(4) **Appendix Abscess.** A bad diagnosis, because of the absence of suggestive history and inflammatory signs.

(5), (6) and (7) **Abscess Complicating Disease of the Spine, Hip or Sacro-iliac Joints.** One or other of these was suggested by practically every post-graduate. The absence of any symptom or sign of disease in these regions and the normal radiograms must be accepted as conclusive evidence against such a diagnosis.

(8) **Enlarged Psoas Bursa.** A very reasonable suggestion made by one candidate only. One would expect the bursal swelling to be more medial in position, but the possibility of an abnormally extensive bursal sac should have been borne in mind.

This is the diagnosis which most nearly agrees with the clinical picture, but was only made by three post-graduates. Tuberculous adenitis of the iliac glands is a well-known condition, and the close proximity of the glands to the psoas

(9) **Tuberculous Iliac Glands.** muscle is an accepted cause of psoriasis; this gives a reasonable explanation of the intermittent limp which preceded the swelling by more than five months. The glands would eventually soften and break down, and the resulting abscess would track outwards under the iliac fascia and point in the position of the swelling. There it would present all the features of a cold abscess—precisely the picture given by the case under discussion.

It is interesting to add that the swelling was *aspirated* a day or two after the case was shown, and the fluid withdrawn proved to be a typical tuberculous pus.

A TUMOUR OF VOLUNTARY MUSCLE.

BY HAMILTON BAILEY, F.R.C.S.

A WOMAN aged 32 was presented with a swelling on the inner side of the thigh. She stated that she had noticed a lump for the first time three months previously; it was then the size of a walnut. Growth had been slow for two and a half months, after which enlargement had been more rapid. Pain was a feature during the past three weeks only.

History.

The patient was a healthy-looking woman. There was a swelling the size of an orange on the inner side of the lower third of the right thigh. The overlying skin presented a normal appearance, but it was slightly tethered over the

Clinical Signs.

maximal convexity of the lump. The swelling was hard, obviously solid, and regularly irregular. It could be freely moved from side to side but not from above downwards. On abducting the thigh or asking

the patient to voluntarily contract the muscles of the inner side of the thigh it was at once apparent that there was a cessation of lateral mobility.

Almost without exception post-graduates correctly elicited the physical signs, although a proportion failed to demonstrate the last mentioned sign, which typifies a swelling connected with a muscle. In this case the group of muscles with which the swelling was associated were the hamstrings, and because the swelling was situated rather at the back of the group and because it was connected with a fleshy muscle as opposed to a tendon, it seemed probable that the actual muscle connected with it was the semi-membranosus. When asked the nature of the swelling very few members of the class would venture an opinion, and "it might be a lipoma" seemed the favourite

reply. It has been stated that the swelling was hard and the hardness was such that a lipoma never entered the clinical picture.

Now the commonest swellings in muscle from the clinical viewpoint are limited to three: (1) An encapsulated hæmatoma which may calcify; (2) a gumma; (3) a fibrosarcoma. Applying this knowledge to the case in question, a hæmatoma was unlikely, for the patient had had no accident and no bruising had at any time appeared. Moreover, it was exceedingly hard, and was lately increasing rather rapidly in size. A hæmatoma would be likely to be its largest soon after its appearance. Lastly, three months is a short period for calcification in a hæmatoma.

**Differential
Diagnosis.**

A gumma was improbable. Long before a gumma reaches the size of an orange it would surely commence to soften in the centre. This alone was sufficient to rule out this possibility.

The only diagnosis was, therefore, a fibrosarcoma. Indeed, fibrosarcoma is the commonest swelling occurring in a muscle. Fibrosarcomata vary in malignancy. As their name signifies, these tumours consist of a fibrous and a sarcomatous element. When the fibrous element predominates, they are slowly growing and relatively benign.

I was surprised that those who had shown such diagnostic resourcefulness in more difficult clinical problems should have been bowled out by this comparatively simple case, and this is my reason for choosing this case to report.

Four days later I excised the swelling, together with the major part of the semi-membranosus muscle to which the swelling was attached. The tumour was completely encapsuled. The pathological report was "a fibrosarcoma."

A CASE OF GONOCOCCIC SYNOVITIS.

By W. TANNER, M.S., F.R.C.S.

A RIGHT-HANDED male, post-office sorter, aged 49, was shown to the F.R.C.S. candidates on April 26. On April 13 he noticed a painful swelling on the back of the right hand. Two days later he saw his doctor, who found he had a

History. temperature and sent him to a hospital where the hand was placed in a hot antiseptic bath and he was told to attend again next day. The

same evening the patient was seen by his doctor, who, finding the hand more swollen and painful, called in a colleague who incised the swelling under a general anæsthetic.

When seen on April 26 there was a tender, fluctuating swelling involving the sheaths of the extensor tendon of the fingers, and a healing linear wound over the lower part of the third interosseous space with weakness of extension of the two middle fingers and pain on moving the fingers.

All the candidates but two diagnosed the lesion as a septic synovitis. Only two elicited from the patient that he had gonorrhœa twenty-five years ago, that there had been a recurrence of the urethral discharge three years ago and that he is still having prostatic massage. This history and the man's occupation led these two candidates to make the correct diagnosis, *gonococcic synovitis*. I was surprised that the diagnosis was missed by so many, because I find that most of the candidates make a long interrogation

**The
Diagnosis of
Septic
Synovitis.**