, Could this fluid be removed by absorption? This patient recovered strength rapidly, and is now healthy.

3. *Large Ovarian Cyst.*—This case is of interest only from the fact that the tumour and general peritoneum were in a state of intense inflammation. Numerous adhesions existed, especially to the colon. I removed 35 pints of clear gelatinous fluid, irrigated the peritoneum with warm water from the day of the operation (before which the temperature was 103°). There was a gradual decline of all the symptoms of peritonitis, and on the twelfth day she left town perfectly well.

DR. W. J. SMYLY showed a large fibro-myoma which he had removed on account of hæmorrhage. The pedicle was treated extra-peritoneally, and the patient made a good recovery.—He also showed the tubes and ovaries removed for gonorrhœal salpingitis. There was extensive perimetritis, and the uterus was retroverted and adherent. The adhesions were broken down and the uterus was anteverted and stitched to the abdominal wall. The patient made a good recovery.—An ovarian tumour removed in July. The patient had been suffering great agony. The tumour was found universally adherent, and the pedicle was twisted four times on its long axis. The patient made a good recovery. She is now four months pregnant, having been sterile for ten years.

DR. MACAN showed a case of fibrous tumour removed from a patient who was sent up to Dr. Bennett for abdominal tumour. She had been two months married, and was about two months pregnant. The operation was not a difficult one, but the peritoneum became infected from the stump, and she died on the fifth day after operation.

DR. MACAN showed a multiple ovarian cystoma removed from a patient, Mrs. C., sent to him by Dr. Kidd. The chief point of interest was the great difficulty in breaking down the smaller cyst walls. This was impossible with the fingers, and forceps had to be used. There was one very firm adhesion to the transverse colon. The patient's recovery was the most perfect that he had ever witnessed.

#### *Abdominal Section.*

DR. MACAN read a paper on a case on which he had performed abdominal section three times, and removed an ovary each time. He then drew attention to the fact that a great many similar cases to this



had been explained by a separation of one ovary into two parts by some constricting band, and that Professor Winckel, in his work on the "Diseases of Women," says that no case is absolutely proved to be one in which three ovaries are present unless the three ligaments of the ovaries are also found, As his case did not fulfil this condition, he was obliged to place it in the second class, where there was a greater or less probability of three ovaries being present. The chief points of interest in the case were—1st, the performance of laparotomy three times on the same patient; 2nd, the probability of three ovaries being present; 3rd, the occurrence of a hernia in the abdominal walls, which would, in any case, have called for operative interference.

DR. F. KIDD thought that the title of the paper was based on an assumption—as no microscopical examination of the tumour had been made at the time—nor was any description given as to where or in what manner the pedicles of these various tumours had been ligatured with reference to their attachments to the uterus. Dr. Kidd was surprised that Dr. Macan did not find that there still remained two ovaries when he operated on the so-called ovarian tumour, as most operators adopted the precaution of examining the condition of the uterus and of the ovary before closing the incision. Dr. Kidd believed that the presence of a third testicle had never been demonstrated, and there was a great analogy between the testicle in the male and the ovary in the female.

MR. HORNE wished to know if both Fallopian tubes had been removed, and thought the occurrence of menorrhagia, subsequent to the removal of two ovarian tumours, was very unique and difficult of explanation.

DR. BAGOT said that Dr. Macan had stated that this was the first case in Ireland in which a third laparotomy had been performed. He thought that it must have escaped Dr. Macan's memory that he had previously performed a third laparotomy in the case in which he mentioned that he had operated for abscess of the bladder wall. As to the method of flap-splitting the abdominal walls in operating for hernia, he had seen patients operated on by this method by its originator, Dr. Hänger, in Leipzig; it was certainly the best method he knew of.

#### *Fæcal Fistula.*

DR. W. J. SMYLY said this fistula was the result of coitus, and passed through the navicular fossa upwards and backwards into the rectum. The case was cured by dividing the perinæum, and thus splitting flaps on the lateral walls and uniting them by continuous catgut suture. The accident is one of extreme rarity.

DR. MASON said a patient had recently been in the Coombe Hospital who had been locked into a room by a man who had forcible connection with her. She lost an enormous quantity of blood, and when admitted to hospital the post fornix of the vagina was found to be torn transversely;

the rectum was uninjured, and though she lost a very large quantity of blood she made a good recovery, the vagina being kept clean by frequent injections.

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SECTION OF ANATOMY AND PHYSIOLOGY.

President—PROF. PURSER, M.D.

Sectional Secretary—PROF. BIRMINGHAM, M.B.

*Friday, January 3, 1891.*

The President in the Chair.

*Exhibitions.*

(1) PROFESSOR CUNNINGHAM exhibited models illustrating cerebral anatomy of men and the anthropoid apes.

(2) PROFESSOR BIRMINGHAM—(a) A largely developed and ossified hyoid arch, in which the condition of the hyoid apparatus in the dog and some other carnivora was reproduced. (b) A specimen of persistent left superior cava, in which the usual arrangement of the azygos veins was reversed. Prof. Cunningham inquired as to the arrangement of the cardinal veins.

*Series of Human Fibulae.*

PROFESSOR BENNETT exhibited a series of human fibulae, showing the great range of variation which appears to be common in the mode of articulation of this bone with the tibial condyle. Having noticed the fact that even the fracture of the upper part of the fibula, resulting from strain of the ankle-joint, had been unknown until demonstrated by the collection contained in the Museum of Trinity College, he showed examples of complete absence of any superior tibio-fibular joint in consequence of the failure of the fibula to reach up to the tibial condyle. He admitted the incomplete character of the communication, as he had no details of a complete dissection to submit, but he brought the specimens forward in the hope that a knowledge of their existence would lead to the discovery of recent dissections.

PROF. CUNNINGHAM, as one strongly interested in the welfare of the Section of Anatomy and Physiology, welcomed Dr. Bennett's paper. Dr. Bennett stands pre-eminent in Dublin in all questions relating to bones. Dr. Cunningham alluded to the fact that in vertebrates there appears to be a tendency to the entire disappearance of the fibula. He discussed the functions of the bone, and held that the lower end, in its relation to the ankle-joint, is of vastly greater importance in man than the upper. The mode of ossification shows this. The downward shrinking of the

fibula might be regarded as a tendency towards the disappearance of the least useful part of the bone.

PROFESSOR BIRMINGHAM wished also to welcome Prof. Bennett to the Anatomical Section. An undoubted use of the fibula in man was to prevent lateral displacement of the astragalus at the ankle-joint. This it could do effectually only if it had actual contact with the tibia at its upper end. Its length gave it great leverage and power at the malleolus. In one of Prof. Bennett's specimens the articulation of the head was absent, but a little way down a strong exostosis connected the bone with the tibia; this possibly was compensatory. In the present condition of the lower end of the bone the upper articulation could not be well spared.

DR. W. H. THOMPSON stated that he had observed a distinct interval between the tibia and fibula at their upper extremities within a normal capsule and synovial membrane, and considered that in many cases that was the condition present. He also had seen fibulæ with two lateral facets, both cartilage-covered, one on the superior and one on the lateral aspect of the head, and had noted many intermediate conditions between the normal and some of the more marked that Dr. Bennett had shown.

PROF. BENNETT replied, saying that he had to thank the Section for the reception given to his paper. He had, in introducing his paper, strictly limited its scope to human anatomy, and so had avoided going into the question of comparative anatomy connected with it. In regard to Dr. Thompson's mention of the condition of double contact of the upper end of the fibula with the tibia, one of his specimens showed two distinct articulations separated by a wide rough surface. His object, he hoped, had been obtained—namely, to direct attention to the meagre and imperfect account of the upper end of the fibula in our standard text-books of descriptive anatomy.

*Anatomy of the Mastoid Region with Guides for Operating.*

PROF. BIRMINGHAM read a paper on the above subject. [It will be found at page 116.]

PROFESSOR BENNETT said:—Since reading Professor Birmingham's paper, already published, I have tested his method on the dead body, and have found the practical value of his rules to be amply proved.

I have also found that in working with a  $\frac{1}{4}$ -inch American drill no fear need be entertained of plunging into the brain or sinus, for the drill being cone-shaped at its cutting end enters the sinus with its point, and its entry can be readily appreciated. It has never plunged with me even into the mastoid cavity. I have seen in the living the mastoid trephined over the cells, as they are called, without result, simply because the incision failed to open them at all.

I may state, from the knowledge I possess from the possession of specimens, that the spontaneous opening of abscess through the bone

from the antrum outwards is placed in the position indicated by Professor Birmingham.

DR. THOMPSON inquired if Professor Birmingham had noted any differences on the two sides in the nearness of approach of the sinus to the meatus, seeing that, as a rule, the sinus is much larger on the right side than on the left.

PROFESSOR CUNNINGHAM asked if any relation had been found between the cephalic index and the condition of the region concerned.

PROFESSOR BIRMINGHAM, in reply, said that he had, in the beginning, taken note of the points referred to by Dr. Thompson, but he dropped the matter, as it was not averages but extreme limits which were required. Observations had lately been made upon the condition of the parts in skulls of different types, with the result that a tolerably definite relation was found to exist between the cephalic index and the condition of the mastoid region.

#### *The Sylvian Region of the Brain.*

PROF. CUNNINGHAM commenced his paper upon "The Sylvian Region of the Brain," but the time at his disposal was so limited that he was obliged to bring his remarks to an end after he had briefly mentioned some facts concerning the development of the fossa and its surrounding opercula.

## SECTION OF PATHOLOGY.

President—E. H. BENNETT, M.D.

Sectional Secretary—J. B. STORY, F.R.C.S.I.

*Friday, January 16, 1891.*

The PRESIDENT in the Chair.

#### *Fibro-glandular Hyperplasia of Prostate.*

MR. PATTESON showed portions of an enlarged prostate removed by supra-pubic cystotomy by Mr. Tobin in St. Vincent's Hospital. The patient, who was sixty years of age, had suffered great distress for many years. On opening the bladder three large, hard outgrowths from the median portion of the prostate were found, completely blocking the urinary outlet. They were situated closely together on broad bases of attachment. They were removed with a wire écraseur, and the patient made an excellent recovery, with relief from all his more distressing symptoms.

The parts removed were irregular in shape, the largest almost round, its transverse measurements being 3.5 × 3 cm.; the next largest more quadrilateral in shape, 4 × 3.2 × 1.5 cm. in its different diameters. The

three together weighed at time of removal 10 drachms. The surfaces were for the most part smooth, in spots somewhat irregular and nodular. They showed a firm surface on section. Microscopic examination showed a marked increase in the number and size of the glandular acini, the growth in parts bearing a striking resemblance to the earlier stages of ovarian adeno-cystomata. In other parts the fibrous and muscular elements had developed at the expense of the glandular, the fibrous hyperplasia being, however, the most prominent feature. The epithelium lining the acini was of columnar type in general, but in some of the cystic portions of the tumour, where active proliferation was taking place, the epithelial lining was composed of several rows of irregularly-shaped cells, the basement layer alone showing a distinct columnar shape. Having regard to the excessive glandular formation shown in many parts, quite out of proportion to the growth of the fibro-muscular stroma, it seems justifiable to class this tumour as a fibro-glandular hyperplasia of the gland, constituting the *prostatic adenoma* of some Continental pathologists.

*Encephaloid Carcinoma of Skin of Thigh with Lymphatic Infiltration.*

DR. McWEENEY exhibited naked-eye specimens and microscopic slides, which appeared to him to exemplify this unusual condition. The naked-eye specimens consisted of the tumour itself, of infiltrated lymphatic glands from the groin, and of remarkably hypertrophied lymph vessels which connected the tumour with the glands. All these had been removed about six weeks previously by his senior colleague, Mr. P. J. Hayes, at the Mater Misericordiæ Hospital, from a woman, aged about forty-five. The tumour occupied a point about six inches below Poupart's ligament, on the antero-external aspect of the right thigh. It had been first noticed about six months before removal. At the time of operation it was circular in outline, about the size of a hen's egg, but considerably flattened, and distinctly pedunculated, in the sense, at least, that it was constricted at its junction with the surrounding skin. Its colour was red and its surface raw and eruptive. Microscopically, it presented none of the characters of an epithelioma in the usual acceptation of the term. There were no solid, column-like, or nipple-shaped epithelial down-growths, no cell-nests, no apparent connection with the *rete Malpighii*. The tumour consisted of large, roundish, or irregular epithelial cells and a fibrous stroma, in the mostly elongated meshes of which the cells lay closely packed. The entire tumour was lobulated on section, large masses of neoplastic tissue, possessing the structure just described, being separated by distinct thick bands of connective tissue, between the fibrous strands of which, around the periphery of each cancerous lobule, were numerous small areas of small cell infiltration. On examination with high powers, the sections (which had been stained with Delafield's

hæmatoxylin and Orth's picro-lithio-carminé respectively) displayed quite distinctly the very delicate stroma in the alveoli of which the cancer cells lay in oblong groups. The entire structure bore a close resemblance to rapidly growing encephaloid, such as is occasionally to be met with in sections from the periphery of acute carcinoma of the mammary gland. So far as the exhibitor's knowledge of the text-books went, they described two forms of carcinomatous process in the skin, besides squamous-cell epithelioma—viz., sweat gland and sebaceous gland cancer. In the former, according to Birch-Hirschfeld, traces of the tubular structure would usually be found. There were none such, however, in any of the sections of the present tumour, and Dr. M'Weeney was uncertain whether the origin of the neoplasm ought to be ascribed to the epithelium of the sebaceous follicles. No trace of any typical structure was to be found which might serve as a guide to the starting point of the proliferating mass. The lymph glands examined presented the same appearances; in the central parts of the sections the atrophic remains of the lymphoid tissue was still to be seen. As regards the lymphatic vessels, the remarkable hypertrophy (the calibre equalled that of thick whip-cord) was found on microscopic examination to be due, not as was at first expected, to carcinomatous infiltration, but simply to chronic fibrous induration of remarkable density and cellular sparseness. Not a cancer-cell was visible, and the lumen, though narrow, was perfectly clear. In conclusion, he desired to exhibit a section stained by Russell's method, with a view to the demonstration of the *fuchsin bodies*, lately described by that observer. Numerous granules, corresponding in size and general appearance with those in question were found, but the colour reaction had not been successful, as they had, without exception, taken on the iodine-green coloration.

The PRESIDENT, in asking the members to discuss the communication, noticed with pleasure the abandonment of the title of the communication by Dr. M'Weeney. The appearances of the tumour were certainly not those of an ordinary or indeed any epithelioma of the skin. He asked for some clinical details of the case.

#### *Remarkable Enterolith.*

MR. MYLES showed a remarkable enterolith, and gave details of a case in which symptoms of complete intestinal obstruction were produced by it. The patient was a lady sixty-five years old, and suffered fifteen years before from hepatic colic, and since then from chronic constipation. This culminated in an attack of complete obstruction necessitating relief by operation. Mr. Myles, assisted by Dr. O'Connor, of Clane, Co. Kildare, in whose charge the patient had previously been, performed laparotomy, and on searching for the cause of obstruction found the gut completely blocked by the calculus lodged in the ileum, the part above distended,

and that below completely collapsed, the calculus fixed and immovable. Mr. Myles then discussed the possible origin of the calculus and the different ways in which it might have acted so as to cause complete obstruction.

The PRESIDENT regretted that a section had not been made of the calculus, as such would have at once answered the question of its origin. This want, which could easily be supplied, detracted but little from the great clinical interest of the specimen.

#### *Marjolin's Ulcer.*

DR. J. K. BARTON exhibited a specimen of Marjolin's ulcer.

The Section adjourned.

#### RESPIRATORY FAILURE UNDER CHLOROFORM.

THOMAS MANLEY, M.D., describes a case (*Medical News*, Philadelphia, Oct. 4, 1890) of death from chloroform administered in a case of fracture of the skull, in which trephining was indicated, in which the respiratory centres yielded first. "The patient ceased to breathe; his features were black and bloated; he foamed at the mouth; the eyes bulged, and plainly he was asphyxiated. Feeling for the radial pulse, I was amazed to find it full, slow, and regular—about 60 to the minute." Artificial respiration re-established breathing for a time, but it finally ceased in about five minutes, and in two minutes afterwards the pulse had ceased. The condition of the brain was noticed through the trephine hole; with dyspnoea and apnoea the brain tissue swelled up; the vessels were enormously distended, and of a deep black colour. With partial return of respiration the brain gradually receded and the vessels returned to their normal size and colour.

#### INFLUENCE OF MENSTRUATION ON THE COURSE OF PHTHISIS.

DR. KARL VON RUCK (*Medical News*, Philadelphia, 13th Sept., 1890) considers that female patients are apt to lose ground during the menstrual week, and this often in the absence of any special disturbance of their menstrual function. Fever, if absent, is apt to return, and if fever is present it is several degrees higher for a day or two immediately preceding the menstrual flow. If the period is entirely missed, or is delayed, the increased temperature has often been observed to continue throughout the time corresponding to the menstrual week. In addition, increased cough, diminished appetite, and digestive disturbances are frequent, and a loss of several pounds in weight has been noticed in a number of cases who had been gaining.