

**TRANSACTIONS**  
**OF THE**  
**PHILADELPHIA ACADEMY OF SURGERY**

*Stated Meeting, held January 3, 1916*

The President, DR. JOHN H. GIBBON, in the Chair

**CARCINOMA OF UNDESCENDED TESTICLE**

DR. CHARLES F. NASSAU reported a case of carcinoma of an undescended testicle occurring in a man aged forty-one years, who was operated upon in January, 1912, and is still living, indicating that carcinoma of a testicle is probably not as fatal a condition as sarcoma.

Three months before admission he had an attack of pain in lower abdomen, with inability to empty bladder. Left testicle is not palpable in canal or scrotum. Admitted to hospital June 15, 1912, with another attack of pain in pelvis, with inability to empty bladder. There was a large freely movable firm mass present in the abdomen above the pubes. No testicle could be felt in scrotum or canal on left side. Rectal examination: Large freely movable mass palpable in pelvis.

An incision, 5 inches long, made through left rectus, exposed a large mass which proved to be the testicle. It was delivered, pedicle tied off and tumor cut away. Peritoneum was sewed over the stump. No glands palpable. Appendix was found to be inflamed and it was removed.

The tumor was an ovoidal mass, measuring 10 x 7.5 x 5 cm., weight 547.5 gms. Pathologist report: Scirrhus carcinoma. About the middle of the specimen is a whitish constricting band. The specimen is smooth, moist, glistening and firm to the touch. Incision meets with no resistance, revealing moist, lobulated, glistening yellowish-white tissue. Thin serum can be expressed from the entire surface.

**PSEUDO-DIVERTICULUM OF GALL-BLADDER**

DR. GEORGE G. ROSS gave the history of a woman, aged forty-four years, who, three weeks subsequent to an operation for acute appendicitis, developed an acute cholecystitis. On November 23, 1915, she was operated on through a right rectus incision. The gall-bladder was free from adhesions. It seemed to empty itself on pressure, and outside of

some thickening of the wall did not seem to be badly damaged. As the history and symptomatology, including a cholesterin test, were so positive a cholecystectomy was done. When the gall-bladder was opened it was found to be a typical strawberry bladder at the fundal end. At the fundus near the attachment to the gall-bladder a marsupial-like pouch was discovered. The opening was patulous and the pocket appeared to be about one inch deep. The mucous membrane surrounding the orifice of this pouch was the point of the most intense inflammation.

Pathological examination by Dr. Allen J. Smith. In his opinion this pouch was probably an acquired and not a congenital one. The pouch (not a diverticulum) was over a centimetre in diameter and communicated with the general cavity of the gall-bladder by a short, narrow mouth. It was lined by continuation of the mucosa of the bladder and was the seat of marked hyperæmia. The wall of this pouch of the gall-bladder was incised in the longitudinal line of the pouch; and a portion of the tissue on one side of this incision was prepared for microscopic examination.

On examination one side only (thought to be that which corresponds with the interior of the bladder proper) shows a mucosal surface, thin, with villous prolongations, its epithelium largely desquamated and that which remains low, cuboidal, and degenerative. No such appearance is seen on the opposite (corresponding with the lumen of the pouch) side, this surface being free from epithelium and finely fringed with loosened fibrous tissue (artificial tearing or material?). A layer of smooth muscle underlies the mucosal surface (but not the outer surface) Beyond this muscle the tissue to the free surface (of pouch?) is made up of a loose fibrous tissue. The latter is not as dense as one is accustomed to see in a scar but might have been produced by inflammatory change.

The general appearances can be best tentatively explained by supposing that an inflamed and ulcerous surface has had overhanging mucosal borders, that these later adhered to the interior of the pouch thus formed, healed, with a persisting track into the gall-bladder, but the epithelium of the gall-bladder failed to grow into and line the cavity.

#### FOREIGN BODY IN ELBOW-JOINT (MOUSE)

DR. ROSS presented a man, aged thirty years, who two years ago while pitching ball says he felt something crack in his elbow. He had to stop pitching for the rest of the season. The following season he pitched some although his elbow continued to hurt him. About four months ago he bumped the elbow and felt something loose, after this, in

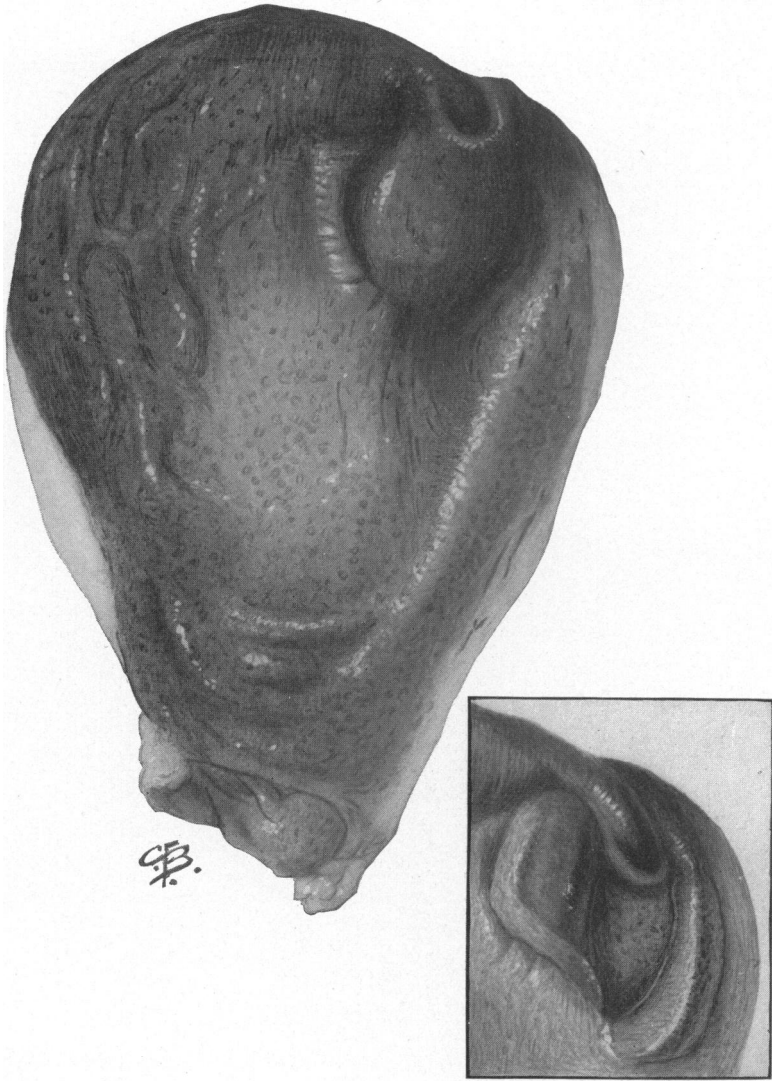


FIG. 1.—Pouch of gall-bladder.



**FIG. 2.**—Bit of the external condyle broken off, and forming a loose body in the elbow-joint. *B.* the fragment removed.

## FOREIGN BODY IN ELBOW-JOINT

the outer side of the joint. An X-ray of the elbow a week ago showed a fracture of the external condyle of the humerus. On the outer side of the elbow just above the joint can be felt a small movable body about the size of a hazel-nut. This is hard and slips when the arm is moved.

Through an incision made over the mass it was easily found and removed. It proved to be a piece of bone the size of a hickory nut, covered with cartilage. It was unattached and was to the outer side of the external condyle.

A perfectly normal functional result was secured.

DR. JOHN H. JOPSON said that Dr. Ross's case of "joint mouse" belongs to that group of cases of fracture of the capitellum which has been especially studied by Kocher and Lorenz, to which he alluded in his paper on that subject published two years ago, and called by them "fractura capituli humeri partialis," in contradistinction to the larger group of fractures of the capitellum in which there is a splitting off in whole or in part of that articular prominence. In the first group the injury partakes of the nature of partial or complete avulsion of the cartilage covering the capitellum, to which portions of the spongy tissue of the bone may also adhere. Kocher has reported four cases and Lorenz two cases of this injury.

It is of infrequent occurrence and in the majority of cases is due to indirect violence, possibly, as Kocher points out, by traction through the anterior capsular attachments pressing backward on the cartilage and prying it off, as when the injury occurs while lifting with the forearm extended. The X-ray shows, as in Dr. Ross's case, irregularity in outline of the normal shadow of the capitellum. Treatment, of course, is by incision and removal of the fragment, which in all of the cases reported has given uniformly good results.