

some degree insusceptible to syphilis" and to have become "as a usual thing" "immune towards syphilis in a certain sense." It matters nothing as I see it, and changes nothing, to regard a mother who gets a chancre from her syphilitic child as getting a second attack or a second infection of syphilis, which seems to be Mr. Hutchinson's view, that is, if I understand him correctly. A woman receives from vaccination something which renders her different from an unvaccinated person in respect of exposure to infection from small-pox—just as carrying a syphilitic foetus does to the woman who carries it in regard to infection from syphilis—but I do not suppose that any one would advise a vaccinated woman to put herself unnecessarily in the way of being infected with small-pox, nor would we, if she did expose herself and became infected, call it a "second attack" or "second infection." I admit that "the something" which is received from vaccination and "the something" which is received from carrying a syphilitic foetus may not be of the same potency as regards infection from small-pox and syphilis respectively. But the difference is one only of degree; and at the most the mother of the syphilitic foetus is only less liable to infection from syphilis than the vaccinated woman is to infection from small-pox. My position is that, as the protection of the mother from syphilis is not complete, she ought never to be exposed to the risk, even if the reason for doing so were much stronger than that which is adduced by Mr. Hutchinson, and which seems to me altogether insufficient.

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## TRANSFUSION OF SALINE FLUID INTO THE AXILLARY CELLULAR TISSUE IN CASES OF SEVERE HÆMORRHAGE.

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THE credit of this method of treatment is due to Mr. Thomas H. Morse of Norwich, and it was owing to his suggestions some time ago that I became aware of it. The instrument used is a very slight modification of Mr. Arbuthnot Lane's transfusion apparatus, made by Messrs. Down Brothers, the only difference being that a sharp-pointed needle of a little stouter make is required instead of the blunt one used for introduction into a vein, and the ordinary saline solution is used—i.e., a teaspoonful of common salt to the pint of boiled water cooled down to the proper temperature (100° F.). Having fitted the needle, tube, and syringe together, fill the latter with the solution, then force the steel point of the needle through the skin of the axilla deep enough to move freely into the cellular tissue, and slowly and gently force the fluid into the cellular tissue. Refill the syringe and proceed again until a pint or more has been used. The following are brief notes of a successful case in my own practice.

In February last I was sent for one evening about 7 P.M. to attend a multipara, as the nurse was alarmed at the excessive hæmorrhage which had taken place during the preceding two hours without apparently any progress being made in the labour. I found the patient had lost an enormous quantity of blood and was in a dangerous condition, being blanched and pulseless, and the pains, which had been going on regularly for several hours previously, had now entirely left her. Upon examination I found the os only partially dilated and the membranes protruding, but no presentation detectable. I ruptured the membranes, a large quantity of liquor amnii escaping, and I found that the cause of the hæmorrhage was right partial placenta prævia. She was now in an exceedingly critical condition, vomiting, in a cold clammy perspiration, with sighing respirations, the bowels acting involuntarily, and she was pulseless, semi-conscious, and apparently rapidly sinking. Two subcutaneous injections of ether were given without the slightest improvement. Dr. Treutler, who kindly saw the case with me and lent me his assistance, agreed that no further interference in the labour was at present justifiable. Remembering Mr. Morse's suggestions, and having my instrument within easy distance, we performed transfusion according to his method, injecting about

a pint, although I must confess without the remotest idea of benefiting the patient, as we considered the case beyond our assistance. However, after a very brief interval there were indications of slight improvement and a very feeble pulse was detectable at the radials. During the next two hours small quantities of warm milk and brandy were able to be taken at frequent intervals. After that time there were decided symptoms of rallying and benefit from the transfusion and pains returned. By examination a vertex presentation could be made out, and ergotinine ( $\frac{1}{100}$  gr.) was injected and we delivered with forceps.

It may be interesting to note that the child (female) was stillborn and very large, weighing eight pounds and three-quarters and measuring twenty-one and a half inches in length. It was in a state of well-marked rigor mortis, the stiffness of the limbs and body adding considerably to the difficulty of completing delivery, which was accomplished at 12.45 A.M. The movements of the child were last felt at 6 P.M. The placenta was easily removed, and the position of the part whence the hæmorrhage occurred found well-marked on its border. The patient made an uninterrupted recovery, assisted by taking iron in the form of Bland's pills (bi-palatinoids) for several weeks.

The results of the transfusion were rapid absorption of the saline fluid (hardly any swelling remaining at the end of two hours) and decided and rapid improvement of the urgent symptoms, thus enabling the patient to take minute quantities of nourishment; and its advantages are the quick, ready, and easy application of the method which could be managed any time single-handed. Mr. Morse has had two successful cases, one being for a pulseless patient, due to hæmorrhage as a result of extra-uterine foetation, and he says "that the pulse became quite a good one in fifteen minutes," and he further suggests the use of this method "before certain operations in collapsed conditions due to hæmorrhage," and on future occasions he intends performing the operation in both axillæ.

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## Clinical Notes: MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

### CASE OF OBTURATOR HERNIA SUCCESSFULLY TREATED BY COPIOUS ENEMATA.

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ON June 25th, 1895, a fisherman aged thirty-eight years was carried home from his boat suffering great pain along the line of the adductor muscles to the knee of the left leg. The day before he had hobbled to his boat in pain in the same region, and had been obliged to remain on his hands and knees until he was carried ashore, as stated. The bowels had not been moved for two days. A slight sense of fulness to the inner side of the femoral vessels, inability to extend the thigh, the great pain at the groin, complete loss of appetite, and a sense of nausea, with the tongue dried in the centre, suggested the diagnosis, the inguinal and femoral canals being clear. Having tried moderate taxis without result I ordered an enema of a gallon of warm water, which was injected almost without the patient being aware of it, so complete was the loss of sensation in the lower bowel. After a quarter of an hour, there being no desire to defecate, he was asked to make an effort to move the bowel, with the result that about a pint of hardly discoloured water was passed. He was then put on morphia, belladonna, and tincture of chloroform, which somewhat relieved his pain and induced sleep for an hour or two. On June 26th, 10 A.M., I found that nothing had been passed by the bowel during the night. The tongue was drier and the condition was evidently worse. The temperature was 101° F. and the pulse was 112. I gave another enema of a gallon of warm water and applied taxis, with the result that I fancied I heard and felt a slight gurgle under my thumb. He now stated that he was not suffering so much pain. There was still loss of sensation in the lower bowel, but on the patient's trying to evacuate the enema about two pints were passed with a