confined to the mediastinum; the associated soft and potato-like swellings met with elsewhere in the body are usually characteristic. A moderate eosinophilia and associated anæmia with occasional fever and increase in the leucocyte count are frequently in the clinical picture. The X-ray evidence is that of a fairly well-defined mass on one or both sides of the mediastinum.

Aneurysm of the Aortic Arch.—Pulsation of the tumour was at one time regarded as being pathognomonic of this affection. It is, however, not infrequently a matter of considerable difficulty to decide whether a large, pulsating tumour in the mediastinum would turn out to be an aneurysm of the aorta or a new growth with transmitted pulsation. The history, a positive Wassermann and examination in the oblique diameter are of much greater value; the absence of "clubbing" being the deciding factor in a case of aneurysm.

Sarcoma of the Mediastinum.—Sarcoma sooner or later will be seen to invade both sides of the mediastinal space and will be seen to cause compression or deviation of the trachea with definite signs of compression and interference with the circulation.

Tumour of the Thyroid.—A substernal thyroid when viewed in the lateral plane will reveal itself as a tongue-like process growing downwards and forwards, and depressing the arch of the aorta. Such tumours are of very rare occurrence.

The characteristic feature of tumours of the thyroid, whether benign or malignant, is the definite and readily observable lateral compression of the trachea.

SURGICAL RESURRECTIONS—I.

IT must have fallen to the lot of every surgeon of experience to meet with cases which proceeded to that pitch of desperation that it seemed impossible to believe that recovery could take place, in which, nevertheless, the forces of nature aided by the surgical art have triumphed over the depressing influences and led to recovery. In some instances life may temporarily have seemed extinct, but has revived against all expectation. The relation of some of these cases should be of general interest, both as to the particular events which may have led up to the crisis and the means taken to combat the profound vital depression.

The first two cases I propose to relate illustrate recovery after profound circulatory failure due to hæmorrhage, and may possibly show something new in the technique of treatment.

Case 1—SEVERE HÆMORRHAGE FROM THE BOWEL IN DYSENTERIC TYPHLITIS.

This case was one of the most remarkable recoveries that I have ever seen and at the time astonished me. The patient was a private in the Middlesex Regiment, between 30 and 40 years of age. He was serving in an eastern part of the theatre of the Great War during its last year. The time was mid-July and the weather was exceedingly hot. Admitted to hospital as a walking patient, he was regarded as a trivial case suffering from occasional attacks of diarrhœa. He was given an aperient the day following admission, and two days later complained of abdominal pain and developed a temperature of 101° F. When I saw him on that day a tender lump could be felt in the right lower abdomen, and in view of the history I had little hesitation in diagnosing appendicitis. That same day I

operated by a right iliac incision and found the appendix swollen and inflamed, but no more so than the cæcum itself, which was red and juicy like a tomato. Here indeed was a typhlitis with a secondary involvement of the appendix. The appendix was removed and the abdomen closed without drainage. Apart from headache the progress after operation was uneventful for two days. On the third day he complained of abdominal pains and some mag. sulph. was prescribed. At 8.30 p.m. on the third day he vomited several times. Soon after 9 very severe rectal hæmorrhage occurred and the pulse became weak and almost imperceptible. The amount of blood passed *per rectum* was estimated at from four to five pints.

When I was called to see him the condition was extremely serious and rapidly became desperate. There was no pulse to be felt at either wrist nor in the brachials. The heart, however, could be heard and slightly felt at the apex beat. The mask of death was on the face and the extremities were cold and clammy. One after another the usual remedies were tried. Morphine was administered. Strychnine, camphor, digitalin and brandy were given. Oxygen inhalations were tried. No improvement occurred, and it was clear that the man was moribund. Blood was not available for transfusion, so I tried the usual injection of normal saline into the veins. A vein was exposed at the bend of the right elbow and an attempt made to inject the saline fluid. The veins were found contracted, and at first the fluid could not be made to flow, though there was no doubt that the cannula was well in the lumen of the vein. This was my first experience of that active contraction of the veins which occurs in extreme circulatory depression, and for which the explanation has only been furnished by the physiologists during the last few years. By using greater pressure the fluid was made to enter the vein. It was now about 10 o'clock at night. The fluid was flowing very slowly

and no pulse could yet be felt at the periphery. I said to myself and to the nurse in attendance that I should continue to give the saline infusion until either the pulse came back at the wrist or the heart ceased to beat. The rate of flow was about a pint in three-quarters of an hour. At the end of an hour no pulse could yet be felt, and when after another hour had passed without any appreciable improvement, I felt it was almost hopeless. But I persevered, and some time after midnight there came the faintest flickering of a pulse at the wrist. This gave one hope, so the saline infusion was continued steadily for another two or three hours until six pints or more had been added to the circulation and the pulse at the wrist was easily felt. About 4 o'clock in the morning I felt justified in leaving the patient and retiring to rest with the almost certain knowledge that the saline effect would soon pass off and I might find the patient as bad as ever in the morning. To my surprise, however, though the pulse became small and weak again the next day, the condition of the patient was not quite so desperate. More bleeding occurred *per rectum*, but the pulse remained palpable at the wrist. For some days the condition gave great cause for anxiety. Restlessness, delirium, incontinence of urine testified to the strain on the body, whilst frequent stools mixed with blood gave an indication that the underlying cause for the condition was dysentery. The exhibition of emetine produced a rapid improvement in the bowel state, but the uphill fight for improvement of the general strength was prolonged. Suffice to say that I had the pleasure of seeing the patient come down the line six months later in a fit, ruddy, and almost fat condition.

ZETA.