

the cases the tarsal plate was deformed, but this apparently, does not affect the efficiency of the operation.

The steps of the operation are as follows:—

Snellen's clamp is applied and the lid adjusted so as to expose its edge as much as possible. The bosses of the first and second fingers, of the left hand, are placed upon the lid, as in Figure III, and firmly pressed in an upward and

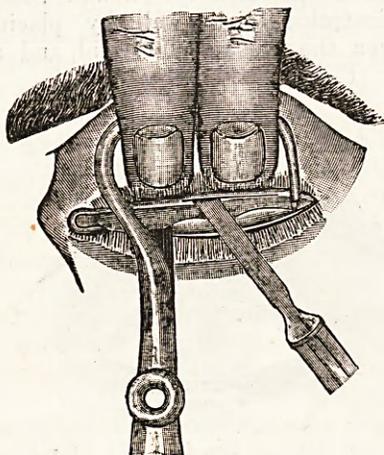


FIG. III.

backward direction, so as to bring the hairs well into view and into a straight line. In this position the free border of the lid is split, from end to end, to a depth of about 7 mm., taking care to keep the incision well behind the hair follicles. The edge of the anterior flap, containing the hairs, is picked up, and steadied by a fixation forceps, while a second incision is made, from end to end, through the skin only along its anterior border, parallel to and 2 mm. from the line of hairs. The edge of the skin forming the upper border of this incision, is now picked up by a couple of fine toothed clip-forceps, by means of which an assistant puts the skin of the lid upon the stretch, by traction in a downward direction to facilitate the making of the third incision. The third incision is a curved one, shaped not unlike the curve of the free edge of the soft palate and uvula; it is made through the skin only, and extends from one end to the other of the second incision, the height of the curves depending upon the effect required. The forceps are removed, the piece of skin, contained between the two skin incisions, is dissected off, leaving a raw surface, as represented in Fig. IV.

The edges of the skin incision are brought together by seven horsehair sutures, the central one being put in first, those through the curves second, and those at the extremities last, and, after the clamp has been removed, as, by so doing, their insertion is facilitated and their exact position the better judged. The suture should take a good hold of the edge of the lid passing amongst the hairs if necessary. They are tied by a double twist only, the upper ends

being cut off fairly long, to facilitate subsequent removal, while the lower ends are cut off close

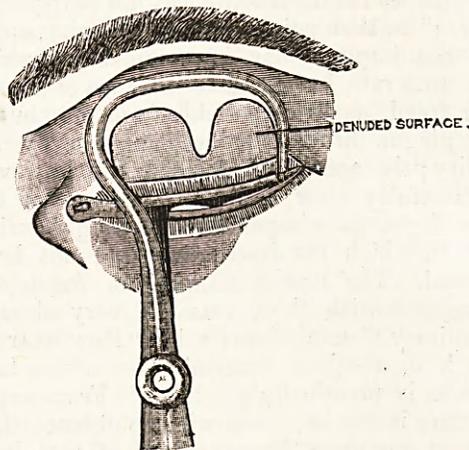


FIG. IV.

to the twists. Any hæmorrhage is arrested by pressure, and the clot removed from the edge incision, which is left open. A semi-circular pad of gamgee tissue is applied over the orbit and the everted hairs, and retained in position for 24 hours, by a bandage. The stitches are removed on the fourth or fifth day.

The immediate effect of the operation is a perfectly straight edge, with the lashes turned well outwards from end to end. There is no gaping of the palpebral fissure, and the lids meet perfectly.

If, during the splitting of the lid, at the commencement of the operation, some of the follicles are accidentally divided and remain in the conjunctival portion of the flap, they should be dissected out, as otherwise, a few hairs may appear subsequently along the line of scar.

The difference between this operation and that known as the "Arlt-Jaesche" is evident. The results of the latter operation have not been found altogether satisfactory, because, as I believe, the principle of the operation is not sound. Modified in the way that I have explained, *i.e.*, making the upper incision with a double curve instead of a single one, thereby influencing the outer and inner thirds of the lid more than the central portion, and securing perfect approximation of the lids when closed, the operation is very effective.

Recently I have had made by Messrs. Down Bros., of London, special clamps for the operation which facilitate the making of the curved incisions.

MELANOTIC SARCOMA AND "SARCOMA-TOUS MELANOMA."

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THE case I am about to describe is one full of interest from the point of view, not only of pathology, but also of diagnosis and prognosis in their relation to one

another and to surgical treatment. On July 21st, 1906, Fulia, a married Hindu woman, 30 years of age, native of Durbunga, wife of a local sweetmeat vendor, came to hospital for advice on account of a tumour situated in front of her right eye and growing from the lower eyelid. Her main cause for complaint was the intense pain from which she suffered, night and day, for which she could find no relief, and which, developing recently in association with the growth, extended over the entire right side of her face and head. The inability to see did not trouble her much, as she had become accustomed to doing without the use of her right eye, and the inconvenience due to this sank into insignificance in the presence of the terrible pain to which she was a martyr, and which rendered her well-nigh distracted. From the "previous history" of her case, as obtained from the patient, it appeared that the trouble commenced about a twelvemonth before, in a tiny pigmented spot of the nature of a raised mole, situated at the mucocutaneous junction of the right lower eyelid, beside the punctum lachrymale, causing no inconvenience at the time, increasing in size somewhat slowly at first, but taking on later a more rapid growth and coming to be associated with the painful element in her condition. She gave no account of previous eye-disease, or of any specific ailment, and denied any taint in her family history. She had to a certain extent the appearance of a person with a strumous constitution, although beyond the mere appearance there was nothing to indicate the actual presence of such. There was no circumstance worthy of special note in regard to her habits, mode of life, diet, or religious observances, and alcohol was said to be completely out of the question, as well as narcotics, for she denied indulgence in these. The only other points of interest in her personal history were that she had lived the greater portion of her life in her native place, from whence she had come over to Dhubri only nine months previous to the date to which this history refers, and further, that she lost her first child in its infancy, from some cause unknown to her, while her only other child was living and in good health.

The woman was at once admitted to hospital, and she expressed a desire for the speedy adoption of some radical measure that would give her relief from her fearful sufferings. Photophobia and lachrymation were markedly present, and both eyes were almost entirely closed up as the result of a tumefaction of the conjunctive and, on the right side, owing also to the presence of the tumour. All these, and perhaps to a certain extent also the pain, appeared to be due to an affection resembling very closely indeed, the phlyctenular or strumous conjunctivitis and keratitis, which occurs more frequently in children,—(what Horner calls "eczema of the conjunctiva and cornea,") or, more precisely, the multiple or military variety of that affection, the "eczematous conjunctival catarrh of children" (Horner). The new growth itself was solid, about the size of a pigeon's egg, dark in colour, and ulcerated on its surface from whence there exuded a very foul-smelling, irritating, muco-purulent discharge, mixed with lachrymal secretions. The use of local applications of a cleansing and soothing nature, of blisters over the temple, and of bromide and chloral internally, proved equally futile in either causing benefit to the tumour or diminishing the pain to any appreciable extent, although they did undoubtedly serve the purpose of reducing the swelling of the conjunctivæ and rendering the surface of the new growth less foul than it used to be.

That melanosis entered into the composition of the affection there could be not the slightest doubt, for the tumour itself was deeply pigmented, while the skin of the face, arms and chest was covered with innumerable, small, round patches of pigment, resembling freckles, a shade or two darker in colour than the brown skin generally. That there was a certain element of malignancy in the nature of the trouble, as it existed at this time, there appeared to be very little doubt, for, in spite of the fact that there were no enlarged

lymphatic glands in the neighbourhood, no signs of secondary deposit and no marked degree of cachexia, there still were to be found points in the latter part of the history of the case, such as sudden rapid growth, ulceration of the surface, exudation of a foul and irritating discharge, general constitutional disturbance and intense pain, which indicated the presence of the malignant element. However this might be, it seemed quite manifest that removal of the tumour was the first step to undertake in dealing practically with the case. Accordingly on July 26th the patient was operated on under a general anæsthetic, as it was difficult to gauge beforehand what extent of surrounding tissue would require removal in the proceeding. The tumour was removed along with as much tissue around as it was found possible and deemed desirable to take away. The operation itself was an exceedingly simple matter, requiring no special notice with regard to any of its steps, except perhaps the mere mention of the fact that a solution of the hydrochloride of adrenalin (1 in 1,000) was found very useful in checking the hæmorrhage from the tumefied conjunctiva. Recovery from the effects of the operation was steady and uninterrupted.

The tumour, when removed, proved an object of great interest. To the naked eye it had the appearance of a firm, dark blood-clot that had begun to organize about its centre. It was preserved in formalin (1 in 10) and sent to Calcutta, to Major L. Rogers, I.M.S., who, after subjecting the specimen to a pathological analysis, very kindly informed me on August 2nd, 1906, that the tumour was "found to be a melanotic sarcoma, under the microscope."

Of late years dermatologists have recognized and described a benign type of melanosis, spreading generally from a congenital mole, presenting at first no signs of malignancy, and at this stage, showing, under the microscope, merely a deposit of pigment in the deeper layers of the cutis vera. Recently, too, it has been made out that in the middle of such a patch, elements of a malignant nature may come to develop, sometimes carcinomatous but more often sarcomatous, and further, that such tumours are not rapid in their progress, though, if allowed to remain, they finally become disseminated. The case of the woman, Fulia, seems very clearly to illustrate this sequence of events. One of a number of small pigmented patches or moles, of long duration and covering mostly the exposed parts of this woman's person, suddenly takes on a tumour-like growth, about the middle of the year 1905. The stimulus to this increased activity in the part, is probably an irritant of a simple nature, for the rate of growth is at first slow, and there are no enlarged emphatic glands or other signs of malignancy,—in fact, the condition is one of melanosis of the benign type. At a later period in the course of the trouble, however, the malignant factor supervenes, and the hitherto benign melanosis is converted into a malignant tumour whose rate of growth is comparatively more rapid than that of the foregoing condition, and which at this stage corresponds histologically to a melanotic sarcoma. It is exceedingly difficult, nay almost impossible, to conceive that the growth which progressed at first so slowly, without signs of malignancy, and which developed so steadily, without manifestations of secondary deposit, could have been malignant from its very commencement, and, moreover, of the nature of perhaps the most malignant of all new growths, a melanotic sarcoma! Erichsen says that "melanotic sarcoma is one of the most malignant of all forms of tumour," and that "it may be broadly stated that if a melanotic sarcoma reach the size of a filbert, secondary deposits have in all probability occurred, and no local treatment can cure the patient." Indeed, far from the condition having been of the nature of a malignant tumour from the commencement of its existence, the fact that no secondary deposits had occurred with a melanotic sarcoma of the size of a pigeon's egg, would appear to indicate that the malignant

or sarcomatous element supervened late in the history of the tumour, presumably late enough before the operation, as it were, to give no time for the occurrence of secondary deposits. Further, it would seem that the operation was undertaken early enough, not to say thoroughly enough, after the supervention of the malignant factor, to entirely do away with the risk of recurrence so far, now a matter of fully six months. In the face of what Erichsen tells us, an opinion in which he is supported by most authorities, it would be equally difficult to believe either that secondary deposits would have been wanting or that local treatment would have been of so much avail, with a tumour of a year's duration, which had reached the size it did, and yet had been of the nature of a melanotic sarcoma throughout, or indeed for anything more than a very brief period of the latter part of its existence. Of course, as to the chances of recurrence of similar malignant disease at a later date in one of the other numerous pigmented patches which my patient continues to carry about on her skin, considering the occurrence of such complication once, it would be distinctly hazardous to make a favourable prognosis, although I can safely say that if a recurrence were to take place, it would not be for want of removal of the original seat of malignant development. In the meantime, however, there is the satisfaction one feels in thinking that the nature of the melanosis is primarily benign, and that the malignant element is probably not an essential one in the condition. From the point of view of pure pathology therefore, distinction might be drawn between the melanotic sarcoma and what might well be termed to "sarcomatous melanoma." For although in every case the sarcomatous element deposits itself, primarily at any rate in-tissues of the body normally containing pigment, the latter of the two terms may be used to denote such cases as the present one, where the affected part at first takes on a simple tumour-like growth, in which the presence of melanin in increased quantity is a characteristic feature throughout its existence (melanoma)—while the onset of the malignant (sarcomatous) element is a secondary, possibly a late, development. It may be urged that this suggested distinction in nomenclature constitutes a mere play upon words, or at best involves a point of mere theoretical interest, concerning pathology pure and simple. But this is not quite the case. On the difference in the pathology of such tumours, that is, on the diagnosis between the melanotic sarcoma and what I have ventured to term, the 'sarcomatous melanoma,' will depend very largely on the prognosis that may be made and the local surgical treatment that should be adopted. The points to guide one in the diagnosis of a case of melanotic sarcoma are laid down in every text-book on surgery, the prognosis and the chances of success to be expected from local treatment, are bad. But in the other variety of case, where the sarcomatous development may be late, the diagnosis will depend largely on the slow rate of growth of the tumour, as well as the absence of signs of malignancy, at an early stage, whereas the prognosis is favourable in comparison with the former affection, while so far as treatment goes, the surgeon must never despair, but must always keep in mind that at whatever stage of the tumour-growth the case comes into his hands, he must, if possible, operate and, moreover, operate as early as practicable, regardless of the size of the neoplasm, provided he finds no apparent signs of secondary deposit present. Needless to say that as in the case of melanotic sarcoma, it is wise to make the excision extend as wide of the tumour as possible.

In the case of the patient Fulia, these methods were of remarkable avail. I saw the woman last a few days ago, looking in better health than she had ever done since I first saw her, and able to attend to all her household duties perfectly well. In conclusion, I take the opportunity to pay a tribute to Mr. H. Lyngdoh, L.M.S., Assistant-Surgeon, whose help during an operation did much to contribute to the welfare of the case.

TWO SURGICAL CASES.

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CASE OF FATTY TUMOUR OF THE HAND.

AN infant, eight months' old, Hindu parentage, was admitted into the Darbhanga Raj Hospital on 22nd December 1906, for a tumour of the right hand and forearm larger than the child's head. The parents stated that at birth there was a small swelling about the size of a betel-nut over the root of the thumb. It grew gradually to its present size, which is larger than the child's head. Under chloroform an attempt was made to save the hand and remove the tumour by dissection. The tumour by its size had caused partial dislocation of the wrist joint, and elongation of the flexor tendons of the hand. The surface left uncovered by skin after removal of the tumour was very extensive, and this fact in conjunction with those just mentioned made it appear to be the wiser course to amputate through the forearm, which was accordingly done.

Section of the tumour showed it to be made of firm fat with a fibrous stroma and capsule. It appeared to have commenced from the fat on the thumb side of the palm. Its rapidity of growth, the large size it attained, the early age of the patient, and the unusual situation for a fatty tumour make the case one of clinical interest.

CASE OF STRANGULATED INGUINAL HERNIA WITH GANGRENE OF THE INTESTINE.

A boy of ten years, Hindu by caste, was admitted into the Banwari Lal Hospital, Laheria Serai, on the 31st December 1906, with a left-sided strangulated inguinal hernia dating from two days previously. An operation was done at once. The intestine was found gangrenous at its lowest part over an area of about 2 inches by 1 inch. The rest of the knuckle of intestine was inflamed, but not in a very bad state. The condition of the patient contra-indicating more extensive interference, the constriction at the neck of the sac was divided, the gangrenous area of bowel snipped away, and the knuckle of intestine left *in situ* for the fæces to drain. The next day but one, the child having rallied and his condition having improved by the drainage of the bowel, the intestine was excised. About four inches in length were removed, the cut ends were sewn together with Czerny Lembert sutures, and the bowel replaced into the abdominal cavity. The mesentery was not removed—where it was divided from the intestine, sutures were applied. Three days later fæces were passed per anum. On the 7th January the hernial sac was excised, and the peritoneum and the opening in the abdominal wall sewn up. A stitch abscess formed later, but the wound was healed by the beginning of February, and a firm abdominal wall resulted.