of cerebral symptoms. Presumably a small embolus had lodged in one of his cerebral vessels without causing symptoms, the preliminary headaches were due to the gradual formation of an aneurysm and the sudden seizure to partial rupture. It is known that after such leakage from an intracranial aneurysm, the patient may recover and live for months or even years.

SURGICAL OUT-PATIENTS

AT

PRINCE OF WALES'S GENERAL HOSPITAL.

BY

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THE following five surgical cases appear to be worthy of record :—

CASE 1.—A. B., male, aged 34. Gave a history of severe melæna 20 years ago. Since then he has had many attacks of "indigestion." The present attack has lasted two months. An average day is as follows: Wakes up free from pain, has light breakfast, pain in epigastrium follows and lasts about one hour. After his midday meal pain recurs and is generally felt both in epigastrium and between the scapulae. He has very bad nights indeed, pain in the back being very marked. He does not vomit, but is losing weight rapidly. Appetite good but he dare not take much food. X ray examination shows hyperperistalsis, but no deformity of stomach or duodenum.

Diagnosis: probably lesser curvature ulcer adherent to pancreas near œsophageal opening.

CASE 2.—J. B., male, aged 71. Noticed three swellings on the abdominal wall two months ago. They have increased in size and are threatening to break down. He has no other complaints except that he has slight epigastric pain, relieved by sipping hot water. Three hard and typically malignant tumours are present, one in the left hypochondrium, one to left of umbilicus, and one just above left Poupart's ligament. They are superficially situated in the subcutaneous tissues. There is free fluid in the abdomen, a hard, irregular, slightly mobile abdominal mass in the epigastrium, and a hard fixed gland just behind the left cleido-mastoid above the clavicle.

The case is one of advanced cancer of the stomach with very unusual metastases in the skin. It illustrates the insidious onset of cancer of the stomach which has reached an advanced state of development without the patient being aware that he has anything but a slight and easily remedied "indigestion." The gland above the clavicle is an accepted metastasis in cancer of the stomach, but is not often found. The more common metastases in the liver and in Douglas's pouch are not found in this case, though the free fluid is suggestive of a peritoneal carcinomatosis.

CASE 3.—G. O., a boy of $8\frac{1}{2}$ years, has had a lump under the chin for six months. It is steadily increasing in size and is painless. A smooth, semi-fluctuating spherical

tumour is present exactly in the middle line of the neck below the symphysis menti. It is not fixed, the skin moves freely over it, and there are no signs of inflammation.

Discussion turned on the alternative diagnosis of a caseating tuberculous gland and a dermoid cyst. The position of the tumour and its freedom from fixation in spite of its size (that of a good-sized grape) decided the diagnosis of a sequestration dermoid cyst.

CASE 4.—A. M., a married woman, aged 26, gave a five years' history of pain after food, very constant in character and accompanied of late by daily attacks of vomiting. She has lost a great deal of weight. The pain is epigastric but goes through to the back; it follows food very quickly and is very severe at night. She obtains relief by taking bicarbonate of soda. There has never been any hæmæmesis or melæna. A curious feature is that she can take bread and cheese with less discomfort than any other kind of food. The teeth are well cared for and the tongue clean. Examination of the abdomen shows nothing but marked wasting, but there is acute tenderness on even the lightest pressure high up in the epigastric angle.

A barium meal X ray examination has not yet been done, but a suggested diagnosis was made of an hour-glass stomach resulting from an active ulcer of the lesser curvature, probably eroding the pancreas. Epigastric pain going through to the back is very characteristic of lesser curvature ulcer, especially if the pancreas is involved, and the frequent vomiting is irritative rather than obstructive and points to an active ulcer and probably some narrowing of the gastric lumen.

CASE 5.—A. H., a married woman, aged 62, who has had several children, has noticed a lump in the left breast for one month. The lump is painful but not tender, and she has "rheumatic" pains in the left shoulder. The patient is stout and the breast large. The surface of the whole breast is puckered, the deepest pucker being at the upper and inner quadrant, where there is a hard, irregular mass intimately attached to the mammary gland, and apparently anchored somewhat to the pectoral sheath. The nipple is indrawn and there are several glands palpably enlarged in the axilla.

The case was obviously one of carcinoma of the breast, but it was pointed out that a new diagnostic problem had arisen with the discovery of what is called "fat necrosis of the breast." This condition is found only in women with large breasts, and one is generally able to obtain a history of some injury with bruising. The area of the breast affected is generally the lower half, where a lump is found moving with the mammary gland and causing puckering of the skin which resembles closely that seen in a late case of breast cancer. This condition is innocent and does not affect the mammary gland, but so difficult is it to differentiate it from cancer of the breast that the complete operation has been done in nearly all the few cases recorded and the true diagnosis has been made only on a microscopic examination.

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