

England certainly, due to these great Fellows of the College of Physicians.

I have already lectured long enough, and you will see I have upon the table a great many other books. Here is Wepfer's "Treatise on Apoplexy," which when once you have read you will be sure to read often. It is delightful from the way in which each observation reveals a little more truth to him till a great addition to knowledge is established. Here is Nicholas Tulpius, whose portrait giving an anatomy lesson was painted by Rembrandt. He was the first person to give a drawing of fibrinous bronchitis and one of the first to describe beri-beri. Here are the volumes of Morgagni, and there is the Sepulchretum of Bonetus. They hit upon the plan of collecting large numbers of cases of morbid anatomy and putting them side by side with clinical notes, and so was founded the modern method of the study of morbid anatomy. Here is Dr. Freind's "History of Physic from Galen to the Revival of Learning"; it is the best history of physic in English. Freind was a great physician and was sent to the Tower because it was supposed he was concerned in a plot to bring in the House of Stuart in the reign of George I. His imprisonment had this beneficial result, that it gave him the leisure in which to write this book which he had long had in his mind. It is one of those books which satisfies you whenever you read it. He makes the contents of the writers of that period delightfully clear. Here is the treatise of Dr. James Douglas on all the writers of anatomy, "Bibliographiæ Anatomiciæ Specimen," a small shabby-looking book now, but which you will never consult in vain. He has read every book which he mentions and gives a most precise account of each writer. Here are the two authors which I remember devoting most time to when I was reading for my bachelor of medicine degree, the lectures on medicine of Sir Thomas Watson and the treatise on medicine by Dr. Felix von Niemeyer. They are both excellent books, both now obsolete in many parts as you will see from this extract: "Mr. Paget" (that is Sir James Paget) "states his belief that there are no signs, microscopic or other, by which degenerate lymph or pus can be with certainty distinguished from ordinary tuberculous matter." Niemeyer was an excellent physician of the most precise method, who always begins by describing first hypertrophy of an organ and then atrophy of it, and so continues all through the body, and divides all kinds of inflammation into catarrhal, and croupous, and diphtheritic. I feel deeply grateful to those text-books. Watson is written in the most admirable style, and contains many passages which will always remain worth reading in English medicine. Niemeyer contains amidst the drier collection of facts several touches of humour, such as the mention of the wife of a Prussian general who held that the whooping of whooping-cough was voluntary, and said if children were whipped sufficiently they did not whoop much. And the other remark of Niemeyer himself as to the difficulties of determining the causes of alopecia, in which he says that people declare alopecia is due to excessive learning or to extreme dissipation, according as they take a favourable or unfavourable view of human nature.

These are a few of the books which at different times have given me pleasure or to which I feel grateful. But, of course, books which please one man do not necessarily please another; every man must choose his own; and you will find it a useful training of your minds in the practice of medicine to make some friends, permanent and long-lasting friends, among medical writers.

ROYAL ACADEMY OF MEDICINE IN IRELAND.—

The annual general meeting of the Royal Academy of Medicine in Ireland took place at the Royal College of Physicians of Ireland on Oct. 12th, when Dr. J. Magee Finny was elected President in succession to Sir Thornley Stoker.

UNIVERSITY OF OXFORD.—Degree days for the ensuing term are announced as follows: Thursday, Nov. 8th, at 10 A.M.; Thursday, Nov. 29th, at 10 A.M.; and Thursday, Dec. 6th, at 10 A.M.—Scholarships in natural science are offered for competition as follows: Dec. 4th, Balliol College, Christ Church, and Trinity College; Dec. 11th, University, Lincoln, and Magdalen Colleges; and Jan. 15th, 1907, Jesus College.

SOME OBSERVATIONS ON ENLARGED VEINS IN CHILDREN.¹

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1. *Introductory.*—A large number of children attending the out-patient department of a hospital suffer from general debility, wasting and listlessness. A cursory examination of such cases reveals nothing abnormal but more careful observation in many cases shows a ramification of small venules on the chest and elsewhere. Many of those in whom venules are easily seen also show a certain degree of prominence of one or both jugular veins.

2. *Conditions of the veins in these cases.*—The venules seen on the chest are small ramifications flush with the surface of the skin; in front they tend to converge towards the upper part of the sternum but behind they usually show a stellate arrangement. In some of the most marked cases large veins can be seen as far out as the deltoid region. As a rule no veins are seen below the chest but I have seen cases in which there was no abdominal disease showing such venules about the groin. The jugulars can almost always be seen either as blue streaks or distinctly dilated; one or both sides may be affected. Veins can frequently be seen also under the chin, at the temples, and very occasionally on the forehead. A normal adult from a number of causes may present a full jugular vein, but in very few children with no suspicion of disease is such a condition seen. In adults a large jugular vein is always emptied during inspiration, a fact which can most readily be verified by watching the neck of a person breathing deeply under ether; but in children who have large jugular veins together with venules on the chest a deep inspiration produces only a slight collapse, if any, of the veins; this is true of the upright as well as the recumbent position. Records have been kept of 14 cases showing visible venules together with dilated jugulars which behave abnormally on respiration. The descriptions are in some details incomplete, taken as they were in the hurry of hospital practice and many points were noted in the later cases which were omitted from the earlier.

3. *Description of cases.*—CASE 1.—The patient, a boy, aged eight years, was taken to hospital because of wasting and a "dry" cough in the morning. There were enlarged veins in both supraclavicular fossæ which did not completely or quickly collapse on inspiration. The chest was fairly well formed and measured 11½ inches on the right side and 11½ inches on the left. The note was very slightly duller on the right side than on the left in front and behind. The breath sounds were normal and equal in intensity; there were no adventitious sounds. As regards the heart, a systolic murmur was heard at the apex not traceable outwards but heard up the sternum to the second right costal cartilage; it was not altered on retraction of the head. The abdomen was normal. No superficial enlarged glands.

CASE 2.—The patient, a female, aged eight years, had always been a delicate child. Her appetite was bad, she vomited occasionally, and had been getting thinner lately. She suffered from a cough of a somewhat paroxysmal nature, bringing up a very small amount of phlegm. She occasionally had some pain over the præcordium. The bowels were regular. A few prominent venules were seen on the chest, the jugulars were large and did not collapse completely on inspiration, the temporal veins were easily visible, and the capillaries of the face were dilated on the cheeks. There were no veins on the abdomen. The hair on the skin was not markedly long. The chest signs were not abnormal; a retraction murmur (systolic) was present over the upper part of the sternum. A few glands were felt in the groins and in the neck. The tonsils were not large and there were no adenoids.

CASE 3.—The patient, a female, aged nine years, was taken to hospital because of indefinite ill-health for five or six months, pains in the joints, and cough of a barking and paroxysmal nature. There was no sputum; the appetite was fair but sometimes failed; there was no sickness; the bowels were costive. There was no tuberculosis in the father or mother; her grandfather, however, lost three sisters from consumption and of the family of which she was one there

¹ A paper read at the Oxford meeting of the Society for the Study of Disease in Children on June 23rd, 1906.

were eight living while three were dead, one dying from "rapid consumption," another from meningitis, and a third from a cause not known. The patient was a thin child, especially so about the shoulders; the hair of the skin was very long. Veins were seen over the front of the chest; the jugulars were easily visible and did not collapse on inspiration. Of signs in the chest there was no dulness or diminished expansion of one side more than the other, the breath sounds were very slightly harsher on the right side, and there was a slight systolic murmur over the upper sternum on retraction of the head. There was one gland on the right side of the neck of about the size of a filbert and one on the left side about the same size. The mucous membrane of the throat was thick and pale.

CASE 4.—The patient was a female, aged eight years. For some months she had had a failing appetite and had been looking paler. She had had no cough. There were nine children in the family, all being healthy except the patient. The father suffered from consumption. Once the child passed some round worms. The patient was a well-grown but thin and pale girl. On the chest there were many visible veins in front, not lower than the xiphisternum, and above they stretched out towards the shoulders. Veins were seen on the temples and the jugulars, which were enlarged, did not properly collapse on inspiration. The chest moved fairly well, if anything more on the right side. The right side measured $12\frac{1}{4}$ inches and the left $11\frac{1}{2}$ inches. The percussion note was very slightly duller on the left than on the right side, especially in the axilla. Breath sounds were well heard. No adventitious sounds were heard. The heart was normal but over the aortic region was a loud diastolic and feebler systolic murmur. There were no glands in the groins or axillæ but a few small ones were found in the neck. The abdomen was normal. The throat also was normal.

CASE 5.—The patient, a female, aged six years, suffered from loss of appetite and had got thinner, paler, and more languid lately; she was often sick and she had occasional headaches. The bowels were regular. She was the twelfth child; five of these had died from chest troubles. She had chicken-pox two months ago, since which time she had been worse. Veins were seen on the chest in front; the jugulars were large and did not collapse on inspiration. A retraction murmur was present. Glands were felt on both sides of the neck and in both axillæ, small and soft. The throat was normal and no adenoids were present. With treatment this child increased three pounds in weight in a fortnight, became less pale, and the appetite improved.

CASE 6.—The patient, a female, aged nine years, suffered from lassitude and dyspnoea on exertion. There was no loss of appetite. This had been going on for a year, during which time she had got much paler and thinner. She had a little cough in the morning and she had been much subject to "colds." The bowels were regular. She had had measles three years ago. Her grandfather died, as far as could be ascertained, from consumption. A few dilated veins were seen over the sternum. The jugulars did not collapse properly on inspiration. There were also veins on the temples. There was a well marked retraction murmur. Glands of about the size of filberts were felt on either side of the neck in the anterior triangle and a few shotty glands in both clavicular triangles. The hair on the back was downy.

CASE 7.—The patient, a female, aged seven years, had been ailing for three years. She was irritable, suffered from cough, which was relieved on bringing up a small amount of mucus; she had got paler and had a bad appetite. The bowels were regular. She sweated sometimes at night. She had had measles twice; there was no history of consumption in the family. The mother had had four children, two of whom died at birth. There were a few dilated veins on the chest; the jugulars were prominent and did not collapse properly on deep inspiration. The hair on the back was downy. There was a retraction murmur, the chest being otherwise normal. One gland on each side of the neck was felt and a few shotty ones in the posterior triangle and groins. The tonsils were slightly enlarged. There were no adenoids.

CASE 8.—The patient, a male, aged seven years, had had diarrhoea and sickness every three or four weeks for three years. An attack lasted two days. The motions during the attack were white and frothy and there was great pain. He had had no previous disease. There was consumption on his father's side. The patient was pale and undergrown. The muscles were wasted; the hair on the back was downy. The veins on the chest were numerous;

the jugulars were prominent and did not collapse on deep inspiration. In the chest there was an impaired note in the upper part of the right chest with bronchial breathing further to the right of the sternum than normal but there were no adventitious sounds. A retraction murmur was present. The abdomen was full, the walls were thin, showing coils of bowel through; it had a doughy feel and some doubtful deep glands were felt. The liver and spleen were normal. No glands were felt anywhere. This child had a febrile attack with crepitations on the right side of the chest during my observation of him; he also developed a little fluid in the abdomen but both signs cleared up and recovery was complete with a marked increase in weight.

CASE 9.—The patient, a male, aged five years, was brought for advice about lumps in the neck. He had suffered from bronchitis every winter and had had whooping-cough. He was getting feebler for the last two months; he coughed a great deal and breathed badly at times. The glands had been present for three months. There was a strong history of consumption on the mother's side. The face was pale, the skin was very dry, the hair on the back was fine and long, the nutrition was poor, and the fingers were not clubbed. There were veins on the front of the chest and the jugular, which was prominent, did not collapse on inspiration. Measurement of the chest gave: right side, $9\frac{1}{2}$ inches; left side, $10\frac{1}{2}$ inches. The right side gave a slightly impaired note compared with the left. Breath sounds on the right were bronchial at the apex, becoming broncho-vesicular and, finally, vesicular at the lower limits of the lung in front and in the axilla. Behind the air entry on the right side was less. In the neck there were many enlarged glands, some large, some small; the larger ones were matted together. There were small glands in the axillæ. The tonsils were large. The spleen was two inches below the costal margin and the liver one inch below. There was no fluid in the peritoneal cavity. The blood count showed a secondary anæmia with no change in the white cells. This case was supposed to be a case of lymphadenoma but the further symptoms—matting together of glands, condition of the hair on the back, &c.—seemed to point to a chronic tuberculosis of the glands.

CASE 10.—The patient, a male, aged five and a half years, had had some chest trouble one year ago. There were two living children in the family; one died from pneumonia and there had been one miscarriage; no history suggesting syphilis was obtainable. Two maternal uncles had died from consumption. A few venules were seen on the back; the temporal veins were seen and the jugulars were prominent and did not collapse completely on deep inspiration. Measurement of the chest gave: right side, $11\frac{1}{2}$ inches; left side, $11\frac{1}{4}$ inches. On the right side vocal resonance was slightly increased and the breath sounds were slightly diminished in intensity. No adventitious sounds were heard. There were glands at both sides of the neck in the region of the angle of the jaw and a few smaller ones down the neck. The tonsils were large.

CASE 11.—The patient, a female, aged four years, had never been a healthy child; her appetite was variable and she was always constipated. She had had a slight cough recently and sometimes sweated at night. A paternal uncle died from consumption. She was a pale, thin girl and showed veins on the chest and upper part of the abdomen. The jugulars were large and did not collapse on deep inspiration. The chest measurement was $9\frac{1}{2}$ inches on the right and 10 inches on the left. The note on the right side was slightly flatter than on the left. The abdomen was full; the liver was one inch below the costal margin; what appeared to be mesenteric glands were felt in the umbilical region. One large gland lay under the sterno-mastoid on the left side of the neck; a few smaller ones were felt in the right groin.

CASE 12.—The patient, a male, aged ten years, had suffered from wasting for ten months, previously to which he was a healthy boy except for bronchitis about one year ago. Two other children were healthy. There was no history of tuberculous affections. The patient was thin and wasted, with a soft sweating skin; the features were pinched. Veins were obvious on the chest, abdomen, chin, temples, and neck. The left jugular vein was large and did not collapse on deep inspiration. The hair of the head was thin and wiry. On the right side of the chest the note was slightly flatter than on the left; breath sounds were poorer and had a slight bronchial element. No retraction murmur was heard. The abdomen looked natural but on palpation had an irregular mass in the right iliac fossa. Some shifting dulness

was found in the flanks. The temperature was intermittent and the pulse was 150. The leucocytes numbered 22,000 per cubic millimetre of blood. An operation was performed in view of the possibility of there being a collection of pus in the right iliac fossa but an enlarged thickened appendix was found studded over with tubercles, tubercles being abundant on the neighbouring peritoneum, and a large mass of glands in the iliac region. This patient died and the mediastinum was examined; it is described later.

CASE 13.—The patient, a male, aged six years, had measles nine months previously; five months previously he had a "cold" in his abdomen and pain. The week before

prominent, doughy, and showed no definite fluid or tenderness. One month later there was definite evidence of fluid in the abdomen and a slight lump developed later in the umbilical region.

In the accompanying synopsis will be seen the main features of these cases. 50 per cent. are male and 50 per cent. are female; the ages range from four to ten years. In 57 per cent. there is a history of tuberculosis in the family; visible veins on the chest are present in 92 per cent.; downy hair in 42 per cent.; a Eustace Smith retraction murmur in 71 per cent.; and palpable glands in the neck in 64 per cent.

SYNOPSIS OF THE CASES.

Case.	Age and sex.	Complaint and chief symptoms.	History of tuberculosis in family.	Enlarged jugular veins.	Do they collapse on inspiration.	Veins on chest.	Veins on back.	Veins under chin.	Veins on temples.	Condition of hair of skin.	Eustace Smith retraction murmur.	Glands.	Tuberculous lesions elsewhere.
1	8, M.	Wasting; cough.		+ (R. & L.)	No.	+				—	+	—	—
2	8, F.	Wasting; cough; vomiting.		+ (R. & L.)	„	+			+	Downy.	+	—	—
3	9, F.	Debility; cough.	+	+ (R. & L.)	„	+				„	+	One gland in neck.	—
4	8, F.	Falling appetite.	+	+ (R. & L.)	„	+			+	—		Small glands in neck.	—
5	6, F.	Falling appetite; wasting.	+ (?)	+ (R. & L.)	„	+				—		„	—
6	9, F.	Lassitude; breathlessness on exertion.	+	+ (R. & L.)	„	+			+	Downy.	+	„	—
7	7, F.	Irritability; cough.	0	+ (R. & L.)	„	+				„	+	Two large and several small glands in neck.	—
8	7, M.	Diarrhoea and vomiting in attacks.	+	+ (R. & L.)	„	+				„	+	Absent.	? Tuberculous peritonitis.
9	5, M.	"Weak chest"; cough.		+ (L.)	„					„			—
10	5½, M.	Debility; "chest trouble."	+	+ (R. & L.)	„	+			+	—	+	Gland at angle of jaw.	—
11	4, F.	Debility; bad appetite.	+	+ (R. & L.)	„	+				—	+	Gland in the neck and right groin.	—
12	10, M.	Wasting.		+ (L.)	„	+	+	+		—	0		Tuberculous peritonitis.
13	6, M.	Delicate boy.	0	+ (R. & L.)	„	+			+	—	+	Submaxillary glands.	—
14	6, M.	Debility; frequent defæcation.		+ (R. & L.)	„	+	+	+	+	—	+	Glands in neck.	Developed tuberculous peritonitis.

R. = right; L. = left; + = present; 0 = absent.

admission he had pain in the abdomen. He was a delicate child but no tuberculous history was elicited. The patient was a fairly healthy looking child. The colour on the cheeks was slightly bluish. He had long eyelashes, otherwise the hair was not abnormal. Veins were seen on the temples, ears, and chest. Both jugulars were enlarged, the left being larger than the right; neither collapsed on deep inspiration. The subcutaneous fat was fair in amount. The chest was normal but a blowing retraction murmur was heard in systole and diastole. In both submaxillary regions there was a gland, larger in the right, which was of about the size of a Barcelona nut. Small glands were felt behind the sterno-mastoids, one on either side; the axillæ and groins were free.

CASE 14.—The patient, a male, aged six years, until nine months previously was a healthy boy but since then had suffered from a frequency of defæcation. The desire was especially after food and was sometimes so sudden that he had to leave the table. The motions were light yellow, at times liquid, and always very offensive. His general health was failing, he was getting thin, and only "picked" at his food. Occasionally he was sick in the morning; he brought up sometimes as much as a pint at once. He was less playful and more irritable than formerly. He had had measles, pneumonia, and "brain fever" when three years old. His father had abscesses in the neck and a maternal great-aunt suffered from consumption. He was a thin, delicate-looking boy. Veins were seen on his temples, chest, back, and groins. The jugulars were large and did not collapse completely on inspiration. The lungs were normal; a well-marked murmur was heard. One gland was felt on each side of the neck of the size of a large pea; the tonsils were normal and there were no adenoids. The abdomen was

4. *The cause of the conditions in the veins.*—I believe these cases to be examples of tuberculous bronchial glands described by Barthez and Rilliet² and amongst English writers by Eustace Smith.³ The former writers, who first accurately described the condition clinically, refer to the conditions of the veins as follows: "*Dilatations, veineuses, &c.*—Un phénomène que nous n'avons que rarement observé, peut-être parceque notre attention n'a pas été suffisamment portée sur ce sujet, est la dilatation des veines du cou. Elle était fort remarquable chez un enfant de cinq ans, qui présentait à lui seul la plupart des symptômes de la phthisie bronchique. Elle est analogue à la dilatation des veines abdominales, que l'on observé quelquefois dans la phthisie mésentérique. D'autres effets de la compression vasculaire se rapprochent du précédent et doivent être mentionnés bien qu'on ait rarement occasion de les constater; nous voulons parler de la teinte violacée de la face, des lèvres et de la langue, résultat évident de la congestion veineuse. Les larges anastomoses qui existent entre toutes les parties du système veineux supérieur expliquent le peu de fréquence de ces symptômes. Le facies de quelques uns des malades, se reproche de celui que l'on observe chez les individus atteints de maladies du cœur. Cependant, nous n'avons jamais constaté de lésion anatomique ou fonctionnelle de l'organe central de la circulation." Eustace Smith, the only writer of recent years so far as I have been able to find who refers to the condition of the veins more than to mention the possibility of venous obstruction, mentions that enlargement of the

² Barthez et Rilliet: *Maladies des Enfants*, tome iii., p. 623, second edition, 1854.

³ Eustace Smith: *The Wasting Diseases of Children*, sixth edition, 1899, p. 309.

veins of one side of the face and neck with a prominent jugular on that side should always lead one to suspect the existence of enlarged bronchial glands.

In describing the tuberculous diathesis several writers have referred to the presence of visible veins; Landouzy,⁴ describing the tuberculous predisposition, says: "Peau blanche, fine transparente marbrée de veinules, souvent tachetée de macules; système pileux soyeux, de coloration rousse ou rouge; iris bleu; chairs molles; sueurs faciles, parfois odorantes; formes plutôt graciles et élégantes." Eustace Smith⁵ says: "Such children are tall for their age and slightly made, the skin is delicate and transparent-looking, allowing the superficial veins to be easily seen," &c. It is questionable whether thinness and transparency of the skin, a condition which has been accepted by medical writers, is sufficient to explain the condition in which these veins become visible. In wasting other than that due to tuberculosis it is not common to see superficial venules; it is possible to see, as I have seen, superficial venules in children with a moderately good layer of superficial fat; further, in view of the association in the cases quoted of dilated jugular veins along with visible venules on the chest, it is legitimate to assume that the two conditions may be due to the same cause. Only once (Case 12) has it been possible to observe the conditions under which the enlarged veins are produced and in this case only the left jugular vein was dilated. A dissection of the anterior mediastinum shows a ring of fleshy enlarged glands encircling the left innominate vein (Figs. 1 and 2) attached

FIG. 1.

FIG. 2.

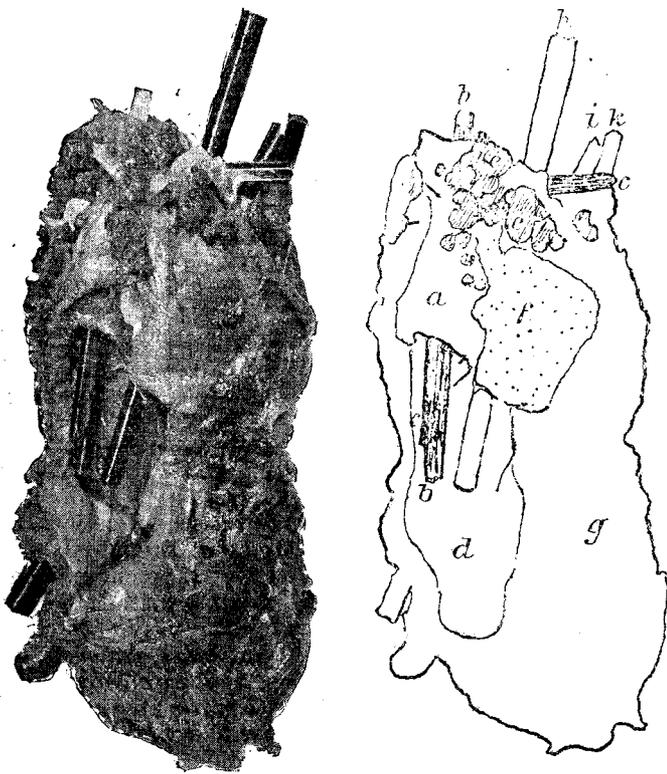


Fig. 2 is a tracing from Fig. 1. *a*, Superior vena cava. *b*, *c*, Glass rods in the right and left innominate veins respectively. *d*, Pericardium. *e*, Small, fleshy lymphatic glands compressing the left innominate vein. *f*, Thymus. *g*, Root of left lung. *h*, *i*, *k*, Glass rods in the innominate artery and the left carotid and subclavian arteries respectively.

below to the thymus. Microscopic sections of one of the glands shows giant cell systems and a few tubercle bacilli. The primary focus of infection in this case has been a mass of caseous glands containing numerous bacilli in the posterior mediastinum. Stretching up from this focus along the lymphatics are several small fleshy glands of the same type as that encircling the vein. In assigning the cause of the condition in the other cases supposition must necessarily take the place of proof, but in view of the facts enumerated above, the history of tuberculosis, the condition of the hair, the presence of a retraction murmur, and the presence of small glands in the neck, the importance of which has been insisted on by Legroux⁶ as an aid to the diagnosis of tuber-

culosis in children, it becomes highly probable that tuberculosis of the mediastinal glands is the cause.

From the pathological standpoint we have adequate proof that tuberculosis of the glands, especially those of the mediastinum, is extremely frequent in children who have died from diseases other than tuberculosis, and that where death has been due to tuberculosis an overwhelming percentage of cases show the glandular mediastinal affection in addition to that of other organs. It is sufficient in this connexion merely to mention the writings of Sims Woodhead,⁷ Coleman,⁸ Walter Carr,⁹ Leonard Guthrie,¹⁰ in this country, and C. Spengler¹¹ and Neumann¹² in Germany as a few examples of writers dealing with the subject from this point of view. Some of the French writers have recognised from the results of this work that most children attending the out-patient departments of our hospitals harbour tubercle bacilli somewhere in their bodies. As yet, however, we have had no means of detecting minute glandular lesions of the mediastinum so frequently the cause of a general infection, but it is suggested that the presence of visible veins on the chest, dilated jugular veins which do not collapse on inspiration, visible veins under the chin or on the temples, together with the other suggestive facts (enumerated above) in the history and state of the patient may lead to an increase in the number of these cases diagnosed during life. It is hardly necessary to mention how quickly these children improve under a liberal diet and ordinary attention to health and therefore what a valuable weapon for prophylaxis the knowledge of the presence of mediastinal tuberculosis may become.

My thanks are due to Dr. H. P. Hawkins of St. Thomas's Hospital and to Dr. W. T. Brooks and Dr. W. Collier of the Radcliffe Infirmary, Oxford, for the opportunity to study and the permission to use the cases referred to in this paper. Oxford.

STRANGULATION OF THE APPENDIX VERMIFORMIS IN HERNIAL SACS.

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THE appendix as a content of a hernial sac is by no means infrequent. Many statistics have been compiled showing a percentage of cases in which the appendix is herniated. These, however, can hardly be quoted as an accurate interpretation of the relative frequency of the appendix in hernial sacs, since in many cases the latter is empty at the time of operation and the viscus which has occupied it must remain unknown. The combined statistics of Hoffmann, Colzi, Wassiljew, Coley, and Bundschuh are that in 3054 cases of inguinal and femoral hernia the appendix was present 53 times. In 250 cases of inguinal and femoral hernia of adults collected from the statistics of Charing Cross Hospital the appendix is mentioned as being a content of the sac in four only; in 100 consecutive cases of radical cure of inguinal hernia in children I have found the appendix present eight times. The total of these figures (which comprise cases at all ages and in both sexes) is that in 3404 cases of inguinal and femoral hernia the appendix has been present as a content of the sac in 65. These figures merely show the occasions on which the appendix has actually been seen and not the possible relative frequency of the organ in hernial sacs; they include cases in which the appendix only is herniated and in which other viscera are also present. The relative frequency of appendicular femoral and inguinal hernia is not far from equal. Statistics vary a little on this point but the larger number of cases collected show very little difference in these two forms of herniæ.

Two accidents may happen to the appendix when herniated. The more frequent of these is an inflammation

⁷ Sims Woodhead: Tuberculosis and Tabes Mesenterica, THE LANCET, vol. ii., 1883, pp. 51 and 99.

⁸ Coleman: The Distribution of Tubercle in Abdominal Tuberculosis, Brit. Med. Jour., 1893, vol. ii., p. 740.

⁹ Walter Carr: The Starting-point of Tuberculous Disease in Children, Transactions of the Medical Society, 1894, p. 238.

¹⁰ Leonard Guthrie: The Distribution and Origin of Tuberculosis in Children, THE LANCET, Feb. 4th, 1899, p. 236.

¹¹ C. Spengler: Zur Bronchialdrüsen Tuberkulose der Kinder, Zeitschrift für Hygiene, 1893, Band xiii., p. 347.

¹² Neumann: Ueber die Bronchialdrüsen Tuberkulose und ihre Beziehungen zur Tuberkulose im Kindesalter, Deutsche Medicinische Wochenschrift, 1893, Nos. 9, 10, 12, 13, 14, 15, 16, and 17.

⁴ Landouzy: Prédilections Tuberculeuses, Révue de Médecine, 1899, p. 422.

⁵ Loc. cit.

⁶ Legroux: La Micro-polyadénopathie considérée comme Indice de la Tuberculose Profonde chez les Enfants, Congrès pour l'Étude de la Tuberculose, 1888.