

25th.—Condition unchanged. The dose of opium to be given night and morning; belladonna continued.

26th.—During the night three semi-solid motions were passed naturally. Child much relieved; temperature 97° 6'; pulse 100. Tongue moist; abdomen much softer and less tender. Opium discontinued; belladonna continued.

27th.—Two more large motions passed yesterday. Child much improved. Abdomen quite soft, and not in the least tender; pulse 84. Taking milk, beef-tea, and bread. Belladonna stopped. One drachm of glycerine to be given by the mouth every four hours.

28th.—No more motions. Great improvement.

Dec. 6th.—Since last note child had perfectly recovered. Bowels acted daily and naturally. Temperature and pulse normal. Taking ordinary diet. Up and about the ward.

11th.—Child went home well.

## Medical Societies.

### PATHOLOGICAL SOCIETY OF LONDON.

“*Sable Intestinal.*”—*Retro-peritoneal Hernia.*—*Ruptured Spleen and Kidney.*—*Myxo-fibroma of Pelvis.*—*Malformed Fœtal Generative Organs.*—*Infantile Enlargement of Spleen.*—*Epithelioma of Eyelid.*—*Cancer of Pancreas.*

AN ordinary meeting of this Society was held on Feb. 4th, Dr. W. H. Dickinson, President, in the chair. Before the commencement of the regular proceedings,

THE PRESIDENT asked the Society to pay a brief tribute of regret for the recent loss of one of their oldest and one of their most distinguished members. Few words would be needed where so many had been spoken, but few though they were it was right that the especial regret of the Society should be expressed. Sir William Gull was a great physician and a great genius; he was pre-eminently a great pathologist. It was true that the Society was not his habitual resort; indeed, in his later life his enormous practice made it impossible for him habitually to resort to any Society, but he occasionally took part in the discussions, notably on those which had been arranged upon cancer and syphilis. Together with Dr. Sutton, he contributed one paper to the Transactions, one of great labour and detail, on the Spinal Cord in Arterio-capillary Fibrosis. The best of his pathological work was elsewhere, but none the less to be appreciated. In proof of its quality he needed only to instance his papers on Abscess of the Brain and on Reflex Paraplegia. In his later work, that on Arterio-Capillary Fibrosis, he had a coadjutor. Besides this, Sir William Gull was the author of many other papers, all of value, bearing on pathological questions, and indeed it always seemed that his pathological knowledge was the largest element in his deserved success. The President was for many years often brought into contact with him, and often had occasion to admire the self-denying way in which he pursued his cases to their pathological issues. At the height of his practice he never hesitated to put aside the living for the dead, and Dr. Dickinson concluded by saying that he never met a physician in the post-mortem room whose diagnosis was so well borne out by what was found. The Pathological Society was not the place to discuss his powers, great as they were, otherwise than as a pathologist, but in that respect the members must lament the loss of one who deserved a place second to none in the Society.

It was unanimously agreed that an official letter of condolence should be forwarded to Sir William Gull's relatives.

DR. DELÉPINE read a paper on “*Sable Intestinal*” and other Intestinal Concretions. The first specimen shown came from a lady seventy years of age, who was hysterical and had suffered from obstinate constipation for a long time. Her motions had at last assumed the form of rabbit droppings. On chemical examination, the particles were found to be composed almost entirely of cellulose and of a small amount of oxalate, phosphate, and carbonate of calcium. On microscopical examination, they showed distinctly the structure of the gritty particles found so commonly in cooking pears, plus a few crystals of oxalate of lime and indistinctly crystalline particles, some of which were soluble in acids, and others were insoluble in the strongest acids, and were evidently silicious. These small

concretions were therefore composed of lignified vegetable cells, which, owing to a rather prolonged stay in the intestine, had become slightly incrustated with calcareous salts, which had also entangled other particles, probably introduced with the food. It was found on inquiry that the patient had latterly been in the habit of eating baked pears. The specimen was a good instance of what Laboulbène had described under the name of *sable intestinal*, the vegetable cells forming the basis of the sand being constantly found in the fæces, as well as seeds and other indigestible products. It was, however, only when, owing to constipation or obstruction, these indigestible products remained for a long time in the intestine, and became coated with calcareous salts, that they formed the basis of small or large intestinal concretions. The second specimen was of the same nature, and he selected it from several other cases because it illustrated the resemblance of effects between simple constipation and obstruction of the bowel due to organic stricture of the gut. It presented in almost every respect the characters which had already been described in the first specimen, the only difference being that instead of sclerenchymatous tissue forming the basis of the concretions, as in the other case, fig seeds were found in this case. There was also but little calcareous matter connected with them. The specimen was chiefly interesting on account of the fact that on inquiry it was found that the patient had partaken of figs many days before evacuating their seeds, so that they had remained for some time in the intestine, and had accumulated so as to be expelled in rather large numbers at the same time. Both cases showed well how retention of fecal matters, whether due to constipation or to obstruction, favoured the formation of enteroliths or intestinal concretions. He brought forward two other cases, which were quite analogous, though not falling under the head of *sable intestinal*. A patient with bladder symptoms suggesting the presence of stone or tumour was told by a well-known specialist that he had a growth at the trigone of the bladder. Examination of some suspicious masses passed per urethram revealed the fact that they were the outer coats of barley grains, and as part of the patient's diet consisted of whole meal bread a recto-vesical fistula was diagnosed. The last case was one to which Mr. Knowsley Thornton had already publicly referred. A patient had been treated for gall-stones with large doses of olive oil; after a time he evacuated a large number of rounded bodies which were supposed to be gall-stones. Mr. Thornton not falling in with that view, sent some of these concretions to Dr. Lauder Brunton, who, after satisfying himself as to their not being gall-stones, handed them over to Dr. Delépine for examination. These concretions were about forty in number, irregularly rounded in shape, some almost spherical. The largest measured 16 mm. ( $\frac{5}{8}$  inch) in diameter, the others were generally speaking much smaller. They were of a pale yellowish-green colour, and had a rancid butyric smell. The surface of the large ones was pretty smooth, but slightly granular and soft looking. The smaller concretions were much more uneven and looked very much like frozen oil. The large concretions were just hard enough to be cut with a sharp knife and to present a smooth surface. This surface was dotted all over with small, whitish, rounded spots which contrasted with the green ground substance of the mass. On chemical examination some reactions which are supposed to be typical of olive oil were obtained, whilst there was no indication of the presence of bile pigment or cholesterine. A number of the small whitish nodules referred to above were examined microscopically; they were in great part composed of tufts of curved acicular crystals, and in the centre of each some particles of undigested food, such as muscular fibres, starch granules, vegetable hairs, spiral vessels, &c, were found. It was therefore evident that (1) the concretions had been formed within the intestine, and not in the gall-bladder; (2) that they had not the character or composition of gall-stones; (3) that they were almost entirely composed of crystallised fats. It seemed probable that this crystallisation was not due in this case to the formation of earthy soaps. It seemed more probable that a partial splitting up of the oil having taken place under the action of steapsin, the fatty acids, stearic and palmitic acids, which are solid at the temperature of the body, had crystallised, holding between them what remained of the oil not decomposed. This would explain why these concretions had slowly resumed the fluid form.—DR. SIDNEY MARTIN had seen a case of pancreatic functional disease, in which the patient passed in his fæces a quantity

of fatty acids. They were completely soluble in ether, and this made him agree with Dr. Delépine's view as to their composition.—Dr. DICKINSON said the fig seeds referred to by the author were from a case of chronic intestinal obstruction at the sigmoid flexure, the patient being still alive. The figs were eaten three weeks before the seeds were noticed in the fæces.

Mr. LOCKWOOD read notes of a case of Retro-peritoneal Hernia of the Vermiform Appendix. He said that the surgical importance of the vermiform appendix suggested that its various conditions should be reported. In some of those cases in which operators had failed to find the appendix it might have been hidden in a pouch behind the cæcum. It was very questionable whether the appendix was ever absent except as the result of disease. The present form of hernia was not particularly rare. Within a year two cases had been found of complete retro-peritoneal hernia of the vermiform appendix, and a third of partial hernia. The vermiform appendix might herniate into either the subcæcal fossa or into the ileo-cæcal fossæ. The two specimens shown belonged to the former class, but the other had been met with. The causation was either developmental or pathological. The subcæcal fossa was formed during the descent of the colon, and in one case the appendix had probably become immured in it during its formation. In the other case there was, in addition to the hernia of the appendix, a very large right inguinal hernia, and it was probable the displacement of the iliac peritoneum which had accompanied the formation of its sac had taken a part in the causation of the hernia. Retro-peritoneal herniæ of the vermiform appendix seemed, according to authors, sometimes to become strangulated. The morbid anatomy was very simple. When the cæcum was raised a small aperture was found beneath it, leading into a large peritoneal pouch behind the ascending colon. The appendix lay within this pouch, either free or attached by a mesentery.—Dr. DUNN said he had shown a specimen last session, and he had met with several in the dissecting-room at Guy's Hospital.

Mr. D'ARCY POWER read a paper on Repairs after Rupture of the Spleen and Kidney.—The first specimen was the left kidney taken from the body of a man aged twenty-seven, who was admitted into St. Bartholomew's Hospital for numerous injuries from falling off a scaffold. Death occurred eighteen days after the accident. Whilst in the hospital he had never complained of any abdominal pain. On the day after the accident a little blood was found in the urine, and also on the succeeding day. Afterwards it was free from blood and albumen. The kidney showed a rupture one inch and a half in length, and extended from the hilus into the cortex. The second specimen was a spleen taken from the body of a woman aged forty-two, who had fallen from a window a distance of thirty feet. Death occurred ten weeks after the accident. At the necropsy the spleen was found to have been torn upon its anterior and external surfaces. The rent had passed quite through the organ and had involved the capsule, and was found to have been closed by a firm white scar. The interest of these cases consisted in the small amount of hæmorrhage which had occurred from so large a laceration; this the author considered to be due probably to the fact that there was very little room for a large quantity of blood to be extravasated into; and so the hæmorrhage could only have proceeded slowly into the abdominal cavity, and that clotting had soon formed. He also pointed out that the hæmorrhage only occurred from veins or arterioles, and never from arteries of any size, as if such an artery was ruptured fatal hæmorrhage infallibly occurred. The specimens likewise showed how readily repair in these organs could take place and how considerable laceration of these organs might be accompanied by only very slight symptoms.—Dr. DICKINSON said that Mr. Holmes had put a specimen of ruptured kidney into St. George's Hospital Museum. The patient received a kick from a horse, the abdomen swelled, and the man passed a quantity of urine like pure blood. The fluid in the abdomen gradually cleared up and the patient got better. Years after he was recognised in the medical wards dying of uræmia. At the necropsy it was found that one of the kidneys had been torn entirely in two from the pelvis to the capsule, and it had united by fibrous tissue. The pelvis and ureter were obliterated. The opposite kidney was markedly granular. He had only seen one case of spontaneous rupture. It occurred in a jockey who caught cold

and developed acute nephritis accompanied by such violent pain that it was thought that stones were present in both kidneys. Post-mortem both kidneys were found enormously enlarged, and one had burst, a large capsular rent existing in its outer side with blood extravasated both without and within the capsule.—Dr. ANGEL MONEY said that rupture of the kidney was a dramatic accident when it happened in medical wards unaccompanied by traumatism.—Mr. SOLLY referred to the case of a patient who was run over across the abdomen; hydronephrosis developed, and the tumour was aspirated thirty times. The kidney was then cut down on, and was found to have a scar running towards the pelvis. The man lived for at least a year after the accident.

Mr. SOLLY exhibited two specimens of large Fibromata containing cavities due to myxomatous degeneration. During life they had been diagnosed as ovarian tumours, of which they gave all the usual signs. At the operation, however, one was found to spring from the pelvic tissues between the uterus and bladder, and the other from the anterior surface of the uterus. The pathology of the formation of so-called cysts in fibromata and myo-fibromata was briefly discussed, myxomatous change being the commonest condition, though cases of cysts due to hæmorrhage and to lymphatic obstruction had been described. An epithelial lining had been found in a few cases, but only in submucous uterine fibromata, and evidently due to the involvement of uterine mucous glands in the growth of the tumour. Microscopic slides and micro-photographs were exhibited.—Mr. SUTTON who had seen several such tumours, discussed their genesis. They arose either from the uterine round ligaments, the ligament of the ovary, or muscular and fibrous tissues of the broad ligament itself. Fibroids arising from the uterus and burrowing in the broad ligament should be distinguished from them. They underwent myxomatous degeneration and softened down interiorly, while the outer part remained muscular. Clinically, they were often associated with ascites, though they showed no sign of malignancy.

Mr. SHATTOCK showed a specimen of a Female Fœtus, presenting arrested development of the generative organs. The rectum and anus were normal, the clitoris and its prepuce were unnaturally large, the former being grooved on its inferior aspect, and when traced backwards led to a small aperture in the perineum. This was the urethral opening, which above was surrounded by a full-sized and perfectly normal prostate. The bladder, uterus, and ovaries were well formed. Below the uterus was a vagina, which passed through the posterior portion of the prostate and opened into the urethra, being narrowed at its lower end. The specimen was of interest because it threw a side light on a question relating to the hymen and to the vesicula prostatica of the male. It bore out Leuckart's view that the vesicula prostatica represented both the uterus and vagina, and it also demonstrated that the orifice of the hymen might be regarded as the narrowed aperture by which the vagina communicated with the urino-genital sinus. If this were the case, the analogue of the hymen in the adult male should be found at the spot where the prostatic vesicle opened into the urethra, and he showed specimens which demonstrated a considerable narrowing at this point. He submitted that the view which Mr. Bland Sutton brought forward last year at the College of Surgeons, that the hymen was the remains of the septum between the proctodeum and the vagina, was untenable, and he illustrated his contention by diagrams.—Mr. SUTTON admitted that there was much to be said in favour of Mr. Shattock's view, and he had a specimen which completed the chain of evidence in this direction. He asked if there existed anything at the cloacal opening representing the hymen.—Mr. SHATTOCK replied in the negative.

Dr. LITTLE showed a Spleen, weighing eleven ounces and a half, which he obtained from an infant eleven months old. The child was born in Marylebone; the swelling was first noticed when it was five months old, and there was no evidence of syphilis, rickets, or malaria. He had no opportunity of examining the blood; but he opined that it might be a case of leukæmia.—Dr. PERRY said it was possibly leukæmic; but one would have hoped to have found cap-sulitis. Dr. Hamilton had stated that Malpighian bodies were absent in these cases, but in one he examined he had found them easily.—Mr. BOWLBY thought the colour of the organ and the absence of small nodules were against leukæmia.—The PRESIDENT asked what were the conditions of the child as to feeding.—Dr. LITTLE replied that the

mother had continued to suckle the child, and gave it in addition some artificial food.

Mr. H. B. ROBINSON brought forward a specimen of Epithelioma of the Lower Eyelid which was removed from a healthy man of seventy-two. The small lump had been growing slowly for twelve months without any pain. It did not appear to have started on the site of a mole or wart. The tumour was small and firm, reaching almost to the free edge of the lid; it was somewhat circular, about the size of a sixpence, and its surface was convex, its centre being quite a quarter of an inch above the surrounding skin. It was reddened and granular over that part of its surface not covered by dried exudation, and its edge was well defined except on the inner side, where there was a slight tendency to undermining; there was no induration. It was freely movable on the deep tissues, and there was no enlargement of glands. Microscopically it was an epithelioma of the squamous type, in the midst of which were large masses of granulation tissue. The epithelium was of the form met with in the deeper layers of the skin, showing a large number of "prickle cells" with columnar cells next the masses of granulation tissue. There were very few "birds' nests," and these were ill-defined, showing no corneous centres. There were several hair-follicles, sebaceous and sudoriparous glands at the edge of the growth. At one spot there was extensive proliferation of the inner root-sheath of a hair-follicle. The growth seemed to agree with, and to be an early stage of, the "crateriform ulcer" described by Mr. Hutchinson. From the marked histological differences from ordinary skin epitheliomata, it appeared to suggest that the growth might have started from some skin appendage, such as sebaceous gland or hair-follicle. An origin from the former seemed excluded, as it would be expected to take on the form of a glandular carcinoma, but whether arising from the latter or not it would be difficult to say. One point in the specimen suggested such a derivation—viz., the marked proliferation of cells in connexion with the inner root-sheath of a hair-follicle; but it was possible that this was only due to involvement of the follicle from without.—Mr. JONATHAN HUTCHINSON, jun., said the sharp margin was very striking, but it differed from crateriform ulcer in containing very few epithelial nests. The specimen was referred to the Morbid Growths Committee.

Dr. WETHERED then gave the history of a case of Primary Carcinoma of the Pancreas. The patient from which the specimen was taken was a warehouse man, aged fifty-four, who was for some time under the care of Dr. Sidney Martin as an out-patient at the Victoria-park Chest Hospital, and was afterwards admitted as an in-patient under Dr. Eustace Smith. The patient had been wasting for eighteen months. He suffered constant pain in the epigastrium, which was increased after food and relieved by vomiting. The vomit consisted of food matter only until ten days before death, when it was black, and described by the patient as small in amount and like coffee. On examination of the abdomen, there was deep-seated tenderness in the epigastrium, but no tumour could be felt. At the post-mortem a tumour, about the size of a tennis ball, was found occupying the head and part of the body of the pancreas. The tumour was only adherent to the posterior wall of the stomach. In the interior of the stomach at this part was an oblong ulcer about three inches long and one wide, the edges of which were only slightly thickened, and the floor formed by thickened connective tissue. Microscopical examination showed the tumour to be an encephaloid cancer. All the other organs were healthy; the bile-duct was patent, and there were no secondary deposits. The case was interesting in many ways. Affections of the pancreas were, as was well known, extremely difficult to diagnose. The continuous wasting, deep-seated pain, and absence of hæmatemesis would, however, suggest that the pancreas was the organ chiefly affected. Jaundice, which was generally present in malignant disease of the pancreas, was absent in this case. Apart from the rarity of primary malignant disease of the pancreas generally, encephaloid cancer was extremely seldom met with. The head of the pancreas was the part most attacked. It was unusual that the parts around were entirely unaffected, and the bile-duct remained patent. Secondary deposits were stated by most authors to be almost invariably present, especially in the liver, but in this case none could be found.—Dr. SIDNEY MARTIN referred to another case of sarcoma of the pancreas in-

volving the tail, in which there were secondary growths in the lungs, duodenum, and elsewhere.—Dr. LITTLE had seen a case of cancer of the pancreas, in which there was no tumour to be felt, but the symptoms were pain referred to the lower end of the œsophagus, and a dislike to fatty food.

This specimen was also referred to the Morbid Growths Committee.

The following card specimens were shown:—

Mr. ROBINSON: (1) Lupus Verrucosus; (2) Duct Carcinoma of Male Nipple.

Mr. SHATTOCK: An unusually long Vermiform Appendix.

## OPHTHALMOLOGICAL SOCIETY.

### *Glaucoma after Extraction of Cataract.*

AN ordinary meeting of this Society was held on the 30th ult., the President, Dr. J. Hughlings Jackson, in the chair.

Mr. TREACHER COLLINS read a paper, in which he described the conditions found in ten eyeballs excised after sight had been destroyed, and which he had examined microscopically. In nine cases the cataract was the ordinary senile form; in one case it was of traumatic origin. Five of the patients had undergone successful operation for cataract in the fellow eye. In one case iridectomy was performed previously, in nine cases at the time of removal of the cataract. The interval which elapsed between the extraction and the onset of the glaucoma varied from three to twenty-one months. In three cases the increase of tension came on simultaneously with iritis and keratitis punctata, and in these patients the second eye became affected with sympathetic ophthalmitis. In nine of the eyes there was adhesion of the lens capsule to the extraction scar. In the remaining one, in which the lens had been removed in its capsule, the hyaloid was adherent to the corneal cicatrix. In all the specimens the angle of the anterior chamber in the parts corresponding to the coloboma of the iridectomy was blocked, either by adhesion of the root of the iris, which had been left, or by the tips of the ciliary processes dragged forwards by entangled lens capsule. After enumeration and discussion of the various causes to which glaucoma after extraction might be ascribed, Mr. Collins said he thought, from the study of these cases, that the adhesion of the lens capsule to the corneal cicatrix strongly predisposed the eye to an attack of glaucoma. In some cases this adhesion, combined with an entanglement of iris, was sufficient to set up glaucoma; in others some additional irritation was necessary, such as resulted from a discission operation. The treatment of these cases was, in his experience, very unsatisfactory. In only one had he seen the glaucoma permanently relieved by operation. In that case an iridectomy and capsulotomy were performed after paracentesis of the interior chamber had failed to relieve tension. Mr. Collins exhibited macroscopic specimens of the eyeballs, and showed some excellent magic lantern slides made from photographs of microscopic sections.

Mr. CRITCHETT said the needle for discission of the capsule after cataract extraction should be graduated, so as not to allow the escape of aqueous humour. Many eyes were undoubtedly lost after cataract extraction, but that they should be destroyed by glaucoma was to him surprising, seeing that such cases should be under the direct observation of the operator, so that the condition ought to be at once relieved.

Mr. PRIESTLEY SMITH said that Mr. Collins's paper was of great value, as it supplied accurate anatomical information on the subject with which it dealt. These cases he should regard as belonging to the category of secondary glaucoma. In primary glaucoma he attributed to the lens a very prominent part in the causation of this condition, but its occurrence in the absence of a lens was against that view. He drew attention to a class of cases not mentioned in this series—namely, glaucoma following successful needling, in which, notwithstanding that there was a clear central pupil, with no delectable adhesion, "iris bombée" occurred, doubtless on account of adhesions between the lens-capsule and the iris. Cases such as Mr. Collins described were effectually relieved by sclerotomy, provided the septum between the vitreous and aqueous chambers was carefully divided. In one case, where simple sclerotomy released but a slight