catheter under an anæsthetic. The catheter passed on easily up to the neck of the bladder, when it was partially arrested. By keeping up the pressure for about half a minute it passed into the bladder and about ten ounces of clear urine were drawn off. The tumour disappeared completely. The urine was acid and had no deposit.

The case, as is unfortunately so common in this country, was lost sight of and never returned for treatment.

It is curious that two boys by the same parents should have had this congenital defect. The elder boy has apparently overcome his defect but has cystitis.

Case 3.—A baby seven months old was brought up with a tumour as large as the baby's head, on the left side of the chest. The swelling had been present at birth but had been increasing in size ever since, and during the last month had got rapidly larger.

On examination the tumour was found to be adherent to the chest wall, adherent to the skin, dull on percussion. There was no increase of tension when the child cried and it was not capable of being reduced by pressure; no large vessels seemed to be connected with it. Its consistency was irregular. Hard lumps could be felt in parts, whilst other parts were soft and partially compressible.

Various diagnoses were made; none were correct. It was thought that it might be nævoid and on that account preliminary cauterisation was suggested before removal by operation.

On the withdrawal of the heated needle after the first puncture, clear deep yellow fluid flowed out in a jet and by exerting slight pressure about eight ounces were evacuated. This was collected and examined. It contained a very large quantity of albumen and within five minutes of being evacuated set in a semi-solid jelly. The tumour was easily removed the next day and found to be a multiloculated cystic tumour which was easily removed from the chest wall. The report of the Assistant Director at the Central Research Institute, Kasauli, on the specimen was as follows:—

"The tumour consists of a comparatively dense fibrous network enclosing spaces of various size. Some of these are the size of, and resemble in appearance, ordinary lymph spaces, while others are much larger and have the appearance of definite cysts, which are lined with endothelium. Scattered throughout the tumour are small collections of lymphoid cells, some of which are evident in the lymph spaces referred to above. The tumour is covered with normal skin, and contains several sweat glands, normal in appearance. It is probably a congenital lymphangioma, such as is described by Bland-Sutton under the name lymphatic cyst.

5th June, 1923.

L. A. P. ANDERSON, CAPT., I.M.S."

Case 4.—*Stone in the Bladder*:

This may be of more interest to those at home than in India, where stone is so common, and is only recorded on account of the size of the stone.

A man aged about sixty years came to hospital and was found to have a stone in the bladder. On examination it was found to be too large to crush with a lithotrite and suprapubic cystotomy was decided on.

On opening the bladder the lotion immediately flowed out and the bladder was found to be filled by an enormous stone. The peritoneum was stripped off the front wall of the bladder up to the top of the fundus, and the viscus opened right up to the top. Even then it was with difficulty that the stone was delivered as it was adherent to the posterior wall and had to be peeled off. Some soft fragments remained attached to the bladder wall. The bladder was sewn up, a drainage tube being left in. The stone weighed 8½ ounces.

These cases are typical of the way in which the Indian seeks competent medical relief and only faces operation as a last resort. It shows how little real progress has been made among the masses in India as regards education when people will suffer, or allow their children to suffer, discomfort and pain for years before giving up "treatment" by indigenous medicines.

CANCRUM ORIS TREATED BY EXCISION AND SUBSEQUENT TUBE GRAFTING.

By L. W. HEFFERMAN, M.R.C.S., L.R.C.P., (Lond.),

Assist. Chief Medical Officer, Burma Corporation Ltd., Namtu, Surgeon to Namtu General Hospital.

THE patient was a Chinese girl, aged eleven years.

Previous History.—Patient had "fever" for a period of three weeks before admission to the hospital. Six days after this "fever" began she developed an ulcer inside the mouth on the left side which caused her pain. Chinese medicines were applied and after a few days a dark area began to appear. This began to spread and became foul. She had had practically no nourishment except water for the last four days.

13-3-22. *Present Condition.*—The patient is much emaciated. At the left corner of the mouth is a dark area about the size of a shilling. The area around is red, indurated, and very swollen. A foul smelling discharge is present. The other cheek is red and swollen. The child's head and face appear enormous compared to the trunk, which is very emaciated. Temperature 98.2, pulse 120. General condition very bad.

14-3-22. *Operation.*—Under light anæsthesia all the gangrenous area was removed. About five loose teeth were extracted. The condition of the check was extremely foul. "Bipp" dressing applied.

16-3-22. *Further Progress.*—Two days later a piece of slough came away from inside the

Fig. 1.—Photo of patient taken 17 days after excision of gangrenous area of left cheek. Shows tube graft. Note emaciated condition of child.

Fig. 2.—Photo taken 12 days after that shown in fig. 1. The tube graft carrying skin from clavicular region has been swung into position, the skin surface towards interior of mouth.

right cheek. From now onwards the child improved and the gap in the left cheek became much smaller. The disfiguration was great and there was actually difficulty in feeding because of loss of substance of the cheek.

31-3-22. *Operation* (Fig. 1).—Tube graft prepared. Two parallel incisions were made over the left sterno-mastoid from the level of the angle of the jaw to the sterno-clavicular joint; skin, platysma and subcutaneous tissues were dissected out and the flap thus formed entirely freed except at its proximal and distal

Fig. 3.—Photo taken three months later. The graft has taken and been freed from the remainder of the tube which is now hanging loose. Note great improvement in patient's general condition.

extremities. The edges of the flap were then accurately sutured together thus forming a tube. The edges of the wound were undermined and the skin brought into apposition and sutured. A piece of Eusol gauze was placed between the tube graft and the neck.

10-4-22. *Operation* (Fig. 2).—Ether anæsthesia. The tube graft was disconnected at the distal end, carrying with it a skin flap removed from the clavicular area. The cheek was prepared by freshening the edges and the graft swung into position with the skin surface towards the interior of the mouth. This skin would become mucous membrane.

12-4-22.—The patient's father fed her with solid diet, viz., fried bacon, beef and rice, with the result that the cheek sutures cut through as the result of mastication.

13-4-22. *Operation.*—The cheek end of the graft was removed from its position and the

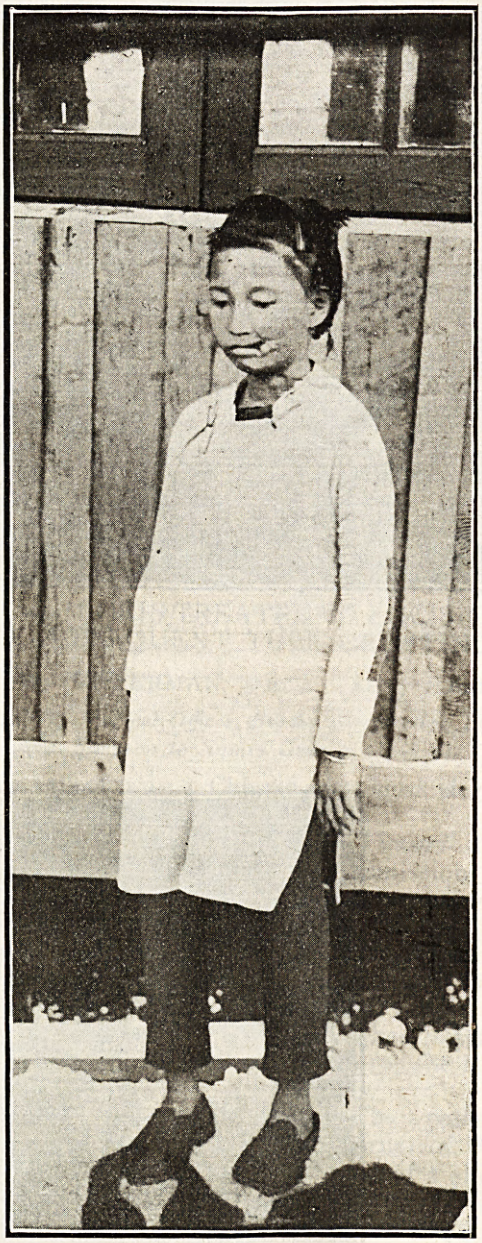

Fig. 4.—Photo of patient taken about a year after her original admission to hospital.

whole area properly cleaned. The graft was replaced and resutured. The patient's lips on the left side were sutured together with silkworm gut. Hot fomentations applied.

25-4-22. *Operation.*—Some trimming of the cheek end of the graft was done. The graft was found to be healthy and very vascular.

A long period now followed during which the graft fought for a position against the septic conditions of the mouth. The patient herself became less thin, was able to walk about, do odd jobs and have a normal diet.

15-7-22. *Operation* (Fig. 3).—The tube was separated at its junction with the corner of the mouth. Bleeding was profuse and the end of the cut tube spurted from two or three small arteries, thus testifying to the vitality of the tube graft.

29-7-22.—The remainder of the tube was removed from the neck. It was not considered feasible to replace the tube graft into its former position in the neck: this procedure is, of course, the usual technique.

The patient was discharged from hospital on 9-8-22 after having been in for five months. I have seen her several times in the local bazaar where her father was selling vegetables. Her appearance is improved (*see* Fig. 4).

THREE SIMILAR YET DISSIMILAR CASES OF GYNÆCOLOGICAL INTEREST.

By W. W. JEUDWINE, LT.-COL., I.M.S.,
Civil Surgeon, Delhi.

MY excuse for publishing these three cases is that they all occurred within a month and form an interesting group, in that they were to all intents and purposes similar and yet all were different.

They may be of slight interest to the specialist, but may prove of greater value to the general practitioner and humble Civil Surgeon who may at any time have to tackle an emergency and act on his own initiative.

Case 1.—Mrs. A., married, two children, age about 32, sent for me at 10 p.m. on 31st December, complaining of abdominal pain.

History of Present Condition.—Was quite well up to the 29th December, when she felt some discomfort in the left side of the lower abdomen and in consequence stayed at home. On the 30th did not feel really well but went about as usual: bowels were open.

On 31st, felt not so well and stayed in bed; bowels not open. No vomiting, no nausea, had light diet.

Previous History.—Had a long confinement with the first child, forceps, no complication. Second confinement natural.

Had always a fair amount of pain at menstrual periods, always worse on the left side. Flow natural—no excess, no clots. Habitually constipated for years, always has to take opening medicine in large quantities. Active habits, walks, rides, plays tennis, dances. Spare frame, always pale.

Immediately preceding her illness had been menstruating from the 26th, and on the 27th had been out shooting, walking for several miles over rough country. Felt none the worse, flow stopped on the 29th.

Condition on Examination.—Patient lying on bed on her back, flat down, legs extended, looked pale (habitual) and rather anxious; complained of dull aching pain in the lower left iliac region. Abdomen moved well and easily on respiration, no swelling seen. Slight tenderness on palpation in the region noted. No rigidity.

Per vaginum uterus retroverted, felt larger than normal, but menstruation was just over.

Per rectum body of the uterus felt, moveable, pushed up.

Temperature normal, pulse 80.

An enema was ordered and only water by the month till seen again.

January 1st, seen at 9 a.m.—Patient had had a good night; pain practically disappeared. Result of enema had been very successful. Sitting up in bed and feeling very hungry, temperature 98.4, pulse 80.

Patient was to all intents and purposes quite well except for some discomfort in the same place in the abdomen. Ordered to stay in bed, allowed tea and toast and scrambled eggs, ordered soup and milk pudding for lunch.

Seen again at 6 p.m.—Did not feel so well, pain had been rather troublesome, bowels had acted at 10 a.m. naturally, temperature 99, pulse 90, abdominal tenderness still persisted. No rigidity.

An enema was ordered and only water by mouth. Left instructions to be called up at 8 p.m.

At 8 p.m. had been called out to another case and did not return till 10 p.m. Telephoned to ask after the patient and heard that there had been difficulty in giving the enema, and that there was apparently some obstruction in the rectum and pain on pressure. Went down at once and examined the patient, temperature 99.4, pulse 100.

Abdomen, the faintest suspicion of rigidity in the left rectus at the lower part.

Per rectum.—A swelling the size of a cherry easily felt in the middle line in front, tender on pressure. Diagnosis, either an ovary or the end of an enlarged appendix.

With the syndrome of pain, commencing rigidity, rise of pulse rate and temperature, with a definite swelling tender on pressure felt per rectum, immediate operation was decided on.

The patient was removed to hospital and was operated on at 12 o'clock. By this time rigidity of both recti was well marked. Patient looked very ill. Pulse 120, temperature 99.6.

The abdomen was opened in the middle line below the navel. Free blood-stained fluid welled out. The small intestines were slightly engorged and distended with gas.