A MEETING was held on 4th June 1913, Dr. Playfair in the chair.

Dr. R. A. Fleming gave a paper on "Ante-mortem Thrombosis in the Right Heart," which will appear in the Journal.

In the discussion which followed, Dr. Goodall said that most of those present must be familiar with those tragedies which occurred in pneumonia, where a patient, after having been safely tided over the crisis, began to suffer from severe dyspnoea, and died sometimes in a few seconds, sometimes in a few
hours. He had made observations on the coagulation time of the blood along with Dr. Ewart, and had found that the coagulation time was always shortened, and that the acceleration progressed till the crisis was reached. Sometimes there was an abrupt increase of the coagulation time just before the crisis. None of the cases in which they had found a coagulation time of less than one minute survived. After the crisis the coagulation time gradually lengthened out to the normal. Blood-plates were an important source of thrombokinase.

Dr. W. T. Ritchie said that he agreed in the main with Dr. Fleming’s conclusions. He would be inclined to pay special attention to diskiness of the ears, lips, and nose, and to weakness of the first sound as indications of dilatation of the right heart. He thought that digitalis and strophanthus were not necessarily indicated in every case of pneumonia. In extreme cases these cardiac tonics should be administered intravenously.

Dr. Eason advocated the use of potassium iodide in pneumonia. It acted as an anti-coagulant, and had other beneficial effects as an expectorant.

Dr. Ninian Bruce gave a communication on “Multiple Neuromata of the Central Nervous System, their Structure and Histogenesis, with a Review of the Present Position of the Neuron Theory.” He first described the case of a man who had suffered from spastic paraplegia and contractures from birth, and had died at the age of 30. Neuromata had been found throughout the nervous system. In the cord these consisted of rounded whorls of axis cylinders. Nerve fibres could be traced from them along the blood-vessels, and could be followed from the anterior nerve roots round the periphery of the cord into the white matter. There were also nodules in the pons and medulla. These were not circumscribed, and also differed from the cord nodules in consisting of fusiform cells, which were often placed end to end, forming nerve chains. The case which at first sight appeared to support the cell-outgrowth theory of nerve development was in reality a very strong demonstration in favour of the peripheral theory. Functional activity was necessary before nerves were completely developed, so that it could neither be said that the neuron theory had had its day, nor that there was no foundation for the cell-chain theory.

Sir Thomas Clouston congratulated Dr. Bruce, and remarked that his results were one more instance of pathology shedding light on the dark places of physiology and embryology.

Edinburgh Obstetrical Society.

A meeting was held on 11th June, Dr. Haig Ferguson, President, in the chair.

Dr. Berry Hart read a paper “On the Pressure Experienced by the Fetus in Utero during Pregnancy; with Special Reference to Achondroplasia,” which is published in the June number of the Journal.

Dr. Barbour believed that Jansen had approached the subject from the mechanical point of view, Dr. Hart from the philosophical. He agreed that it was impossible to see how the condition could be due to local pressure, though he thought that Dr. Hart came up against an equally great difficulty when approaching it from the standpoint of the extrusion of the polar bodies.

Dr. Ballantyne said that Jansen stood for a long line of pressure views, most of which were difficult to entertain. He thought it possible, however, that local pressure might be an explanation of congenital deformities in some cases, e.g. the absence of one pectoralis major as the result of pressure of the child’s hand. So, with an exposed basis cranii, the changes present in anen-
cephaly might be attributed to pressure. He was never able to follow Dr. Hart’s applications of Mendelism.

Dr. Brock believed that Dr. Hart’s suggestion had great possibilities of application in other directions. It might help us in our study of cancer from the biological or genetic standpoint.

Dr. Haig Ferguson read a paper on an “Unusual Case of Hydatid Mole dealt with by Abdominal Hysterectomy.” The patient, 49 years old, had been married for eight years, and had had three abortions previously. She missed two periods, and on 27th November 1912, after an accident, commenced to bleed, This continued up to the time of the operation, 22nd December. When seen then there was severe anaemia, breathlessness, exhaustion, and an enlarged uterus extending in the midline up to the umbilicus. There was free fluid in the abdomen. Pregnancy was present, and the diagnosis lay between a fibroid uterus associated with pregnancy, placenta praevia and hydatid mole. In view of the uncertainty of the diagnosis, the free fluid in the abdomen, possibly indicating uterine erosion, the age of the patient, and, in addition, the danger which forcible dilatation of the rigid cervix would have meant to an exhausted woman, supravaginal hysterectomy was performed. Recovery was good. There were only four other cases on record where hysterectomy was carried out for hydatid mole.

Dr. J. W. Ballantyne showed another specimen of hydatid mole in utero. This was obtained post mortem from a woman 47 years old, who died from haemorrhage immediately after admission to hospital. She was three months pregnant. The uterus was the size of a seven months’ pregnancy.

Dr. James Young gave a lantern demonstration on the pathology of hydatid mole as studied in these two cases, which provided a unique opportunity. In the first case the uterus was 5 in. x 4 in. On section the wall was about one-third of an inch thick, and was expanded uniformly by the mass of hydatidiform villi imbedded in blood-clot. There was no macroscopic evidence of erosion of the muscle. Towards the front of the section the uterine cavity was seen filled with blood-clot. Separating the mole from it there was a thin layer of tissue, the decidua reflexa, whilst on the other side of the cavity there was the decidua vera. It was thus seen that the mole was still imbedded in and enclosed by the uterine mucosa. On microscopic examination the expanded villi were seen to lie close up to the muscular wall, being separated from it by a thin layer of decidua, in which the vessels were expanded, and in which there was extensive haemorrhage. Throughout the uterus there were vascular changes similar to those which Dr. Young has elsewhere shown to invariably accompany chorionic activity. Whilst at no place was there any evidence of an erosion of muscle, this was softened and degenerated in places as the result of the chorionic action. The decidua reflexa consisted of a layer of tissue showing marked fibrinous degeneration.

The second case showed similar appearances. The uterus was the size of a seven months’ pregnancy. The cavity of the uterus was seen towards the upper part of the divided uterus, and from it the mole was separated by a decidua reflexa thicker than in the last specimen. In it decidua cells were evident. Here again there was a definite decidua vera and decidua serotina. Microscopically there was no evidence of a malignant invasion of the muscle.

The most important point revealed by the two cases was the fact that the hydatid mole could reach a large size whilst it was still imbedded in the uterine
The Scottish Otological and Laryngological Society.

The Society met in the Victoria Infirmary, Glasgow, on Saturday, 31st May, Dr. Brown Kelly in the chair.

Dr. Brown Kelly contributed a paper on "Nasal Thermometry," a method of determining the influence of the nose on the temperature of the inspired air, and demonstrated its use. Tables were given showing the difference in temperature between the inspired and expired air, and the variations which occurred in varying degrees of potency of the nasal passages. Dr. Brown Kelly also showed a number of patients.

Dr. Albert A. Gray gave a lantern demonstration tracing "The Evolution of the Round Window and the Aqueduct of the Cochlea from Reptiles to Birds and Mammals." The varying size of the aqueduct of the cochlea and the relation of the round window to the cochlea and to the aqueduct at different stages of evolution were clearly shown. Dr. Gray also gave a microscopic demonstration of the changes in the labyrinth found in cases of otosclerosis and deaf-mutism. He described, too, a nerve ganglion in the human temporal bone which he had discovered, and which had been hitherto unrecognised, showing microscopic preparations.

Dr. J. R. Drever showed two patients with chronic edema of the face. In both there was purulent nasal discharge. From this an autogenous vaccine had been prepared, and in both the use of this has been followed by beneficial results to the facial as well as to the nasal condition.

Dr. J. G. Connal showed a woman on whom he had operated for aural suppuration with labyrinthine symptoms. The radical mastoid operation was performed, and a fistula of the external horizontal canal was found. No pus came from the fistula, and no granulations were present in the neighbourhood. Dr. Connal did not, therefore, open the labyrinth. The woman recovered. An interesting discussion took place in reference to the indications for labyrinthotomy in middle ear suppuration. There is still a good deal of diversity of opinion on this subject.

Dr. W. S. Symé reported at some length a case of otogenous temporo-sphenoidal abscess in which the abscess capsule, a very thick one, had been removed by operation during life. The abscess had evidently been present for some considerable time, and only gave rise to symptoms after the youth had received a blow on the head. The abscess was opened and drained, and two days later he became comatose. The drainage tube was removed, and the opening in the dura enlarged. A necrotic mass presented, and on removal was found to be the capsule of the abscess. The patient did well for six
weeks, and the abscess cavity filled up, but he ultimately died with a second abscess in the frontal region.

Other interesting cases were shown by Drs. Walker Downie, J. L. Howie, James Adams, Albert A. Gray, J. G. Connal, and W. S. Syme.

It was decided to hold the next meeting in the Royal Infirmary, Edinburgh, in November, under the chairmanship of Dr. J. D. Lithgow.

RECENT ADVANCES IN MEDICAL SCIENCE.

MEDICINE.

UNDER THE CHARGE OF

W. T. RITCHIE, M.D., EDWIN MATTHEW, M.D., AND J. D. COMRIE, M.D.

Banti's Disease.

In view of the diverse opinions that have been expressed regarding the nature and pathogenesis of Banti's disease, three of the most recent contributions by Italian writers—Banti (Lo Sperimentale, lxxvi. 91), Cattoretti (Ibid., lxvii. 25), and Luzzatti (Rivista Ospedaliera, 1913, iii. 261)—are of interest.

Banti has defined the disease as a primary splenomegaly, with anaemia and with secondary hepatic cirrhosis, owning no obvious cause and pursuing a very chronic course. Albu, Naunyn, and others have regarded the affection as nothing more than a common cirrhosis of the liver, associated with secondary enlargement of the spleen. In some cases of Banti's disease, however, the liver is not cirrhotic, and in others the spleen is affected for 8 to 10 years before the liver. According to Luzzatti, the view advanced by Gilbert and Lereboullet, namely, that the disease is a biliary cirrhosis with splenomegaly, is disproved by the marked differences in the clinical features of the two affections. Other writers (Raimondo and Foà) believe that both the splenomegaly and the hepatic cirrhosis own a common cause, which is probably of intestinal origin. But in the earlier stages of Banti's disease both the liver and the intestines are usually healthy, and if the disease were of intestinal origin it is difficult to understand why splenectomy should effect a cure. Galvani and Guicciardi, and also Maraglino, although admitting the splenic origin of the anaemia, believe that the hepatic cirrhosis is merely an accidental complication in the course of the disease. Other writers maintain that Banti's disease is due primarily to phlebitis of the splenic and portal veins, and that this may be of syphilitic, and according to Chiari and Marchand of congenital syphilitic, origin. One problem in particular that is still unsolved is the relation of Banti's disease to splenic anaemia. Luzzatti points out that in their clinical and anatomical features the early stages of splenic anaemia and of Banti's disease are identical. Does splenic