

cough. The right side of the chest, near the base, was greatly expanded, very noticeably larger than the left; and there was complete dulness from the line of the nipple downwards, extending two inches below the level of the umbilicus. Along the lower limit of this area of dulness it was easy to distinguish the inferior border of the liver. There was neither ascites nor cedema of the lower extremities. Close to the cartilages of the ninth and tenth ribs a sense of fluctuation could be made out, and at this point a large-sized aspirator needle was inserted its full length. The fluid which was removed was whitish and turbid, and the quantity was one hundred and sixty ounces. As the fluid flowed away, the liver seemed gradually to rise nearer its normal situation. Three hours afterward he had a violent rigor, the pulse 108, temp. 104°, but next morning both were about normal. For some weeks there appeared to be a gradual increase in the area of dulness, as if the cyst were being refilled. In two months it began to diminish slowly, and by the end of the third month there was no more than the normal liver dulness; the patient was in all respects quite well.

### MALIGNANT TUMOUR OF LOWER END OF FEMUR. AMPUTATION. RECURRENCE.

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(Reported at Toronto Medical Society.)

R. C., female, aged 12 years. Family and previous history fairly good.

*History of present illness.*—About the second week in April, 1884, she complained of pains in the limbs which became confined to the front and back of the knee-joint on the right side. About the end of April the pain was situated only in the outer side of right knee, just over the external condyle. It was worse at night; gradually grew more intense until, finally, a slight thickening over the bone could be felt.

About the 7th of May the skin became reddened, swelling became perceptible to the eye, and the part was tender on pressure. Aspirating needle was twice passed down to the bone

with negative results. Poultices and blisters applied.

She was admitted to the Children's Hospital on the 14th of May.

May 15.—Made an incision down the bone, over external condyle, under chloroform. A quantity of blood escaped, with globules of fat floating through it. Wound soon healed without a bad symptom.

June 20.—Under chloroform, made an exploratory incision. A gush of dark blood followed, showing that a blood-containing cavity had been opened. On passing finger, found a cavity in the bone, extending below to the articular cartilage, inwards through almost two-thirds the thickness of the bone, and upwards for about 3½ inches. Fully half of the external condyle was destroyed. The wall of the cavity broke away before the examining finger until firm bone was reached. Some egg-shell crackling was to be noticed. As there was some difference of opinion as to the exact condition present, amputation was done at the junction of the middle and upper third, instead of an amputation at the hip. The modified circular was the operation decided on. The bone looked perfectly healthy to the eye, and seemed to be divided well above the disease. No drainage tube was used. Serous effusion took place, separated the flaps, and the stump healed well by granulation.

About the first of October a small, pigmented spot was noticed to the upper and inner side of the line of cicatrix. It was painful on pressure, and soon developed into the typical fungating sarcoma of J. Hutchinson. As I was out of town from Oct. 1st to 16th, my confreres' wish to amputate at the hip was not acceded to by the parents, and the disease progressed so rapidly before my return that we decided to leave her alone. After several weeks the bone became eroded, and a deposit of bony material commenced in the soft parts around it. The fungating appearance gave way to a hard, bony mass, with large ulcerating cavities from which large quantities of pus were discharged, and into which one or two fingers could be readily passed for an inch or two. Bedsores formed, and the sacrum, trochanter, and anterior superior spinous process of ileum were laid bare, not-