

DECIDUAL ENDOMETRITIS.


CASE I.—C. P., 1-para, aged seventeen, stated she was in good health during pregnancy; gave birth to a living infant after an easy labour. On the third and following days there was a considerable rise of temperature and pulse, and on exploring the uterus a firm growth was found, especially developed at the fundus and right cornu. It was not possible to detach it thoroughly with either finger or curette, and any attempt to do so was followed by bleeding. Copious douching of the cavity was practised, and it was then packed with iodoform gauze. This proceeding was repeated on several occasions; and convalescence though tardy was satisfactory.

CASE II.—L. S., 1-para, aged twenty-two; labour was natural; child alive; a few days afterwards there was considerable pyrexia, and on examination the cavity of the uterus was found occupied by a firm growth, closely adherent to the uterine wall, from which it could not be detached without violence, except in small fragments. Douching and packing with iodoform gauze were tried, but without any appreciable effect on the temperature and pulse. These latter, however, were no doubt aggravated by pulmonary phthisis, of which signs became observable during the first week of the puerperium, and which proved fatal in six weeks from the birth of her infant.

ART. XX.—*Traumatic Rupture of the Spleen, followed by Recovery.* By PERCY N. GERRARD, M.D. Dubl.; District Surgeon, Sēlángor, Federated Malay States.

A CHINESE, aged fourteen, was brought into hospital at 12 15 p.m. on May 20, 1900, with a history of having been run over by a four-wheeled hackney carriage at 11 30 a.m. that morning. His symptoms on admission were all those of severe internal hæmorrhage: he was blanched, his pulse rapid and hardly perceptible, breathing rapid and shallow, pupils dilated. He had smart hæmoptysis of brilliant oxidised blood mixed with some bronchial froth. He exhibited on inspection the usual grazing contusion, marking the passage of a wheel obliquely across the abdomen from left to right, starting immediately over the 10th rib in mid-axillary line, and from that point to and over a point 2 inches internal to the right nipple. On his back a scraped wound over

the angles of the 9th and 10th ribs evidenced the position of maximal counter-pressure. His other wounds were a contusion over the right parietal bone, and a lacerated wound of the right hand, transverse fracture of 3rd and 4th ribs on right side just internal to nipple line.

On inspection of the abdomen at the time of his admission as he lay on his right side, in which position he was placed at his own request, the abdomen was markedly pendulous towards the right giving the belly a right-angled triangular appearance  with the base resting on the bed, the perpendicular being formed by the patient's back. This triangular appearance, although due, no doubt, to the intestines in some degree, was, I consider, to a greater extent due to effused blood in the peritoneal cavity, which view was subsequently supported by the physical signs on percussion.

Percussion of the thorax showed a dull area corresponding to the lower lobe of the left lung, a slight hyper-resonance of the apex of the same lung, an increase upwards of the precordial dull area to the third interspace, passing backwards and becoming merged in the dulness over the lung. Abdominal dulness was present over the splenic area from behind forwards almost to the nipple-line, then with an interval of intestinal resonance passed from the mid-abdominal line absolutely dull downwards to the right side of the abdomen.

Auscultation over the precordial area revealed very indistinct cardiac sounds, heard with difficulty, and an extremely rapid action, without, however, any perceptible endo- or exo-cardial adventitious sounds. Over the posterior portion of both lungs, but more marked on the left side, innumerable large moist râles were heard, and similarly over both apices, but fewer and less marked.

The first lesion to suggest itself, more especially in a tropical country, was rupture of the spleen, which I diagnosed and still believe to have occurred. The next question, as to immediate laparotomy, was not so easily settled, on account of the condition of the lungs and its bearing on the question of chloroform administration, and further in view of the difficulty of sterilising the abdomen in any way satisfactorily in a brief period of, say, a quarter of an hour. Then, again, the disturbance of the patient involved, also the position of the external lesion with the probability of cardiac contusion; and, lastly, of considerable

weight came the fact of the hæmoptysis and the colour of the blood voided *per oram*.

I decided, therefore, on the above premises, that operation would be dangerous and disturbing to the patient, and might probably be ultimately unavailing on account of the contusion of the heart and lung.

The treatment adopted was purely palliative: liquid extract of ergot. \mathfrak{m} xx., with tincture of opium \mathfrak{m} xx., was immediately exhibited, and repeated in half doses every hour until the opium showed its physiological effect; iced compresses, changed every three minutes, were applied from the spine over the abdomen covering the splenic area and across to the right side; an enema of one pint of normal saline solution was given promptly and half this quantity was repeated every hour, no stimulant of any kind being given by the mouth.

About an hour afterwards a sharp attack of vomiting occurred, which caused such marked distress and weakness that a hypodermic of half a drachm of ether had to be administered.

At four o'clock in the afternoon, $4\frac{1}{2}$ hours after the accident, the condition having improved, and hæmorrhage apparently being under control, soup alternating with milk and small doses of brandy were administered every four hours. At the same time iron and digitalis were added to the mixture and the doses of ergot and opium were reduced to \mathfrak{m} v. every two hours.

The dulness on the right side of the abdomen rapidly decreased, and on the 31st of May—*i.e.*, five days after the injury—had disappeared completely.

The temperature chart exemplifies sufficiently well the action of fibrin ferment during absorption as a pyrogenetic substance, and cannot be regarded, I consider, as typical of any form of malarial fever. Although in the hurry consequent on his condition on admission I omitted to examine the blood microscopically, yet I do not regret the fact as it would not be any positive proof of the plasmodium being the cause of a fever of such irregularity as that shown in this case. Again, I may mention that the morning after his accident I gave quinine thrice daily to obtain its prophylactic action and thus indirectly hasten recovery. June 3rd, when I entered the ward, the patient was sitting up in bed trying to read his summons to attend Court as a witness in the case of the man who ran over him. His colour is now excellent, and he is very pleased with himself. The area of splenic dulness

is still enlarged downwards and inwards, the spleen being distinctly palpable as far forward as the nipple line and 1 inch below the costal arch. His left side has not yet regained its roundness, and it is probable that a greenstick fracture of his 6th and 7th ribs is present. A systolic murmur is audible over the apex which is not well transmitted.

The subsequent history of this case calls for no remark. With returning strength the heart sounds became normal, and he left hospital in good health on June 13.

VACCINATION AGAINST TUBERCULOSIS.

PROF. EDOARDO MARAGLIANO (Genoa) deals fully with tuberculosis and vaccination (*Medical News*, New York, April 2nd, 1904). In the course of his paper he says:—"I have lately studied a method for man that is very promising and easy of attainment. I was led to this by what I had observed in my studies of the efficacy of the dead bodies of the bacilli in the production of immunity; and I took as a key-note this fundamental principle: *Create a peripheral focus of tuberculous inflammation without living tubercle bacilli and bring about by this means the active production of defensive materials. In this way a true vaccination may be practised.* I have adopted such a method in man, after having controlled it in animals. In the animals treated in this manner I had the usual results—that is, resistance to the culture of living bacilli, the production of defensive materials, and a high agglutinating power. In man I have observed analogous results, with the exception of the resistance to living bacilli, which I have not proven. I will tell you in detail what happens. The part used for the injection is the same as in Jennerian vaccination—the arm. A superficial subcutaneous injection, but exceedingly superficial, is made in the arm with a small quantity of vaccine material." This is followed by 2 to 3 days slight fever; and a small abscess, which is limited and completely sterile, follows; this may require 3 to 4 months to completely heal. In the meantime the blood shows a progressive increase of agglutinating power.