aneurysm just beyond the disc margin as well as white lines along its borders.

In our case the disappearance of the aneurysms was rather remarkable, but the same change is described as having occurred in the cases of Story and Oeller, although in other respects the cases were not comparable.

It is unfortunate that in most of the cases hitherto reported, the general state of the patient has been omitted or incompletely recorded, and it would be interesting in future cases of the kind to have these records as complete as possible, including measurements of the blood-pressure.

THREE CASES OF SEVERE INJURY AT THE ANKLE-JOINT.[1]

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I SHOULD like first of all to bring in for your inspection the three cases of severe injury at the ankle-joint, noted in the billet, to let you see how very little deformity exists and how well the function has been restored. The first case is one of fracture of both malleoli. The second, one of fracture of the lower end of the fibula with very marked dislocation of the foot backwards and outwards. The third case is one where I removed the astragalus fifteen months ago on account of a severe compound dislocation of the ankle-joint.

CASE I.—The skiagram shows a fracture of the fibula, beginning some distance above the tip of the external malleolus and extending downwards and inwards into the ankle-joint; while at the same time the tibia shows a somewhat oblique fracture involving the joint and separating the entire malleolus from the rest of the bone.

The injury was produced by the patient (æt. 40) slipping on a stair, the foot "doubling-up under her," and being twisted, as she thinks, outwards. She was wearing a stout lacing boot at the time, and, though she felt something crack, there was no marked deformity of the foot when she picked herself up.

[1] Read at a meeting of the Glasgow Medico-Chirurgical Society held on 15th November, 1907.

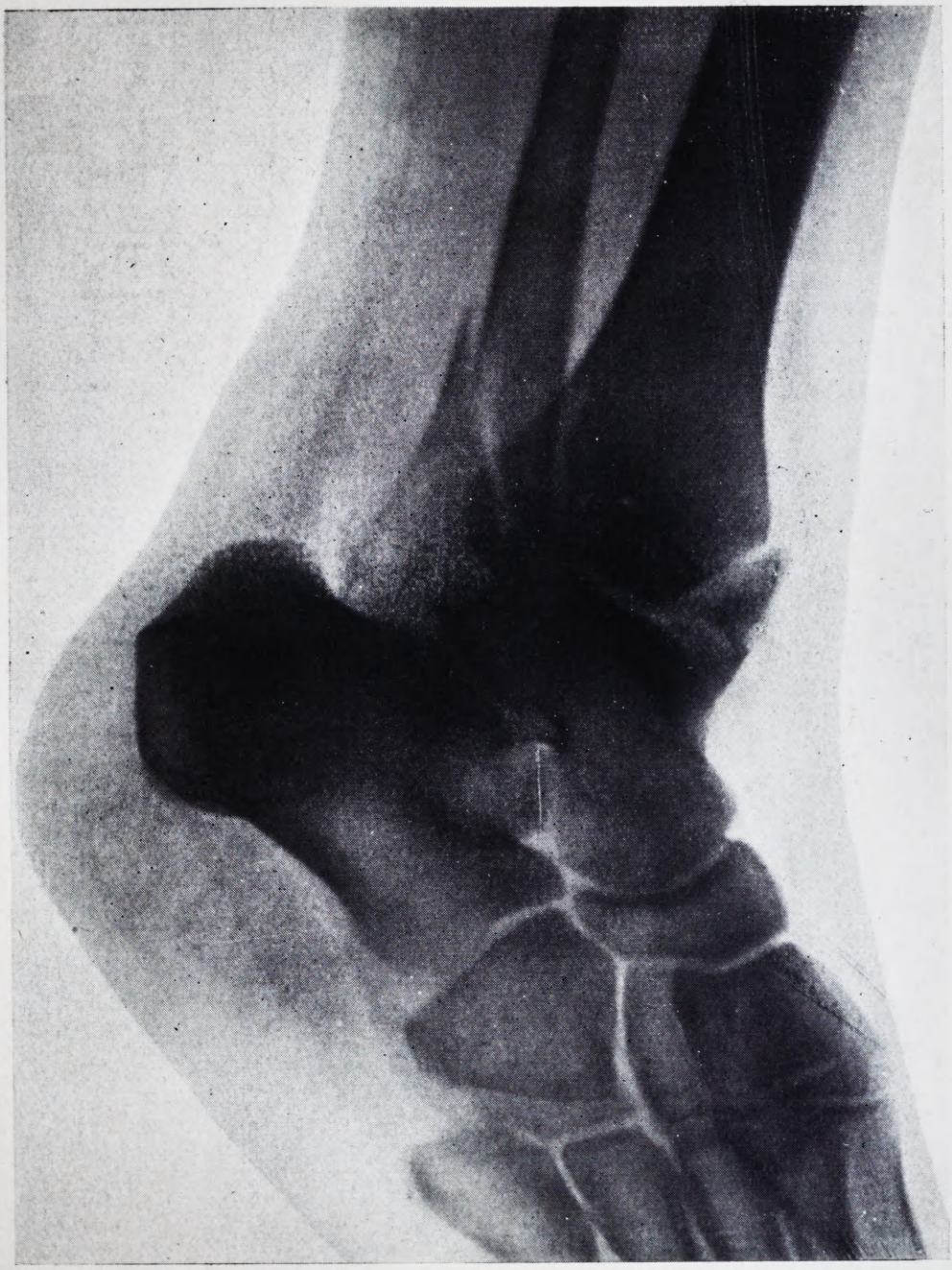
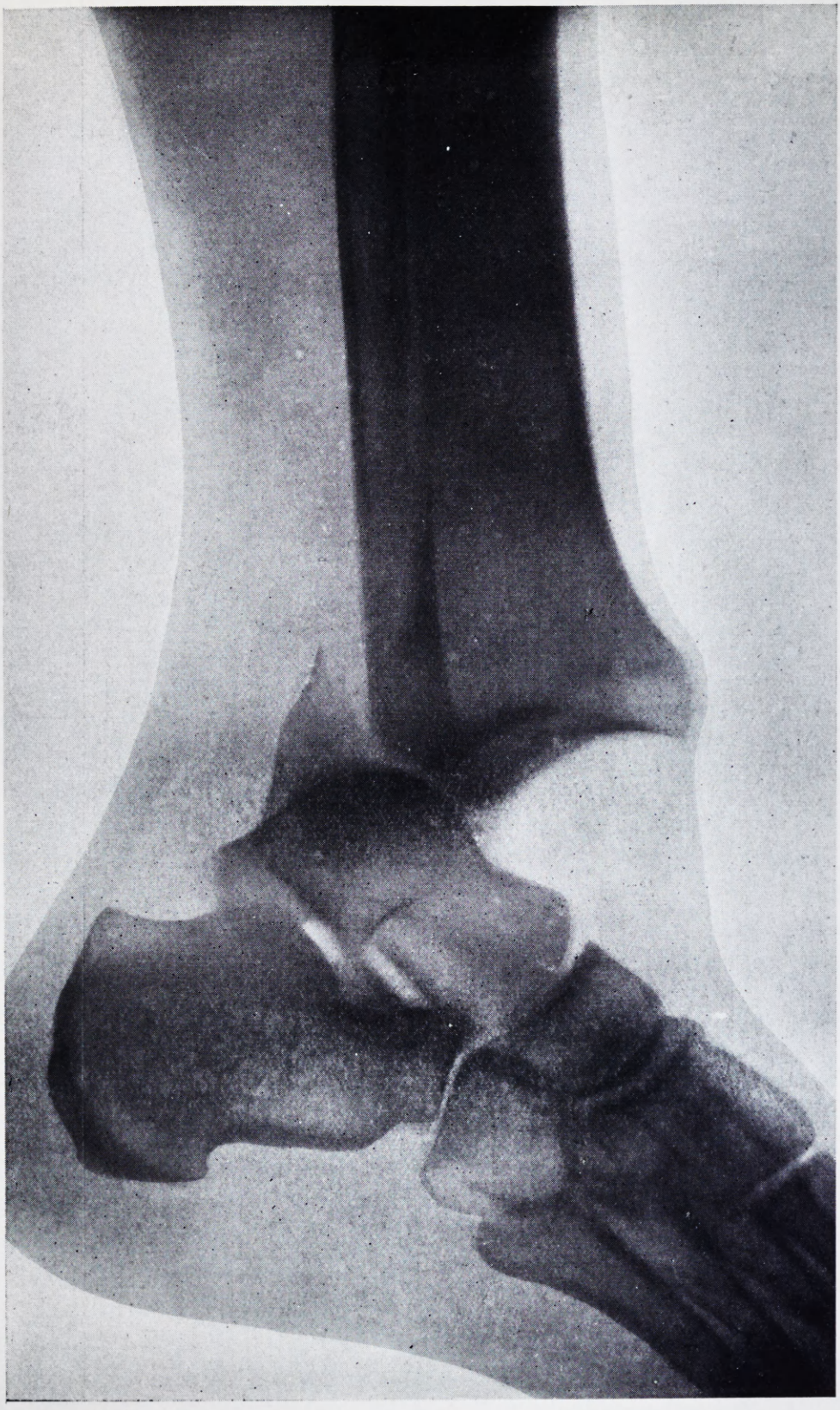


FIG. 1 (Case I).

Fracture of both malleoli. Massage; no splint. Left hospital four weeks after injury, and went about house freely six weeks after injury.



Fibula
roken.

FIG. 2*a* (Case II).

Fracture of fibula and dislocation of foot backwards and outwards, with very marked eversion of foot. Reduction under chloroform. Splint and massage for four weeks. Massage for three weeks longer. Resumed work eight weeks after injury.

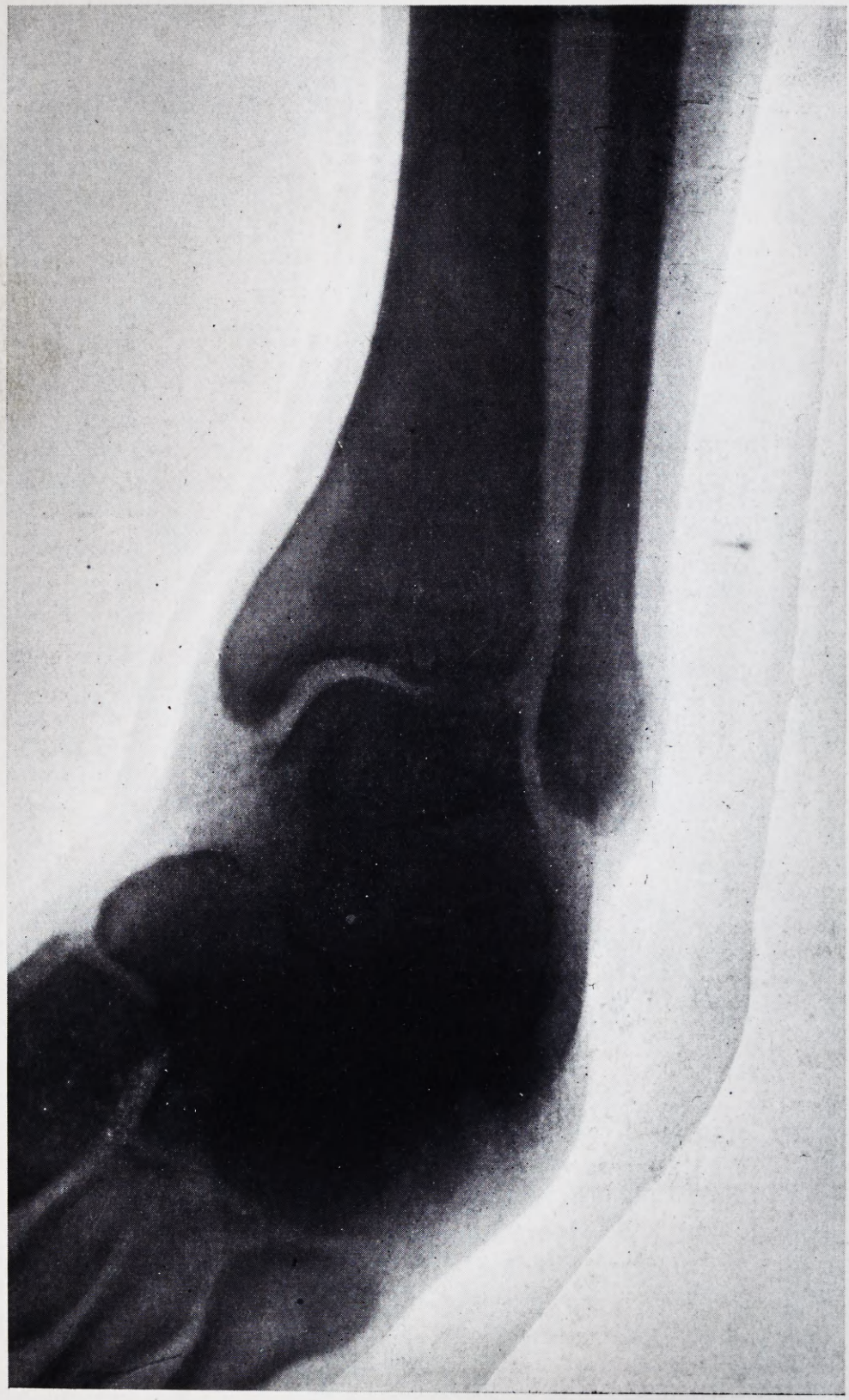


FIG. 2*b* (Case II).

Ten days after injury.

On admission to hospital some hours after the accident there was great swelling about the ankle, with effusion into the joint and surrounding soft parts, and extending some distance up the leg. Crepitus and unnatural mobility were made out with difficulty. As there was no tendency to displacement, the limb was steadied by sand pillows, and no splint was used. Massage was begun next day for a few minutes night and morning, and was continued twice daily for some weeks, the time of each application being gradually increased. The pain and tenderness, which were very marked at first, soon subsided, and at the end of a fortnight the effusion was practically gone. At the end of four weeks she went home, and a fortnight later was able to go about her household duties as well as ever.

CASE II.—This case may be considered as a very exaggerated instance of Pott's fracture. The mode of production was the same, the lower end of the fibula was broken, the internal lateral ligament doubtless torn, the foot very markedly everted ; but instead of the slight backward displacement of the foot, there was a complete dislocation of the tarsus backwards and outwards.

The skiagram taken on admission to hospital shows the deformity very well. The second skiagram, taken ten days after reduction under chloroform, shows the bones in good position. The limb was kept in position on a half-box splint for a fortnight, and thereafter the splint was removed daily to allow of massage. At the end of the four weeks the splint was dispensed with, and the leg massaged daily.

The patient left hospital at the end of seven weeks, and was able to resume work as a quay labourer eight and a half weeks after the receipt of the injury.

CASE III.—This patient, a young man, fell from a scaffolding while at his work, and when admitted to hospital his foot was very markedly inverted, the sole looking almost directly inwards, and there was a wound opening into the ankle-joint, obviously made by the external malleolus tearing through the skin which had been tightly stretched over it. The parts were carefully disinfected by the house surgeon, and the foot got into better position. Next morning when I saw him the astragalus could be distinctly felt projecting on the outer and anterior aspect of the tarsus, and the skin over it was very tensely stretched. I cut down on it and removed the bone, which was free from all its attachments. The wounds healed

satisfactorily, and without any sloughing of skin, as had been feared owing to the severity of the injury.

The ankle was very stiff for some time, but the patient persevered in moving it, and now (fifteen months after the injury) he is able to go to his work and walk with comfort. The spring of the foot in walking is slightly impaired, but there is a fair amount of flexion and extension at the ankle-joint, and he is able to raise himself on his toes.

MEDIASTINAL CANCER, OCCURRING TEN YEARS AFTER REMOVAL OF THE BREAST, WITH SECONDARY NODULATION WELL DISTRIBUTED OVER THE HEAD AND TRUNK.[1]

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THE following case may be of interest, as it affords an example of the considerable duration of time that may elapse between the removal of cancer of the breast and its recurrence. Not only so, but the case presents several interesting features both in pathology and treatment.

The patient, A., unmarried, and over 60, was first seen by me in October, 1904, for slight breathlessness and a hard, brassy, paroxysmal cough. Neither of these symptoms at the time affected her general health, and she was wholly unaware of suffering from any serious ailment. She gave me the following history:—

In 1893 her right breast had been removed owing to a swelling that had appeared in it. This proved to be a cancerous tumour. The operation was considered successful, and a large portion of the adjacent tissues was removed to ensure complete extirpation. She remained perfectly well until the summer of 1903, when she developed a cough and had an attack of right-sided pleurisy. The pleurisy disappeared, but the cough remained and increased in force and frequency up to the time I saw her. In November, 1904, she caught a chill and she had a smart attack of pleurisy over the left infra-axilllary region.

[1] Read at a meeting of the Glasgow Medico-Chirurgical Society held on 29th November, 1907.