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Medical Societies.

ROYAL SOCIETY OF MEDICINE.

CLINICAL SECTION.

Exhibition of Cases.

A MEETING of this section was held on Dec. 13th, Sir THOMAS BARLOW, the President, being in the chair.

Mr. EDGAR REID (introduced by Professor W. OSLER) showed a case of Ochronosis. The patient was a man, aged 68 years. A large ulcer on each leg had been dressed twice daily with carbolic oil, 1 in 20, during a period of 30 years. Six years ago the ears and whites of the eyes began to turn black and two years ago the urine was first noticed to be dark. In June, 1907, the concavity of each ear was stained a deep blue-black and the sclerotics were stained black in their exposed portions. The extensor tendons of the fingers were bluish-black in colour over the knuckles and the latter showed a slight blue staining. The skin of the face and exposed parts was of a dusky hue as compared with the covered parts. Since June the patient had been kept in bed and the ulcers had steadily

months. The patient was knocked down by a motor-car on Feb. 22nd, 1906. The left femur was fractured in the centre and the left hip dislocated. He was admitted into the London Hospital on Jan. 21st, 1907, wearing a 5-inch clump boot with an actual shortening of 3¾ inches and flexion and adduction contracture of the hip. Tenotomy, extension, and manipulation were repeatedly performed and the left hip was replaced on March 14th, 1907. The movements of the hip were now limited but normal. The shortening was 1½ inches, due to overlapping of the fragments of the femur.

Dr. PARKES WEBER showed a case of Arteritis Obliterans of the Lower Extremity with Intermittent Claudication. The patient was a man, aged 42 years, who complained of cramp-like pains in the sole of the left foot and calf of the left leg occurring after walking for a few minutes and obliging him to rest. When the legs were allowed to hang over the side of the bed the distal portion of the left foot became red and congested-looking. No pulsation could be felt in the dorsal artery of the left foot or in the posterior tibial. There was no evidence of cardio-vascular or other disease. Recent treatment had included internal use of iodipin, subcutaneous injection of fibrolysin, local hot-air baths, and local passive congestion. An ulcer on the little toe had slowly healed (dermatol used), but cramp-like muscular pains still occurred on walking. The disease had lasted about five years without gangrene supervening.

Dr. W. ESSEX WYNTER showed a case of Methæmoglobinæmia of 12 years' standing. The patient was aged 45 years and had been under observation since March, 1902. She had been in the same state of cyanotic anæmia for 12 years, being originally considered to be suffering from Addison's disease. There was a general yellowish pallor, with lilac-coloured mucous membranes, associated with feebleness, constipation, anorexia, and occasional vomiting. The temperature was 100° F. and the pulse was from 74 to 96. A pulmonary systolic bruit existed while the patient was in hospital. The urine was normal. The blood was chocolate-coloured, making comparison difficult in the hæmoglobinometer; the colour was not altered by exposure to carbon monoxide; the red cells numbered 3,010,000; white cells, 7000; hæmoglobin, 50 per cent.; index, 0·74; lymphocytes, 22·6 per cent.; transitional, 2·8; hyaline, 1·6; polymorphonuclear, 71; eosinophile, 0·2; and mast-cells 1·8; the bacillus coli was not found in the blood.—After some discussion the meeting resolved that the case was to be investigated by a committee consisting of Dr. A. E. Garrod, Dr. F. J. Poynton, and Dr. J. H. Drysdale.

Dr. WYNTER also showed a case of Amyotonia Congenita. The patient was an infant, aged 15 months. She was admitted to the Middlesex Hospital on Sept. 21st, 1907, on account of general weakness and backwardness. The parents and brother and sister were quite healthy. The child had been attending for two months at the Hospital for Sick Children and was stated to be getting weaker and thinner. The striking feature in the condition was the flabbiness of muscles and freedom of movement in articulations, allowing of flexion and extension beyond normal limits, so that the

toes could be made to touch the front of the leg and the fingers the back of the forearm, while the legs could be flexed up to the chin. The child could sit up and walk and was cheerful and intelligent. The face was not affected. The muscles of the limbs though flabby showed fair bulk and responded to voluntary impulses. They did not contract to strong faradism and moderate currents induced no pain.—The PRESIDENT said he had seen two cases but did not know their ultimate history.—After Dr. H. MORLEY FLETCHER had spoken Dr. WYNTER replied.

Dr. WYNTER also showed a case of Ascites cured by permanent drainage through the femoral ring. The patient was a man, aged 50 years, who was admitted to the Middlesex Hospital on July 11th, 1907. For a week there had been swelling of the abdomen and legs with slight jaundice. There was no evidence of cardiac disease, but the daily output of urine was only 15 ounces, and it contained a trace of albumin; the specific gravity was 1010. Purgatives, diuretics, and Canadian hemp were tried without effect. The ascites increased and on August 26th tension was relieved by removing 300 ounces of fluid. This was only of temporary benefit and on Sept. 23rd Mr. Sampson Handley made a small incision below the umbilicus and several pints of fluid escaped. An incision as for femoral hernia was then made and with the aid of one finger in the abdominal cavity the process of peritoneum was drawn down and split, and the edges were stitched right and left to maintain the opening. The wounds were then closed. Owing to some leakage at the femoral wound paracentesis was performed a week after operation. Some oozing from a stitch puncture in the thigh continued for about three weeks, showing that the communication with the peritoneal cavity remained open, but the ascites did not recur, and by Nov. 20th there was no perceptible fluid in the abdominal cavity. The patient had been walking about the ward for a fortnight and neither femoral hernia nor œdema of the leg had developed; indeed, the girth of the right thigh was an inch less than on the opposite side. In this case the femoral operation was performed deliberately for the cure of ascites with the object of draining the abdominal cavity into the tissues outside the abdomen, so saving repeated paracentesis and the removal of quantities of albuminous fluid and to enable the patient to get about.

Dr. PASTEUR showed a case of Anterior Poliomyelitis. The patient was a boy, aged 13½ years. The illness began in November, 1906, with pain in the abdomen and the thighs, and fever and delirium. Two days later there was loss of power in the lower limbs; the paralysis spread, and the mother noticed that the boy could not cough; the arms were not completely paralysed. On admission on the eighth day (Nov. 19th) there was flaccid paralysis of the lower limbs, the diaphragm was paralysed, the respiration was entirely thoracic, the abdominal muscles were paralysed, and the abdominal and epigastric reflexes were absent. The movements of the thorax were equal on the two sides but deficient; there was paresis of all the muscles of the upper limbs. No paralysis of the face, the tongue, the palate, or the pharynx was noticed. For ten days the condition was critical; artificial respiration was performed every two or three hours; inhalations of oxygen and hypodermic injections of strychnine were given frequently. The fever terminated by crisis on Nov. 30th and the condition began to improve. From March until the present time the condition had remained as follows: complete recovery of power in the upper limbs; considerable recovery of thoracic muscles; persistent paralysis of the muscles of the lower limbs.

Dr. F. J. POYNTON showed two cases of Thyroid Swelling in young girls. The first patient was aged 15 years. She was admitted into hospital with a large thyroid swelling, with marked tremor and nervousness. There was nothing in the family or personal history which threw light upon the illness. In character she had always been heavy and inclined to drowsiness and the swelling of the thyroid first commenced a year ago. The catamenia had not begun. The particular features of interest in this case were: that, apart from ocular changes, which were entirely absent, the condition was one of well-marked Graves's disease; considerable and general thyroid enlargement affecting the right lobe more than the left; very marked fine tremor of the fingers and hands; tachycardia, from 124 to 140 per minute; nervousness and flushing of the face; and slight rise of temperature on admission. The cautious use of thyroid increased the symptoms and was promptly abandoned. The age of the

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diminished in size. Although the carbolic dressings had been continued the staining had perceptibly diminished. Mr. Reid said it was the second case recorded in the British Isles; the first was fully described in THE LANCET of Jan. 6th, 1906, p. 24.—Professor OSLER passed round a copy of Virchow's "Festschrift," Band ii., 1891, containing the article by Professor E. Bostroen, "Ueber die Ochronose der Knorpel," illustrated by coloured plates.—The discussion was continued by Dr. W. HALE WHITE, Dr. F. PARKES WEBER, and Dr. A. E. GARROD.

Professor OSLER showed a case of Splenic Polycythæmia with Cyanosis. The patient was a very healthy, hard-working woman in whom, within the past two or three years, there had been slight failure of health and strength but no other symptoms of importance. She was permanently cyanosed. She presented in an unusual degree the three characteristic features of the disease: a permanent cyanosis, a greatly enlarged spleen, and a polycythæmia of 10,000,000. In regard to the leucocytes there was no increase. There was no marked variation in the size of the red blood corpuscles. There were nucleated red cells in moderate numbers, chiefly normoblasts.—The case was discussed by Dr. PARKES WEBER, Dr. W. PASTEUR, and the PRESIDENT.

Mr. T. H. OPENSHAW showed a case of Traumatic Dislocation of the Hip in an adult reduced by manipulation after 13 months. The patient was knocked down by a motor-car on Feb. 22nd, 1906. The left femur was fractured in the centre and the left hip dislocated. He was admitted into the London Hospital on Jan. 21st, 1907, wearing a 5-inch clump boot with an actual shortening of 3¾ inches and flexion and adduction contracture of the hip. Tenotomy, extension, and manipulation were repeatedly performed and the left hip was replaced on March 14th, 1907. The movements of the hip were now limited but normal. The shortening was 1½ inches, due to overlapping of the fragments of the femur.

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patient and the combination of nervousness and mental dulness were remarkable, and the marked improvement from simple rest in hospital was pointed out, whereas three months out-patient treatment had been quite ineffectual. Within a few days of admission all tremor had disappeared and the thyroid and pulse-rate had steadily diminished since the date of entering the hospital, Nov. 15th, 1907. The second patient was aged 12 years. The interest of this case lay chiefly in the history. The patient had been under Dr. Poynton's supervision for nine years and came to him originally from Dr. Garrod who had treated her for cretinism as an infant. Six years ago the child appeared so natural that Dr. Poynton made two attempts to leave off the thyroid treatment. In both instances within six weeks the following symptoms appeared: a swelling in the neck, obviously the thyroid, mental dulness, slowness of speech, and enlargement of the tongue. The resumption of the thyroid caused the disappearance of all these symptoms. Four weeks ago the patient, who had been steadily treated ever since these attempts, came to Dr. Poynton at University College Hospital showing a definite thyroid swelling. There were no symptoms of Graves's disease. At present no increase had been made in the amount of thyroid given and the neck still showed the swelling. The diagnosis inclined to was partial cretinism, with compensatory enlargement of an inefficient thyroid to supply the lack of secretion when the outside supply was slowly cut off. This case appeared to throw light upon the cases of thyroid enlargement which reacted favourably to thyroid treatment and was in this respect an antithesis to the first case.

Dr. J. GRAHAM FORBES showed a patient, aged 34 years, with an Unusual Form of Gouty Deposit in the Left Olecranon Bursa. He was a beer-drinker. Gouty deposits had been noticed for four years. There were tophi in both ears. There was a much enlarged bursa over the left olecranon, containing fluid and a mass of chalk-like concretion. There was thickening about the left shoulder-joint and wrist and there were subcutaneous deposits in the fingers and thumbs of both hands. There was thickening of the synovial membranes of the left knee and ankle joints but there was no evidence of gouty deposits about the great toe joints.

Dr. H. BATTY SHAW showed a case of Bulbar Paralysis. The patient was a woman, aged 47 years. For 20 years she had had a large bronchocele and slight attacks of periodic huskiness of the voice. In February, 1903, there was cough of a "brassy" character, unaccompanied by any paralysis of the vocal cords, and probably due to pressure on the trachea; tachycardia and tremor of the hands were occasionally observed. In June, 1907, half the bronchocele was removed as the pressure on the trachea was increasing; it presented the microscopic structure of carcinoma. On July 8th the voice was almost completely lost; there were stridor and weakness of the left lower facial muscles. On the 15th there were pain and stiffness of the back of the neck. On August 21st atrophy of the right half of the tongue was noted. On the 28th there was diplopia. On Nov. 5th paresis of the sixth nerve on the right side, paresis of the right half of the palate, paresis and atrophy of the right sterno-mastoid and trapezius and aphonia were noted. She could swallow solids with difficulty; paresis of the left lower facial muscles and complete paralysis of the left vocal cord were noted and vomiting had recently occurred. The diagnosis lay between primary degeneration of the centres of the various nerves involved, possibly due to thrombosis, and a secondary deposit in and about the medulla. The latter view was supported by the presence of severe pain and stiffness of the muscles of the back of the neck. There was no history of syphilis.

Dr. SHAW also showed a case of Hepato-splenomegaly with Ascites. The patient was a child, aged three and a half years, who was noticed to be short of breath in June last. She was now easily tired and unable to walk far owing to shortness of breath. The abdomen was observed to be swollen on Nov. 22nd of this year and this had increased steadily. She was the eldest of three children. Both mother and father had had rheumatic fever and the mother had had one miscarriage since the birth of the youngest child. This child was breast-fed till eight months old and then was fed on boiled milk till solid food was given. There were no signs of tuberculosis or of syphilis. The liver was enlarged and the spleen could be felt easily until recently, when the ascites had increased. There was no albumin in the urine, nor were there signs of cardiac disease. The blood count was normal for a child of three and a half years, except that the percentage of hæmoglobin was only 64 and that a leucocytosis of 36,000 white corpuscles existed. Jaundice had not been observed.

SECTION OF SURGERY.

Complete Gastrectomy.

A MEETING of this section was held on Dec. 10th, Mr. J. WARRINGTON HAWARD being in the chair.

Mr. B. G. A. MOYNIHAN read a paper on a case of Complete Gastrectomy, which is published at p. 1748 of this issue of THE LANCET.

Mr. W. MCADAM ECCLES said that he had a somewhat similar case two years ago. The patient, a woman, aged 46 years, had had symptoms of gastric trouble for the preceding three years. She was very thin and it was quite easy to palpate the swelling in the region of the stomach. The stomach, as judged by the specimen, bore a strong resemblance to that shown by Mr. Moynihan. There was a marked constriction between the pyloric and cardiac ends. There were no adhesions to be found and he considered it a case suitable for gastrectomy. So little of the cardiac end of the stomach was left that it was almost a complete gastrectomy. He proceeded in the same way as did Mr. Moynihan, ligaturing the vessels as far as possible and then dividing the duodenum. He also ligatured the right gastro-epiploic artery, turning the stomach over to the left side and getting well up to the cardiac portion. Then there arose the difficulty which Mr. Moynihan had so graphically shown might be overcome by traction, as to how to manage the suturing of the œsophagus to a portion of the intestine. He boldly cut through the cardiac portion of the stomach just below the œsophagus, and finally ligatured the vessels on that side, and was then able to bring the duodenum to the œsophagus, and he did an end-to-end suture between them. She did very well and was able to take solid food within three weeks and left the hospital in a month. She then died from what seemed to be secondary growths in the liver. No post-mortem examination was allowed and he was unable to see the results of the gastrectomy. The microscopical characters were so similar to those mentioned in the present case that he would not enter into them. The most interesting point seemed to be the method which Mr. Moynihan described of anastomosing between the distal end of the œsophagus and the first loop of the jejunum and that seemed a very practical and useful suggestion. It was only in a few cases that gastrectomy could be performed.

Mr. MOYNIHAN replied.

SECTION OF LARYNGOLOGY

Exhibition of Cases and Specimens.

A meeting of this section was held on Dec. 6th, Dr. J. B. BALL, the President, being in the chair.

Dr. J. COUBRO POTTER and Dr. W. JOBSON HORNE showed a case of Adherence of the Soft Palate to the Pharyngeal Wall in a youth aged 21 years. It was generally considered that the case was one of lupus and that operation was not advisable.

Mr. ARTHUR H. EVANS exhibited a specimen of Leprosy of the Larynx.

Dr. HERBERT TILLEY showed a case of "Bridle" Formation on the Left Ventricular Band, the result of syphilis. He also showed a man, aged 46 years, with Granular Congestion of the Right Cord. There had been no improvement under mercury and iodide of potassium and there was a suspicion of malignant disease.—Sir FELIX SEMON thought that it was a case of unilateral simple laryngitis.

Mr. HAROLD S. BARWELL showed a case of Symmetrical Nodules on the Cords of a boy aged nine years.

Mr. LAWRENCE JONES showed a case of Laryngeal Gumma which had been uninfluenced by oral administration of mercury and iodide of potassium, but rapidly improved under intramuscular injections of benzoate of mercury.

Mr. ARTHUR J. HUTCHISON showed a boy, aged 15 years, with Bilateral Tumours of the Upper Jaw, reported microscopically as sarcoma, but unchanged over 12 months. The condition was more probably allied to leontiasis ossium.

Dr. P. WATSON WILLIAMS showed a man, aged 24 years, with Immobility of the Left Cord and Ulceration of the Left Ventricular Band.

Dr. CYRIL A. B. HORSFORD exhibited a woman from whose