

Transactions of the South Indian Branch
of the British Medical Association
in

Vol. no. 2. May 1900.



32

4, 10, 15, 20, 25, 30, 35, 40, 45, 50, 55, 60, 65, 70, 75, 80, 85, 90, 95, 100

1100-1200

197709

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. GIFFARD, I.M.S.	400

MADRAS:

PRINTED BY H. 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.

Arumoghum, V., Tirutani, 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. Macfadyen & Co., London.
 Fleming, A. N., Capt., I.M.S., Madras.
 Foulkes, T. H., Capt., I.M.S., Chingleput.

197709

L, g m 56, M 84 BM

N 00.8.2, 1

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.D., 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, Malaperumal Street, Madras.
 Krishna Row, H., Trivalar, 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).
 Mamilamani, A. M., General Hospital, Madras.
 Mathias, A. F., Kasaragod, South Canara.
 McGann, R. J., Colonel, I.M.S., Bangalore.
 McKee, G. M. E., Major, I.M.S., 28th M. I., Secunderabad.
 McVittie, C. E., Surgeon-Genl., I.M.S. (Retired, England).
 Mitter, R. H., Captain, I.M.S., Benharapora.

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., Aurungabad.
 Youngerman, E. P., M.B., Major, I.M.S., 2nd M. L., 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	18 2	Expenses of Meetings		...	11	10 0
Sale of Transactions		...	...	...	3	0 0	Charges for sending X-ray apparatus to Bellary		...	20	6 6
Members' Subscriptions		...	...	...	1,800	7 6	Stamps, Postage and Receipt		...	17	4 0
Charges connected with X-ray apparatus		...	...	...	25	6 6	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
Total Rs.		...	...	...	3,452	15 0	Balance on 31st December 1899—		...	...	...
		...	...	...	...	...	With Bankers		...	1,247	6 5
		...	...	...	...	...	Cash with Treasurer		...	89	4 6
		...	...	...	...	...	Total Rs.		...	1,316	10 11
		...	...	...	...	...			...	3,452	15 0

Investment.

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

ASSETS.

C. DONOVAN, Capt., I.M.S.
C. H. L. FALK, Capt., I.M.S.

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

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 showed 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 shows 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

a small and very high up but it was freely moveable, there was also a gonorrhoea. 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 gonorrhoea 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 gonorrhoea all the time was profuse and the patient passed through on the 18th, 19th, 21st, and 22nd days a painful attack of gonorrhoeal 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 shown 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., I. M. S.,
Supt., Government Ophthalmic Hospital.

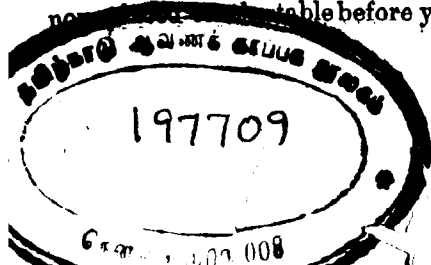
AN UNUSUAL CASE OF OBSTRUCTION OF THE BOWEL.

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-

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 immoveable 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 not available before you). The walls were greatly thick-



3L
L 8 m 56, M 84 BM
NOO. 8. 2. 1