

Transactions of the
South Indian Branch of the
British Medical Association
Vol. No. 2, May 1910.



SL
L, 8 m 56, 1848 m
1900.8.2

196955

Vol. VIII.]

May 1900.

[No 2.

TRANSACTIONS
OF THE
SOUTH INDIAN BRANCH
OF THE
BRITISH MEDICAL ASSOCIATION.

CONTENTS.

	PAGE.
1. List of Members	381
2. Accounts of Society for 1899	386
3. The Relation of Insanity to Tubercular Disease of the Lung. By CAPT. C. H. L. PALK, I.M.S.	387
4. A Case of Hysterectomy of the Gravid Uterus found in a Hernia. By CAPT. G. G. GIFFARD, I.M.S.	391
5. Glioma of the Retina. By LT.-COL. T. H. POPE, I.M.S.	394
6. An Unusual Case of Obstruction of the Bowel. By CAPT. C. H. L. PALK, I.M.S.	397
7. Rare Case of Ovarian Dermoid. By CAPT. G. G. GIP- FARD, I.M.S.	400

MADRAS:

PRINTED BY R. PLUMBE, AT THE LAWRENCE ASYLUM PRESS, MOUNT ROAD.

1900.

SOUTH INDIAN BRANCH,
BRITISH MEDICAL ASSOCIATION.
RECOGNIZED, 1884.

President :

Lieut.-Col. H. ALLISON, I.M.S.

Vice-President :

Lieut.-Col. A. J. STURMER, I.M.S.

Honorary Treasurer :

Major F. J. CRAWFORD, I.M.S.

Honorary Secretaries :

Capt. C. H. L. PALK, I.M.S.

Asst.-Surg. C. B. RAMA ROW.

Council :

Lieut.-Col. J. MAITLAND, I.M.S. (on leave.)

Lieut.-Col. M. S. EYRE, I.M.S. (on leave.)

Lieut.-Col. T. H. POPE, I.M.S.

Major R. ROBERTSON, I.M.S.

Capt. C. DONOVAN, I.M.S.

Representative Member in General Council :

Lt.-Col. E. F. DRAKE-BROCKMAN, Brig.-Surg., I.M.S. (Retired.)

Members :

Adams, C., M.B., Major, I.M.S., Tullybush House, Gilford, County
Down, Ireland.

Allison, H., M.D., Lieut.-Col., I.M.S., Madras.

Amirthasawmy Pillai, D., Asst. Surgeon, Coimbatore.

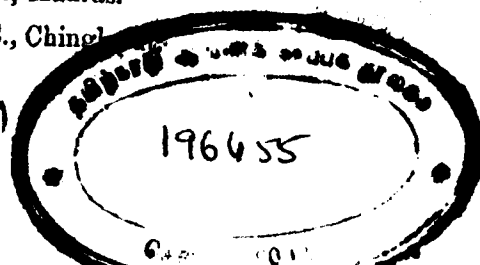
Armogum, T. V., M.B., Civil Surgeon, Shimoga.

Arumookam, P. S. S. S. S., South Arcot District.

Armstrong, H., Lieut.-Col., I.M.S. (on leave, England).

Asirvadam, G., M.B., Maternity Hospital, Madras.
 Bain, D. S. E., Lieut.-Col., I.M.S., Mercara.
 Bannerman, W. B., M.D., Major, I.M.S., Bombay.
 Berry, A. E., M.B., Captain, I.M.S., 5th M. I., Nowgong.
 Bevan, G. F., Lieut.-Col., I.M.S., 17th M. I., Bangalore.
 Blenkinsop, F. L., M.B., Captain, I.M.S., Offg. 21st M. I., Belgaum.
 Branfoot, A. M., M.B., C.I.E., Colonel, I.M.S., Rangoon.
 Browne, W. R., M.D., Lieut.-Col., I.M.S. (on leave, England).
 Browning, W. B., M.D., C.I.E., Lieut.-Col., I.M.S., c/o King, King & Co., London.
 Cama, R. H., Major, I.M.S., 9th M. I., Bellary.
 Chandrasekara Mudaliar, Asst. Surgeon S., Calicut.
 Chester, R. W., South Arcot (Cuddalore).
 Cook, H. D., M.B., Lieut.-Col., I.M.S., Connemara Hotel, Madras.
 Cornwall, J. W., Captain, I.M.S., Madras Club.
 Crawford, F. J., M.D., Major, I.M.S., Madras.
 Currie, J., M.D., Victoria Hotel, Madras.
 Damla, E. M., Lieut.-Col. I.M.S., Pallaveram.
 Dee, P., M.B., Capt., I.M.S., Bangalore.
 Donovan, C., M.D., Captain, I.M.S., Madras.
 Drake-Brockman, E. F., Brig.-Surg.-Lieut.-Col., I.M.S. (Retired), (Richardson & Co., 25 Suffolk Street, Pall Mall).
 Egappa Naiker, Seethanagram, East Coast Railway.
 Ekambaram Pillai, Ellore, Krishna District, Madras.
 Elliot, R. H., M.B., Captain, I.M.S., Coonoor.
 Eyre, M. S., M.B., Lieut.-Col., I.M.S., 28th M. I., (on leave, England).
 Falconer, S. E., Lieut., I.S.M.D., Egmore, Madras.
 Fearnside, C. F., Captain, I.M.S., Rajahmundry.
 Fitzpatrick, J. F., M.D., Lieut.-Col., I.M.S., care of P. Macfadyan & Co., London.
 Fleming, A. N., Capt., I.M.S., Madras.
 Foulkes, T. H., Capt., I.M.S., Chingle

3L
 L, 8 MSB, MSB BM
 N 00.8.2



Fraser, H. St. J., Capt., I.M.S., Madras.
 Frenchman, E. P., Lieut.-Col., I.M.S., Bassein.
 Gabbett, P. C., Captain, I.M.S., Salem.
 Giffard, G. G., Captain, I.M.S., Madras.
 Gnanam Pillay, D., Ag. Civil Surgeon, Negapatam.
 Grant, A. E., M.B., Major, I.M.S., General Hospital, Madras.
 Greany, H., M.D., Major, I.M.S., 5th Infantry, Hyderabad Contingent, Bolarum, Deccan.
 Harington, H. N. V., Major, I.M.S., Alwar.
 Johnson, W. E., M.D., Colonel, I.M.S., Madras.
 Kharegat, M. P., Major, I.M.S., 32nd (4th B.B.) M. I., Bhamo, Burmah.
 King, W. G., M.B., Lieut.-Col., I.M.S., St. Thomas' Mount, Madras.
 Koman, M. C., General Hospital, Madras.
 Krishnamurti Aiyar, S., M.B., 5 Thumbu Chetty Street, Madras.
 Krishnaswami, E. S., B.A., M.S., C.M., Asst. Surgeon, Bangalore.
 Krishnaswami Aiyar, M., M.B., C.M., 48, Maliaperumal Street, Madras.
 Krishna Row, H., Trivalur, Tanjore.
 Kristnasawami Naidu, P., Asst. Surgeon, Vizagapatam.
 Lafrenais, C. A., Civil Surgeon, Tellicherry.
 Lancaster, J., Lieut.-Col., I.M.S., Vellore.
 Leapingwell, A. H., Lieut.-Col., I.M.S., Vizagapatam.
 Lee, W. A., Lieut.-Col., I.M.S. (on leave, England).
 Lukshman Perumal, Asst. Surgeon, Masulipatam.
 Lychlander, J., Ag. Civil Surgeon, Cocanada.
 Maitland, J., M.D., Lieut.-Col., I.M.S. (on leave, England).
 Masilamani, A. M., General Hospital, Madras.
 Mathias, A. F., Kasaragod, South Canara.
 McGann, T. J., Colonel, I.M.S., Bangalore.
 McKee, G. M. E., Major, I.M.S., 23rd M.I., Secunderabad.
 McVittie, C. E., Surgeon-Genl., I.M.S. (Retired, England).
 Mitter, R. H., Captain, I.M.S., Berhampore.

Molesworth, W., M.B., Captain, I.M.S., Government House, Madras.
 Niblock, W. J., Capt., I.M.S., General Hospital, Madras.
 Nailer, H. A. F., M.B., Lieut.-Col., I.M.S., Tanjore.
 Narayanier, A. Y., Tinnevely.
 Narayanaswamy Naidu, T., Medical College, Madras.
 O'Hara, W., Lieut.-Colonel, I.M.S., Ootacamund.
 Oosman Sahib, N., Civil Surgeon, Negapatam.
 Palk, C. H. L., M.B., Captain, I.M.S., Locock's Gardens, Madras.
 Parrie, J. R., Gooty, Anantapur District.
 Pereira, F., Captain, I.M.S., Hospet.
 Pereira, H. Maning, Halgar Estate, Kadur District, Mysore.
 Pettifer, E. C., M.B., Vayitri, Malabar.
 Philipsz, G. L., L.R.C.P. & S., 2nd District, Madras.
 Pinto, J. O., Captain, I.M.S., 21st Regt., M. I., Belgaum.
 Pope, T. H., M.D., Lieut.-Col., I.M.S., Madras.
 Price, W., M.D., Brigade-Surgeon-Lieut.-Colonel, I.M.S., Coonoor.
 Raghavenda Rao, B. D., Asst. Surgeon, Bangalore.
 Rama Row, C. B., Assistant Surgeon, Medical College, Madras.
 Reeves, F. C., Lieut. Col., I.M.S., Madras.
 Reporter, M. E., Lt.-Col., I.M.S., 11th M. I., Secunderabad.
 Robertson, R., M.B., Major, I.M.S., Madras.
 Ross, R., Major, I.M.S., Liverpool School of Medicine.
 Rost, E. R., Lieut., I.M.S., Meiktila, Burmah.
 Runganah, S., Asst.-Surgeon, Gold Fields, Mysore.
 Rungappah, H., M.B., Mylapore, Madras.
 Sarkies, S. C., Lieut.-Col., I.M.S., Masulipatam.
 Sharman, E. H., Capt., I.M.S., 2nd Infantry, Hyderabad Contingent, Raichur.
 Sibthorpe, C., Surg.-Genl., I.M.S., 36 Upper Leeson Street, Dublin.
 Simpson, D., M.B., Major, I.M.S., Coimbatore.
 Sinclair, D., M.B., C.M., C.S.I., Surg-Genl., I.M.S., Madras.
 Smith, F. C., M.B., Surgeon-Major, Egmore, Madras.

Smyth, J., M.D., Major, I.M.S. (Mysore), 5 Infantry Road, Bangalore.
 Srinivasa Rao, M.A., M.D., Chemical Examiner with Govt. of Mysore, Bangalore.
 Srinivasiengar, W., M.B., Asst. Surgeon, Chittaldroog.
 Sturmer, A. J., Lieut.-Col., I.M.S., Madras.
 Subba Row, E. V., Ernakalum, Cochin.
 Subrahmanaiyer, N., M.B., Chemical Examiner, Trivandrum.
 Subrahmanaiyer, M. P., M.B., Palghat.
 Subramony Iyer, A. V., Trichoor.
 Sundram, R., Assistant Surgeon, M.D., Tanjore.
 Thirumudiswami Pillai, Palni, Madura District.
 Thomas, G. T., Lieut.-Col., I.M.S., Rangoon.
 Thomas, W. F., Lieut.-Col., I.M.S., Madura.
 Thompson, C. M., M.B., Lieut.-Col., I.M.S., Secunderabad.
 Thomson, H., M.B., Major, I.M.S., Trivandrum.
 Usman Mahomed, B., Linga Sawyir, Daroga, Mysore.
 VanGeyzel, J. L., M.B., Major, I.M.S., Chetput, Madras.
 Vasudeva Row, R., Mayavaram, Tanjore District.
 Venkataswami Naidu, G., Rajah Mirasidar Hospital, Tanjore.
 Venkata Subbayya, P., East Coast Railway, Bezwada.
 Vickers, W. C., M.B., Captain, I.M.S., Acting Deputy Sanitary Commissioner, Madras.
 Walker, G. L., M.D., Lieut.-Col., I.M.S., Madras.
 Wall, F., Captain, I.M.S., 15th M.I., Belgaum.
 Warliker, D. P., Lieut.-Col., I.M.S. (on leave, England).
 Watson, T. E., Capt., I.M.S., Madras.
 Williams, C. L., M.D., Captain, I.M.S., Ootacamund.
 Wilkins, T. J. Hackett, Lieut.-Colonel, I.M.S., Calicut.
 Wright, E. Hasell, Capt., I.M.S., 3rd Infantry, H. C., Aurangabad.
 Youngerman, E. P., M.B., Major, I.M.S., 2nd M. I., Bangalore.

Balance Sheet of the South Indian Branch of the British Medical Association for 1899.

RECEIPTS.		RS.	A. P.	RS.	A. P.	DISBURSEMENTS.		RS.	A. P.	RS.	A. P.
Balance on the 31st December, 1898—						Home Remittances (£106-1-0)		...	...	1,584	8 10
With Bankers	...	1,324	1 0			Printing and Stationery		...	...	441	14 9
Cash with Treasurer	...	90	12 2	1,414	13 2	Expenses of Meetings		...	...	11	10 0
Sale of Transactions	...	...	...	78	0 0	Charges for sending X-ray apparatus to Bellary		...	...	20	6 6
Members' Subscriptions	...	...	...	1,860	7 6	Stamps, Postage and Receipt		...	...	17	4 0
Charges connected with X-ray apparatus	...	...	...	...	...	Discount on cheques		...	...	1	6 0
Interest—						Honorary Secretary's expenses		...	...	41	8 0
On Investments	...	70	0 0			Honorary Treasurer's expenses		...	...	4	13 2
On Current Account	...	79	3 10	149	3 10	Bankers' Commission and Postage		...	...	12	12 10
						Balance on 31st December 1899—					
						With Bankers		1,247	6 5		
						Cash with Treasurer		69	4 6	1,316	10 11
Total Rs. ...	...			3,452	15 0	Total Rs. ...		...	...	3,452	15 0

Investment.

Government Promissory Notes, 3½ per cent. = Rs. 2,000.

AUDITED.

G. DONOVAN, CAPT., I.M.S.
C. H. L. PALK, CAPT., I.M.S.

F. J. CRAWFORD, M.D., MAJOR, I.M.S.,
Honorary Treasurer.

338

387

THE RELATION OF INSANITY TO TUBERCULAR DISEASE OF THE LUNG.

MR. PRESIDENT AND GENTLEMEN,

It has long been recognised that the mind has an important effect or influence over all bodily diseases. The physician, who is able to gain the confidence of his patient, goes a good way towards effecting his cure or any way ameliorating his disease. The benefit our patients derive from change of air and scene is not so much due to any particular change that is produced on the bodily disease, as the relief of the tension of the mind.

Although the brain is the great stimulator of nutrition and the master of the functions of all bodily organs, it is itself affected through the changes produced in the blood and reflexly through the afferent nerves. The irritability of mind brought about by a disturbed digestion or the lassitude caused by impaired metabolism are familiar examples to us all.

It is, however, only within comparatively recent years that any connection between diseases of the mind and tubercle of the lung has been recognised, although the two facts, one that tubercular disease of the lung is very common among insane, and the other that the scrofulous and insane constitutions are often associated, have existed for a long time.

It was Clouston of Edinburgh who first threw light on this subject and recorded many interesting facts as the result of his studies. He pointed out that the mortality from tubercular disease is proportionately much higher among the insane than it is among the sane population. In days long since gone by when sanitation and hygiene were little understood, statistics of asylums shewed a death-rate of 25 to 30 per cent. from tubercular disease of the lungs, and *post-mortem* records showed that as many as 50 to 60 per cent. revealed more or less tubercular deposit in the lungs.

Later statistics fortunately show a much better result than this, though in spite of improved hygienic conditions, tubercular disease accounts for an unusually high death-rate among the insane. In the Asylum here the death-rate last year from tubercle

of lung was nearly 3 per cent. of the total deaths, though as many as 15 per cent. of the *post-mortem* examinations revealed the presence of tubercular deposit either in the lungs or some other viscera. On looking over the Annual Reports of other Asylums I find their figures are about the same, though the nomenclature is sometimes not universal, for I find such terms as *Hæmoptysis* and *Chronic Pneumonic Phthisis* are used, which should properly be included under the main head tubercular. The figures of Asylums in England are very much the same.

Clouston also points out that tubercular disease of the lungs is three times more common among the insane than among the sane. All who know what Asylums at home are like in these modern days, how replete they are with every comfort and improvement, will, I think, admit that the inmates live under at least as good, if not better conditions than the general populace, so that the reason why the ratio is 3 to 1 in Asylums must have another cause, and what is this? Now all forms of mental disease lead to a depression of nutrition generally, the more acute and lasting the brain disturbance the more rapid are the changes in nutrition that occur. Tubercle of lung is a disease always associated with considerable impairment of nutrition. In order to allow the bacillus tuberculosis to thrive, it is essential to have certain conditions in the soil, these conditions are particularly well fulfilled in cases of brain disease where the general nutrition of the body is seriously impaired by long periods of excitement, or as in secondary dementia where the cortical nerve cells have become permanently injured. Epileptic insanity is specially prone to be followed by tubercle of the lung and a theory has been advanced that the reason is due to the engorgement of the lung which takes place during a fit, rendering the soil specially suitable for the growth of the bacillus. Then again in the case of idiots and congenital imbeciles, why is it they so frequently die from tubercle? in them also is it not likely that owing to the impaired condition of nutrition consequent on defective brain developments they become an easy prey to the microbes of tubercular disease.

Van-der-kolk in his work on Mental Diseases says "It is remarkable when in the same family, some of the children suffer from mania and melancholia, and the brothers and sisters who have

remained free of these diseases die of tubercle." The transmission of the hereditary taint may be from either parent, and the disease may appear in the child before it develops in the parent. Both insanity and tubercle more often appear about adolescence than at other times, and the tendency to both dies away with advancing age. Insanity in the parents is more often followed by tubercle in the offspring than the reverse.

The question may be asked—which disease develops symptoms first?

Undoubtedly in the large majority of cases the mental symptoms precede those of the lung disease, the latter appearing at a subsequent varying period, depending on certain conditions, for instance, where the mental disease is of a very acute type and extending over a lengthened time the constitution breaks down rapidly, and signs of tubercular disease are early in appearing and rapid in course, whereas in melancholia and dementia where the general impairment of nutrition is much slower and more gradual, signs of tubercle are much more latent, and the disease insidious, and may after development remain quiescent for a long time. In the greater number of cases, however, the lung disease runs a more rapid course in the insane than in the sane, a fatal termination may be expected within nine months or a year, after its first appearance. It is towards the close of the disease that it advances most rapidly, so much so that a patient from being in moderate health with few active symptoms will die within a few days; and in these cases an examination of the lungs after death generally shews them to be entirely disintegrated and gangrenous.

As regards the variety of the lung disease, that known as the chronic caseous form is most usually met with. The apex is the commonest seat, but other parts of the lungs seem to be the first attacked occasionally. The disease commences in a localized form and its growth is slow and insidious, and only towards the termination of the disease is its advance rapid. It is strange that tubercular deposit is very rarely found in the brain, that organ is pale and anæmic with scattered patches of congestion throughout the white substance. Tubercular ulceration of the bowel with enlargement and caseation of the mesenteric glands is found in most cases.

Clinically, tubercle of the lung as seen in the insane differs in many ways from the same disease among the sane. A great many of the subjective and objective symptoms are entirely absent, such as cough and expectoration pain, conscious weakness and discomfort. Where the mental disease is of the maniacal type, it is usual to find the patient not only oblivious to his advancing lung disease, but even priding himself and boasting of his robust health. The complication of the mental disease makes early diagnosis difficult in most cases. The first symptom that generally attracts notice is a steady regular loss of weight, indeed, this is such an important one that my attention is always directed to the condition of a patient's lungs, when he has been losing weight steadily for three or four weeks.

Another early and common symptom is a capricious appetite, the patient taking extraordinary likes and dislikes to different articles of food, and after begging for a certain dish, refuses to touch it when placed before him. This capriciousness of appetite is very often accompanied by delusions regarding the food, that it has been poisoned or drugged, that it had been purposely tampered with and so on. There is generally a rise of temperature accompanying these symptoms which help to confirm a doubtful diagnosis and it is important to have the morning and evening temperature carefully recorded. As the disease advances the facial expression becomes more marked, there is progressive emaciation and the usual symptoms of the disease, but among maniacal subjects they are often masked. When tubercular disease of the lung attacks patients in a state of secondary dementia, the accompanying fever has a peculiar effect on the mental state, such patients after being unusually stupid and dirty brighten up as soon as the temperature rises, and a certain degree of intelligence returns, shewing conclusively that the cortical cells, which many believe to be quite dead and useless, to react to the increased supply and overheated blood. This change is wonderfully marked in some cases, and is liable to be mistaken for the early signs of recovery, which of course is impossible.

In conclusion, I would like to add a few words on my own experience of the open air treatment of some of these cases in Madras, where the comparative small variation in temperature

is an advantage. For the last eighteen months or more I have selected certain cases and kept them continuously in open air or on the verandahs of the wards. Most of them improved, two of the more advanced cases died, two other cases who had distinct physical signs of consolidation of the apex of one lung with regular evening pyrexia seemed to recover entirely, in the one case there was a gain of one stone in weight and in the other 13 lbs., and on discharge from hospital they appeared physically sound. Other of my cases shewed partial improvement, that is, their pyrexia abated, a sign I have invariably found to be the case when treated in open air the lung disease seemed quiescent and although weakly, thin and not gaining weight these patients maintained it. I regret I was unable to produce the cases that still remain in the Asylum before you, but their mental condition prevented me.

C. H. L. PALK, CAPTAIN, I.M.S.,

Supt., Govt. Lunatic Asylum, Madras.

A CASE OF HYSTERECTOMY OF THE GRAVID UTERUS FOUND IN A HERNIA.

On my return from camp I found a young woman (probable aged 19) lying in the Vizagapatam Hospital suffering from a large tumour in the lower part of the abdominal wall. The patient stated that she had had one child some 2½ years ago and that she had not menstruated for 5 months. She stated that one year ago she was quite well but that about that time a large abscess formed in the abdominal wall and had burst and healed up again. Since this a tumour had formed and gradually increased in size. The tumour seemed to be immediately under the skin and to involve the abdominal wall, and in an ill-defined way to spring from the cavity of the pelvis. The skin was not freely moveable over the tumour and the tumour was fungating through the skin to the right of the middle line over an area the size of a rupee. This fungation was almost certainly the result of caustic applied at that spot in the hope of relief. I decided not to examine the woman per vaginam that day, but she was prepared for operation and next morning I made, under chloroform, a thorough vaginal examination. To my surprise I found the pelvis apparently quite normal except that the cervix

was *small* and very high up but it was freely moveable, there was also a gonorrhœa. I did not attempt to pass a sound or pull the cervix down on account of the menstrual history. The body of the uterus could not be felt. I decided to cut down on the tumour and deal with it accordingly. The tumour extended from the os pubis to just below the umbilicus and was very prominent. I had quite failed to make a diagnosis but still fancied that I should find it to be a cystic sarcoma of the front wall of the abdomen. I knew that if a sarcoma the possibility of its removal was very doubtful, but I also knew that an exploratory incision could not do much if any harm. An exploratory needle brought away brown clear fluid (like very weak tea) but no blood. The first incision was made about 5 inches long over the most prominent part of the tumour in the middle line. The abdominal wall here proved to be only the skin and a very thin layer of fascia so that the tumour and some intestine were exposed by the first cut. The tumour was pink, muscular and obviously uterus, foetal movements could be felt, no foetus could be made out. I again aspirated with a hydrocele trocar intending to reduce the bulk of the tumour and if possible return it into the abdomen. The dirty tea-coloured fluid ran for a few ounces and then stopped; other punctures brought only blood. I had still not arrived at a diagnosis but began to think I could feel foetal limbs and suspected malignant disease of an impregnated uterus with dead foetus. I now attempted to return the intestine and succeeded but it was obvious that it would be impossible to return the enlarged uterus, even if healthy, as the abdomen would not have taken it and even if there had been room in the abdomen it could only have been returned by an incision reaching far above the umbilicus. As the child, if present, was obviously dead I made a linear incision down the most prominent part of the front of the uterus. A rush of liquor amnii and blood followed and the limbs of a foetus appeared; the bleeding now became terrific and I noticed at once that I had unfortunately made the incision straight into the site of the placenta. The bleeding was now so terrific that I had only time to give the uterus another slash, grab out the contents including the placenta and then squeeze it with both hands to stop the bleeding. The uterus immediately contracted and the bleeding could be controlled by my assistant who held the neck of the uterus with the fingers of both

hands. I now saw that the uterus was normal but had come through a hole in the anterior abdominal wall about 1 inch in diameter. I suppose it had come through this hole when unimpregnated together with a coil of intestine and had enlarged there lying under the skin. I was able now (the Assistant Surgeon holding on to the cervix all the time) to clean up a bit and considered what should be done next. The woman's pulse showed no sign of the loss of blood. I tried to sew up the large cut in the front of the uterus but as the stitches had to pass through the large venous spaces and vessels at the site of the placenta the attempt had to be abandoned as the bleeding again became very severe. I saw no course left but amputation and so I proceeded to amputate the uterus at the cervico-uterine junction leaving the woman her left ovary for her temper's sake. I completely closed the raw stump of the cervix with silk sutures, sponged out the pelvis and by removing a large piece of redundant abdominal skin (including the ulcerated patch) I closed the wound without attempting to sew up the hole in the abdominal wall as I thought that the sooner she was in bed the better. I was pleased and surprised to find that she still had a good full and steady pulse. She was put back to bed and during that day complained of slight abdominal pain and the inconvenience of being kept in the recumbent position. There was no sign of shock such as is usually seen after severe abdominal operations. This I suppose is due to the fact that pregnant women stand loss of blood better than other women. The history of her recovery was uneventful and rather prolonged but now, November 5th, she is quite well and is picking up strength.

The day after operation her left ovary which no doubt was inflamed by the gonorrhœa became the size of a foetal head and exceedingly tender and there was some fever. The woman's health was good; the ovary gradually subsided and is now hard and not tender, about the size of a small hen's egg. The abdominal wound healed well at first, but a small sinus probably due to a stitch abscess formed later on and had to be opened.

The gonorrhœa all the time was profuse and the patient passed through on the 18th, 19th, 21st, and 22nd days a painful attack of gonorrhœal rheumatism of the cervical spinal joints with stiff neck and high fever.

On the 27th day it was noticed that there was a persistent diarrhoea and discharge of dirty blood-stained mucus from the anus. I put her on the table and found that the anus was surrounded by a large venereal ulcer (soft sore). I stretched the sphincter ani, thoroughly scraped the sore and stuffed the anus with cotton wool covered with iodoform. She now made a good recovery and although still weak is practically quite well.

G. G. GIFFARD, CAPTAIN, I.M.S.

GLIOMA OF THE RETINA.

Before entering into details regarding this case, which has lately occurred in my practice; I shall briefly describe the symptoms, pathology, and treatment of glioma of the retina.

Firstly then, it is a rare lesion, seldom met with by general practitioners; and you will excuse me if I mention, how much more useful, I think it is, to bring before this Branch, cases of the more commonly occurring tropical diseases, and their more advanced treatment; rather than those of so rare a nature. Fuchs, of Vienna, mentions, that Glioma is the only neoplasm which occurs in the retina. It is found, almost always, in infants, and children under three years of age, although it has been seen beyond that age. In such a case one notices, that a bright, whitish or golden-yellow reflex, emanates from the pupil, which sometimes is noticeable even, at a distance. For this reason the disease was called, by Beer, "Amaurotic cat's-eye"; "amaurotic", because the eye is blind; and cat's-eye because it shines like a cat's eye in the dark. If such an eye is examined by focal illumination, we recognize as the cause of the reflex, a light-coloured nodular mass (the degenerated retina), situated behind the lens, and covered over with minute vessels. If examined at an early stage by the ophthalmoscope, the disease presents bright patches in the retina, somewhat metallic in lustre. At this stage there is no pain, the eye is blind, but the blindness is not discovered; but the disease is not generally seen at this stage.

In the second stage, the pupil becomes considerably dilated, and increase of tension supervenes. The eye becomes irritated and painful and the child begins to suffer. Examined by focal illumina-

tion, the tumour is seen to project into the vitreous, its surface being smooth or nodulated, and blood-vessels scattered over it. The scleral vessels are congested, the lens is pushed forward, the anterior chamber shallow, in fact, the eye is glaucomatous; and the tissue of the eye cannot bear pressure.

Afterwards in the third stage, the tumour grows out from the eye; first of all along the optic nerve, then in other places as well, particularly through the cornea or its vicinity. The eye at length is transformed into a large ulcerated, painful, and readily bleeding mass, which fills the whole orbit and projects out between the lids.

In the fourth stage, the tumour spreads to remote organs. It becomes transferred either to the brain; or by metastasis to lymphatic glands and also to various internal organs. Children finally die of exhaustion. Glioma, as a rule, attacks only one eye. Fuchs observes also, that its origin at such an early age, must be regarded as a proof of its taking place in foetal life. This, as well as the fact that several children in the same family are, one after the other, affected with glioma, would argue that the cause of it, in many cases, is to be looked for in a congenital failure of development.

Pathology:—(Juler). The tumour presents a yellowish white appearance, it contains blood-vessels, hæmorrhages, and calcareous particles. The neoplasm consists of small round cells, exactly similar to those found in the granular layers of the normal retina. Each cell is a rounded body, and contains a nucleus, in the centre of which, are a few granules. The blood-vessels of the tumour are not in actual contact with the cells, but usually have a distinct sheath. Finally the vessels become destroyed, and whole glioma degenerates from absence of blood-supply.

The structures which are attacked appear to be the nerve elements and the very delicate neuroglia. The mode of extension is, either, along the fibres of the optic nerve, or by way of the choroid. Juler states, that as it is considered to grow from the neuroglia, it ought to be called a "sarcoma."

With regard to the pathology of glioma, Juler's statement is not apparently scientifically correct.

Mr. Treacher-Collins, of Moorfields, who has carefully studied the subject, states that the cells in the retina (granular layers) closely resemble those in gliomatous tumours and if a pathologist were shewn a piece of foetal retina (in which the layers were undifferentiated) under the microscope and was told it was a piece of tumour, he would without hesitation pronounce it glioma of the retina. In text-books generally also, glioma is classed among the sarcomata; but there are clinical and histological differences.

(1). Clinical :—*Sarcoma* occurs at any age. *Glioma* in children during the first two years of life, and never after eleven.

(2). Secondary growths of *sarcoma* are more frequently met with in the liver and internal organs; whereas secondary growths of *glioma* are rare, and occur chiefly in the periosteum of the cranial or facial bones, the glands about the jaws and the brain.

(3). In 20 per cent. of the cases of *glioma* both eyes are affected. *Sarcoma* of the eye is never bilateral.

(4). *Glioma* is more malignant than *sarcoma*, but recurrence never takes place after three years immunity from date of removal. In *sarcoma* of the choroid, the patient may, after removal of the eye, have an interval of ten years, and then get a recurrence in the liver.

Histology :—(Treacher-Collins) cells of *glioma* differ from the round-celled *sarcoma*, the nuclei are larger, there is less cell-protoplasm and little spicules project from them. The cells are always arranged round the blood-vessels, and are always round and none of them are spindle-shaped. In *sarcoma*, when it is round, there there is always spindle-shaped growth with it.

CASES BROUGHT BEFORE THE BRANCH.

(1) The case I brought before the Branch at the last meeting was a typical one, of the endophyte form. The disease had begun in the retinal nerve fibres and extended backwards along the optic nerve sheath. The eye ball was much enlarged and pushed forward out of its socket by the enlargement of the optic nerve. I removed the eye ball, and have now brought

the portion of the nerve enlarged to nearly four times its normal size; and I have under the microscope sections, shewing the round celled growth, so characteristic of the tumour. The little patient has done very well since the operation, one month ago, and as is generally the case, has gained flesh, is stronger and seems quite comfortable; but sad to say, during the last week the periosteum of the orbit is much thickened and there is swelling of the lids, and I much fear the disease is extending.

I have also another case here now, of the disease in its incipient stage, pupil enlarged, bright yellow reflex, watering of the eye, &c.; and I intend to place the child under chloroform and give the members an opportunity of seeing the condition by focal illumination.

T. H. POPE, LT.-COL., R. M. S.,

Supt., Government Ophthalmic Hospital.

AN UNUSUAL CASE OF OBSTRUCTION OF THE BOWEL.

A native criminal insane who was under hospital treatment for chronic mania, was attacked quite suddenly on June 29th, 1899, with symptoms of collapse, he vomited several times, his temperature fell to 97° and his pulse became imperceptible. The extremities were icy cold and his features were drawn. The vomiting very soon became stercoraceous in character and almost incessant. His abdomen was tense and tympanitic, and a diagnosis of acute obstruction of the bowels was made. Through the abdominal wall the bowel could be seen acting spasmodically. A large warm water enema was administered and injected high up into the bowel, the enema after being retained for a few minutes only, came away unchanged, so that an operation was deemed imperative. Laparotomy was performed at once by the usual mesial incision and the peritoneum was opened. The large intestine was empty and collapsed, while the small bowel was considerably congested and distended to a greater size than the normal large bowel. The bowel was also covered with flakes of recent lymph. The obstruction was easily discovered about six to eight inches above the ilio-cæcal

valve, where a tight constriction existed, the walls of the intestine were thickened to the extent of about two inches on either side of the constriction, and felt of stoney hardness to the touch, the adjacent glands of the mesentery were all enlarged, the enlarged glands extending for several inches back into the mesentery.

Owing to the apparently hopeless condition of things, the obstruction being considered due to a hard immovable cancerous mass, the abdomen was washed out carefully and sewn up. Although the patient was removed from the operating table in a seemingly moribund state, the symptoms of obstruction were relieved and he made a wonderful recovery. He was fed entirely by the rectum for four days, and afterwards by liquid nourishment only, by the mouth. He continued to progress marvellously, and on the 6th day after operation he passed a clayey motion well formed but flat as though it had passed through some constricted part of the bowel. Patient convalesced in due course and was able to walk about, the bowels giving little or no trouble so long as only liquid nourishment was given by the mouth. Off and on for the next four months occasional attacks of obstruction occurred with symptoms of collapse and stercoraceous vomiting, but these were only temporary and the obstruction on each occasion relieved itself. Altogether there were some three or four of these attacks, patient having been kept all this time in hospital and carefully dieted. Emaciation was advancing all this time and the patient assumed quite a cachectic appearance.

On November 16th symptoms of obstruction again became manifest and he was collapsed with stercoraceous vomiting, his temperature falling to 96°. The obstruction, however, relieved itself but he never recovered from the collapse and died from exhaustion early on the morning of the 18th November. A *post-mortem* was held about three hours after death. On exposing the intestines there were a few flakes of recent lymph seen, the large intestine was quite normal in appearance, so also the small bowel, except for a stoney hard mass causing considerable constriction of the bowel situated some 6 to 8 inches above the ileocaecal valve, the mesenteric glands in the vicinity were all enlarged. This piece of bowel was excised entirely and then opened (the specimen being now placed on the table before you). The walls were greatly thick-

ened and the mucous coat superficially ulcerated. To my surprise instead of the hard mass being due to cancerous growth I found the following foreign bodies *in situ*—one large half pebble, the size of half a walnut, three smaller stones about the size of ordinary nuts, one square piece of plate glass about $\frac{1}{4}$ inch square and the skin of several plantains (these foreign bodies are placed on the table in front of you). Mixed up with these substances was some very offensive liquid blood-stained pus. On the outside of the bowel considerable inflammatory changes had been going on. The mesenteric glands can also be seen enlarged to the size of large peas in the specimen before you.

On reflection of this case I was entirely misguided at the time of the operation by finding the adjacent glands so much enlarged. I made up my mind that the condition was cancer from the stoney hardness of the bowel, which *post-mortem* examination has amply verified, and from the enlargement of the mesenteric glands in the neighbourhood, which turned out to be the result of irritation and not of cancer at all.

With regard to the after symptoms, I mean those subsequent to the operation, the case certainly was peculiar, the steady emaciation and the cachexia combined with the condition of the bowel which I had already seen certainly pointed very strongly to the malignancy of the disease.

On the other hand, the peculiar intermission of the obstruction was unlike an advancing cancer, as also was the very long time which life was prolonged after what was diagnosed as an almost complete constriction. At the time I was under the impression that these occasional attacks of obstruction subsequent to the operation were caused by temporary spasm of the gut, the idea of a foreign body never crossed my mind.

My difficulties, of course, were much increased by my having to deal with an insane who was quite unable to give me any history or even to describe his own symptoms. The case I think is interesting not only on account of its rarity, but also from the peculiar manner in which this foreign body or bodies kept up a ball-valve kind of action for 4½ months, one would have thought that the

obstruction would either have been overcome and the foreign bodies passed per anum, or else that a fatal termination would have ensued much earlier in the case.

C. H. L. PALK, CAPTAIN, I. M. S.,
Superintendent, Lunatic Asylum,

19th November 1899.

Madras.

Note.—Subsequent microscopic examination failed to prove that there was any malignancy present.

C. H. L. P.

RARE CASE OF OVARIAN DERMOID.

MR. PRESIDENT AND GENTLEMEN,

When I took over charge of the Chingleput Municipal Hospital I found in the shed ward set apart for "septic females" a woman who could only be induced by rather forcible means to leave her bed and hobble across the ward. She appeared to be quite well except that she had a sinus midway between the tip of the ninth right rib and the umbilicus, which was plugged by a short length of tightly-fitting drainage tube and from which a small quantity of offensive pus was daily discharged. This patient had been in hospital for nearly two years and because of the offensive nature of the discharge from her sinus and because of the apparent hopelessness of all attempts to close the opening she had been relegated to the comparative seclusion of the 'septic ward.' I noticed, and, I wondered that it had not struck the eye of her former medical attendants, that although a great deal had been done for the woman she bore no scar of any operation wound such as it is usual to see on the bodies of patients on whom ineffectual attempts have been made to close a long standing sinus. I now turned up the case book and made enquiries and I found that she was a person of whom it might well be said that she had "suffered many things of many physicians." To extract her history from the hospital case book, her hospital history is as follows:—

Name—Narayanee. Age, 35.

Disease—Hepatic abscess. Admitted, 3rd April 1898.

Admitted 3rd April 1898 with a swelling of the right hypochondriac region said to have been of 10 days' duration. She says that she suffered from shivering and fever for five or six days before the appearance of the swelling. On palpation a hard and painful swelling can be felt in the right hypochondriac and upper part of right lumbar region. On percussion it is dull and the dullness is continuous with the liver dullness. Complained of catching pain in right side.

She was given 3iv. of Mag. Sulph. at once. Her temperature is noted as normal. She got Acid Nit. Hydrochlor, Chloride of Ammonia and Ext. Taraxaci in a mixture. Her temperature during the next four days ranged between 100 and 102, and the swelling was poulticed every four hours. On the fifth day after admission the swelling was explored with a grooved needle and as pus was reached an opening was made and a drainage tube inserted. The opening was apparently only large enough to admit a medium-sized drainage tube and it was noted at the time that about a pint of cheesy-looking pus welled out through the incision. It was allowed to drain under carbolic gauze. "Temperature has become sub-normal, there is incessant vomiting and about a pint of pus was discharged that day", says the Assistant Surgeon who wrote the notes.

On 8th April 1898 she vomited 4 round worms (passed by the mouth!! say the chronicler) and since then had no more vomiting.

9th April.—Temperature normal.

14th April.—The discharge had lessened to such an extent that she was only dressed once on the 10th. The cavity was now syringed with boracic acid.

12th April.—Reported doing well.

15th April.—Discharge decreasing in quantity and general health is improving.

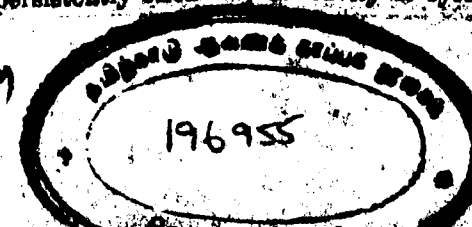
16th April.— Do. do.

22nd April.—It is noted that discharge is getting offensive.

29th April.—Glycerine iodoform emulsion was daily injected and she was ordered the same mixture as on admission with the addition of Mag. Sulph. 3ss.

8th June.—No note again till 8th June when it is stated that discharge being persistently offensive, the cavity is syringed daily

82
1898, MAY 13
No. 8.2



with iodine lotion, and the medicine is somewhat changed ; pepsine being now given. She now had shivering fits and temperature from 100 to 102, 103 until 29th July, when it is noted that she was looking "poorly and weak."

1st August.—Temperature was noted as normal and not till 23th August when it is noted that she has broken out in a syphilitic eruption on the body and Donovan solution m. 10 twice daily was ordered.

15th August.—Abscess cavity no better.

1st October.—Discharge is thick and very offensive, the opening has become very small and the injected lotion does not freely return but has to be squeezed out. Corrosive sublimate 1 in 1000 is now used, and as far as can be seen from the notes the iodine lotion which had been used for three months was now stopped.

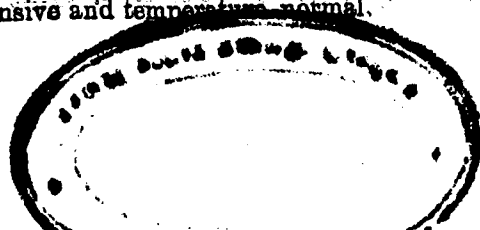
And so she went along now with fever and now without until 26th November, when she was given chloroform and the opening in the abdominal wall was enlarged by incision to admit a finger freely and the cavity was scraped (what with is not stated) and touched with pure carbolic acid *freely*—and subsequently washed out with 1 in 1000 perchloride lotion—and a large drainage tube inserted.

Next day it is noted that the dressings are blood-stained but no pus.

On 5th December.—Temperature normal and discharge decreased in quantity and less offensive.

Treatment.—Injection of Benzoin. Co. was ordered to stimulate the granulation of the cavity," but unfortunately no perceptible improvement in discharge is noted on 10th December. Next day, however, another Surgeon happening to be present, a consultation was held and it was decided to use nitric acid to bring this obstinate sinus to its senses. So the note says that on December 11th, the interior of the cavity of the abscess was scraped (with the ear scoop out of the pocket-case) and cauterised with pure nitric acid.

It is scarcely to be wondered at that the note next day mentions a certain amount of pain and tenderness in the right side : two days later it is noted that pain and tenderness have subsided, discharge still offensive and temperature normal.



As these desperate means had effected no improvement, the case seems to have been relegated to the limbo of incurable chronics and from 12th December 1898 to 20th October 1899 no notes are available.

However on October 26th, the Assistant Surgeon fired with fresh enthusiasm or stung into fresh action by continued contracting of the opening of the sinus and the continued "awful offensiveness" as he himself calls the nature of the discharge again *freely* opened the sinus until it admitted a finger and notes that on exploring the interior with a finger it was found to contain a dark offensive piece of lint and gritty bone-like matter, (no suggestion is hazarded as to its source or length of stay in the wound)—the granulation near the external opening was *scissored* off and the sinus was *freely touched* with pure carbolic acid.

Nothing further is noted till my arrival, 6 weeks later, when the simple note "the sinus is still open and discharge is still offensive" gives the situation in a nutshell. It would have been as well to add "the patient is getting fat, is very loath to leave her bed, the kidneys are still sound and there is no trace of syphilis.

On December 23rd.—I decided to make a thorough exploratory incision and try to get to the bottom of the disease. I found on close examination that a few dark hairs seem to be mixed up with the opening of the sinus but as the skin was much puckered round the opening I imagined that some skin had been drawn in and was lining the mouth of the sinus and that the chronic irritation had caused the skin hairs to grow long and strong.

The patient was put under chloroform and a long incision made parallel to the right edge of the ribs, half way between the costal margin and the umbilicus and the skin retracted so as to get a good view of the muscles and in order to trace the direction of the sinus. "The probe passed almost directly backwards from 2" to 2½" but somewhat downwards: the track of the sinus as it came into view through the muscles of the abdominal wall was now seen to be lined with coarse black hair. I must admit that when I saw the hair and the sinus coming up like the skin of a rotten hairy caterpillar turned inside out I nearly put the woman back to bed to give myself time to think. She was taking the chloroform very badly and wa

very weak, and although I had met many funny things in the abdomen I had never met a hairy liver and was completely non-plussed for a pathological explanation.

However, I decided to go on. A further opening was made partly by cutting and partly by separating the fibres of the right side of the rectus and oblique muscles until a solid tumour the size of an orange was found lying inside the peritoneum and into which the sinus ran.

The peritoneum was opened and the tumour (now seen to be the remains of a dermoid cyst) brought up into the wound. It was adherent to the large intestine, the adhesions were easily broken down and cut away and the tumour pulled out. The fimbriated extremity of the Fallopian tube, (to my no small surprise) was seen to lie on the posterior part of the tumour and the tumour seemed to have taken the place of the right ovary. The right Fallopian tube was in a condition of moderate hydrosalpinx and was thick walled; the tube was cut across and tied and allowed to fall back in the abdomen.

The wound was closed in the ordinary way completely without drainage tube except at the lower end of the skin wound which seemed a little loose. She was very weak after the operation and was very ill with constant vomiting, distension of the abdomen and sleeplessness for the next two days. Most of these symptoms were due to chloroform and she is said to always suffer much from the after effects in spite of morphine and rectal injections of hot water.

She complained of pain for 2 days, her belly was distended and tender but practically all the symptoms ended with the administration of a large warm water enema and she has made an uninterrupted recovery. The difficulty now is to make her leave her bed as she has been in bed so long that she seems inclined to stay here for the rest of her life.*

G. G. GIFFARD, CAPTAIN, I.M.S.

* Since this was written she has completely recovered and has left hospital and returned to her native village.

156955

FL
L, g m 56, M 84 BM
NCO. P. L

NOTICE.

Members are requested to notify changes of address to the Honorary Secretary, at the earliest possible opportunity. The attention of members is invited to the following by-law of the Branch :—

BY-LAW XII.

Members absent from Madras are invited to send papers of professional interest to the Secretary, by whom they will be read before the Meetings of the Society, and all matters of special value will be printed and circulated.