pressure forceps were applied to the ovarian artery, and another small vessel was tied with fine silk. Oozing also occurred from the part from which the old clots had been removed. A litre of salt solution was injected into the rectum, and the abdominal wound closed. The parts removed consisted of the amniotic sac, a fœtus much discoloured, evidently undergoing maceration, about five inches in length, with a long cord in which there were several twists. The mouth of the fœtus was widely open, but the eyelids were closed. The cord lead to a chorionic mass in which placental structure could not be discovered. The ovary contained an old and small corpus luteum. It and the tube were enveloped in a mass of blood clot. The several parts of the tube could not be made out, nor where the rupture had taken place.

The after-history is a very long one; she seemed on the point of death in more than one occasion, but rallied to our surprise each time. On the 27th July some of the stitches were removed, and it was found that union had not taken place; as there was a good deal of distension, a pair of forceps were pushed into the wound and a large quantity of bloody fluid escaped, followed by some pus. Later on a tube was introduced into the same, which was cut off from the abdominal cavity. At first she suffered from continual rises of temperature, and her pulse kept abnormally fast. At the time of writing she is still an inmate of the hospital; she has gained flesh very considerably, is able to walk about, but still has a sinus leading almost to the right iliac fossa. This is gradually, but very gradually, filling up. Her temperature is normal, and the pulse rate has fallen. At the time of operation I never expected her to recover. Why this sinus is left I cannot say; there is no ligature at the bottom.

Case VIII.—Eurasian, *æt.* 31, admitted 13th September, has had one child 16 years ago, and an abortion at the 5th month, 14 years ago. Periods regular, lasting 8 days, painless, no clots or shreds. Had a period in May, none in June; in July she had a fall, and a few days after that she noticed a red discharge from the vagina. This was accompanied by severe pain in the lower abdomen, shooting down the thighs; slight rise of temperature in the evenings, inability to pass water and slight hæmorrhage from the vagina. She was treated in a hospital for 32 days, where she was told she had aborted. Subsequently she was informed that she was still pregnant. Her breasts were distended and contained milk, but there is no secretion now. Finding she was not improving, she came to the Maternity Hospital. An examination showed that the uterus was anteflexed, and only slightly tender. On the right-hand side of the uterus, and closely attached to it, was a soft cystic tumour extending as far as the pelvic wall on the right side. The uterus was fairly central. There was a slight brownish discharge on the finger. The case was diagnosed as a ruptured tubal gestation, and laparotomy was performed on the 20th September. Operation commenced at 8-35 A.M., finished at 9-30 A.M. The abdominal walls were thickly covered with fat and were very vascular. On inserting two fingers into the peritoneal cavity, the uterus was found anteflexed with a tumour closely adherent to it behind and on the right side. This was gradually enucleated, and during the process, old, black and discoloured blood oozed out. The right tube was brought to the surface together with the tumour, tied in a double loop and cut off. There was very little oozing after the removal.

The parts removed consisted of the right tube which was removed very close to the uterus, and a small cyst below the tube. On opening the cyst, it was found to contain some light yellow fluid like amniotic fluid. The cyst appeared to be the ovum; it was smooth internally and lined with a fine smooth membrane like the amnion; no trace of an embryo could be found, and no chorionic villi were detected. The tube was greatly enlarged, was thicker than the thumb and contained blood clot. It had ruptured nearer to the uterine end; the abdominal end was closed and filled with brown clot, whereas the other end was full of hard black clot. An old blood clot coated with fibrin was first dissected out. All the rest of the blood effused had apparently been absorbed.

The after-history was uneventful. The highest temperature recorded was 99°. There were no complication of any sort, and she was discharged on the 11th October.

The fall precipitated matters, and evidently was the cause of the rupture; the tube was no doubt much thinned and would have ruptured later. The history in this case is a very typical one,—no pregnancy for many years. Then suppression of menstruation, rupture of tube and discharge of blood per vaginam (if it had not been for the fall, the latter would have occurred most probably before the rupture), great pain and a swelling to be felt at one side of the uterus, and milk in the breasts.

A CASE OF DEPRESSED FRACTURE OF THE SKULL.

By A. W. DAWSON,
MAJOR, I.M.S.,
Civil Surgeon, Roorkhi.

A Hindu, aged 33, was admitted into the Civil Hospital on the evening of the 14th October 1899, suffering from depressed fracture of the frontal bone, with laceration of the brain. During an explosion of some fireworks at a native festival he was struck by a piece of bamboo, eight inches long and one and half inches

in diameter. When admitted to hospital, about two hours after the injury, he was more or less conscious, pupils dilated, pulse slow and weak, tongue dry. There was slight bleeding from the wound, which before had been considerable. The wound was circular in shape, one and half inches in diameter, and situated in the centre of the forehead, the lower margin being about half an inch above the nasal bones. The splinters of the bone had been driven into the brain, which was lacerated and protruded slightly. There was considerable discharge of cerebro-spinal fluid. The edge of the bone around the fractured part was clean cut and not depressed. The splintered fragments of bone were removed, portions of the brain also coming away. The wound was dressed antiseptically. Next morning the patient was quite conscious; temperature 98°F., pupils slightly dilated. He had vomited once during the night. He complained of headache. On removing the dressing a little of the brain substance came away on it, and pulsation of the brain was marked. The discharge of cerebral fluid continued for eight days, so much so that the wound had to be dressed daily. The severe headache continued for about ten days. The temperature never went above 99° F., and after the fourth day was below normal. Recovery was uninterrupted and complete. He left hospital in three weeks in perfect health, the wound being healed, leaving a depressed scar. No pulsation could be discovered. He has now returned to his ordinary occupation.

CANCER OF THE PLEURA.

By GOPAL CHUNDER CHATTERJEE,

ASST.-SURGEON,

Dr. B. N. Bose's Hospital.

I am permitted to report the above case through the kindness of Dr. Harris, Principal, Calcutta Medical College. The patient was in his ward while I was his house physician.

Patient named K. O., a Mahomedan female, aged forty-eight, was admitted in the Medical College Hospital with a history of three months' illness. Her chief complaint was pain over the left shoulder-blade which was so severe as to make her life a burden to her. She had a slight cough from the beginning which became troublesome towards the end. There was no history of hæmoptysis.

The following were the symptoms and physical signs present at the time of admission:—The patient was rather emaciated and had a very careworn and cachectic face. There was lateral curvature of the spine, convexity being towards the right side. The left shoulder-blade was depressed; and she had a peculiar stiff gait, when walking. The left side of the chest was markedly tender. There was no œdema of either upper extremity. The axillary glands were not enlarged.

Physical examination of the chest revealed marked immobility of the left apex and marked dulness on percussion. Vocal resonance and fremitus were slightly increased over this region. There was distant tubular breathing audible. The upper part of the axillary region was dull on percussion. No breath sounds could be heard. In the lower part of the axilla distinct vesicular breathing was audible. Over the left scapula, it was dull on percussion; dulness had a peculiar woodeny character, not at all like that present in ordinary consolidation. Vocal resonance and fremitus markedly diminished. Distant tubular breathing was audible. The left base was slightly dull in comparison to the other side. Vocal resonance and fremitus were increased over the base.

Heart apex was in the normal situation. Heart sounds normal. Heart sounds were distinctly audible at the back over the left scapula. Urine normal.

Progress of the case.—Four days after admission friction sound became audible at the left axilla Left base became gradually dull on percussion with loss of vocal resonance and fremitus. At the level of the angle of the scapula, about one inch to the left of the spine. There was a spot, area of which could be covered by the chestpiece of a stethoscope, where pectoriliquy and cavernous breathing could be made out.

The physical signs remained unchanged from this time up to the time of her death, which occurred two months later, except the appearance of some loose rales in the axilla towards the end of her life. There was no expectoration at the beginning. About a week before her death, she used to bring up purulent expectoration. There was no hæmoptysis at any stage of her disease. She used to get evening rise of temperature about 100 or 101° every evening.

Pain was her main symptom, and this became worse towards the end. She could not get any sleep or rest except what she could get when under the influence of morphia.

Her general condition became gradually worse, and she died of general marasmus.

Diagnosis.—At the time of her admission, from the peculiar nature of her signs and symptoms, a diagnosis of *malignant growth in the pleura* was made. The principal points which guided us in the diagnosis were (1) curvature of the spine; (2) constant pain; (3) absence of marked cough and absence of phthisical sputum; (4) the peculiar woodeny dulness at the upper part of the lung while the base was comparatively resonant; (5) absence of displacement of the heart. All these points served to distinguish it from the tuberculous disease of the lung or pleuritic effusion.

But there was some doubts, as there was no hæmoptysis which often accompanies cancer of