

afterwards but she had had no return of the so-called rheumatism.

CASE 3.—The patient, a woman, aged 37 years, was seen on March 10th, 1903. She had been suffering from hamorrhoids, had lost a good deal of blood at times, and was somewhat anæmic. She had also recently had a slight attack of influenza. She complained of headache and pain over the region of the heart. There were systolic bruits at the base and apex. There were no signs of pleurisy or pericarditis. On the 14th the pain over the heart was of a spasmodic nature and was worse at nights. A belladonna plaster was applied on the cardiac region and nitro-glycerine was ordered to be taken when the pain was severe. On the 16th the nitro-glycerine had relieved the pain somewhat but it was still severe at times. Early on the morning of the 17th the patient had a very severe paroxysm of pain and was obliged to sit up in bed gasping for breath; the hands and the feet were cold and she thought that she was dying. On examining the chest I found the sixth intercostal nerve to be very painful on pressure and also found a tender spot on the spine corresponding to the origin of this nerve. Having marked the spot I ordered a blister to be applied. On the 18th the blister had taken well. The pain over the heart was much less. On the 19th there was no pain over the heart. The intercostal nerve was still tender, but from this time there was no return of paroxysmal pain. I continued to treat the patient for anæmia for two months.

CASE 4.—On April 20th, 1903, I was asked to see a woman who was suffering great pain. She was being attended for "acute indigestion." On the 21st she was still in great pain. By the kind permission of her medical attendant I was allowed to see her. For several days she had been confined to bed on account of severe pain over the region of the stomach which was so severe that little or no food had been taken for the last two days. The pain was of a spasmodic character. This fact led me to examine the spine, where a very tender spot was found in the dorsal vertebra, corresponding to the nerve supplying the painful area. A blister was applied to the spot on the spine. On the next day she was so much better that she was able to sit up in bed and have a chop for dinner without the least discomfort. When seen five months after she had had no return of pain nor had she since suffered from indigestion and was much improved in health.

CASE 5.—The patient, a woman, aged 46 years, came to see me with severe pain extending up the back of her head. She held her head with both hands and rocked from side to side as she sat in the chair. There was a very tender spot at the upper part of the cervical vertebræ. A blister was applied. On the next day the pain was much relieved and on the third day it was quite gone. She has kept well since.

Two cases of ovarian neuralgia with tender spots on the spine were treated in the same way with the same satisfactory result. In some cases the tender spots are multiple and in these pain is complained of in more than one region.

CASE 6.—The patient, a woman, aged 58 years, was seen on Oct. 5th, 1902. A week previous to that date she went to London on business and while going up some stairs was seized by a severe pain at the lower part of the sternum and could not get her breath. She was taken into a room where she remained some hours before she sufficiently recovered to be able to return home. She continued to have pains, but these were less severe in character. On the evening of the 4th she had another severe paroxysm of pain. When seen the pain was still severe on the left side of the chest extending to the lower part of the sternum and she also complained of acute pain over the region of the left kidney. Acutely tender spots were found on passing the finger over the dorsal and lumbar spines. These were painted with linimentum iodi. On the 6th the pains were better and on the 8th they were quite gone. There had been no return of pain when she was last seen on Oct. 22nd.

I am indebted to my partner, Dr. F. Percy Elliott, for brief notes of 13 cases from which I select the following.

CASE 7.—The patient, a woman, aged 39 years, was seen on Feb. 23rd, 1902. She had had pain and great tenderness over the ribs of the right side and at the epigastric notch for two months or more. The pain varied but was never absent. There was also pain down both arms. She had been unable to sleep for several nights on account of it. The pain in the side increased by the act of breathing. There was pain on pressure over four vertebræ. Two blisters were applied. On the 24th the pain in the arms was better but that in the

side was no better. The lower blister was found to have slipped and this was reapplied. On the 28th there had been no pain in the side for the last two days and the arms were quite free from it. On March 7th she was quite well and free from pain.

CASE 8.—The patient, a man, aged 28 years, had been under treatment for two months for "dry pleurisy" and was getting worse. When seen on Nov. 20th, 1902, there was great pain on the left side of the chest which was most marked just below the left nipple. Tenderness of the intercostal nerve extending to the spine was found as well as a tender spot on the spine. There were no signs of pleurisy. He had not been able to do any work on account of the severity of the pain. A blister was applied to the tender spot on the spine. On the 21st the pain and tenderness were nearly gone and on the 23rd he was quite well and returned to work. The patient was greatly pleased with the result of the treatment.

CASE 9.—The patient, a woman, aged 22 years, had had great pain on the right side for three months and had been under medical treatment for two months without receiving any permanent relief. When seen on Feb. 25th, 1903, a tender spot on the spine was found which was painted with linimentum iodi. On the 28th the pain was nearly gone and on March 3rd she was free from it. On March 30th she was keeping quite well and had had no return of pain.

CASE 10.—The patient, a woman, aged 62 years, who had been attended for dyspepsia for four or five days, complained of pain of three weeks' duration over the spleen. The spleen was not enlarged but there was tenderness on pressure. There was a tender spot on the spine which was painted with equal parts of tinctura linimentum iodi night and morning. After three days the pain was better and it was quite gone in a week. There was no return.

Had time permitted it would have been interesting to have compared the above cases with some cases of herpes zoster recently under my care and to have pointed out the similarities and the differences in the two classes of cases. In zona I have failed, as also in some cases of intercostal neuritis, to find corresponding tender spots on the spine. Blistering the spine has not proved to be of any use in shingles either in relieving the pain or in cutting short the disease.

One other point I wish to draw attention to—namely, that patients never complain of pain in the spine in the class of cases brought before your notice in this paper. They may even protest when an examination is suggested that they have nothing the matter with their spines, yet when the tender spot is found by pressing on the spine with the point of the finger they flinch or even call out with pain. With apologies for the imperfection of this somewhat hurried paper I leave the subject for your consideration, discussion, criticism, and elaboration.

Walthamstow.

A CASE OF RUPTURE OF THE UTERUS DURING LABOUR; LAPAROTOMY; RECOVERY OF MOTHER AND CHILD.

BY ELGAR DOWN, M.R.C.S. ENG., L.R.C.P. LOND.

ON June 1st, 1904, at 5 A.M., I was called to a married woman who had engaged me to attend at her confinement. Her obstetric history was curious and was as follows. She was 38 years of age and had been married 13 years. Her first pregnancy had terminated at the sixth month, the child being stillborn. The second ended at six and a half months, the child being again stillborn. The third pregnancy went to full term and the child, a boy, is still living and healthy and aged ten years. During this pregnancy she was under the care of Dr. C. J. Cooke of Plymouth who tells me that she was taking perchloride of iron throughout. During the fourth pregnancy she was untreated and this resulted, as in the earlier ones, in the premature birth of a stillborn child. The fifth pregnancy ended in the same way, but the sixth terminated in abortion at the end of two months. At the beginning of the seventh pregnancy she put herself under medical treatment and took iron throughout. I attended her in her confinement, which took place in August, 1900. The child

was living up to the day labour commenced, when she was suddenly seized with severe pain in the abdomen. The pain was continuous, intense, and sickening. The foetal movements were not felt afterwards. I was sent for at once and found the uterus very tense, hard, and painful; the os was not dilated and the membranes were unruptured. It appeared to be a case of concealed accidental hæmorrhage, so I ruptured the membranes and applied a binder. Pains came on at once and the labour terminated naturally the same day. The child was stillborn. After the birth of the placenta a large amount of dark clot came away and the patient had all the symptoms of having suffered from severe hæmorrhage. She was very ill for some time, phlegmasia alba dolens occurring, and she was in bed altogether for about eight weeks. During this eighth pregnancy she had been taking a mixture of iron and chlorate of potash since the beginning of the fourth month and had expressed herself as feeling very well and the movements of the child had been strong and vigorous.

When I arrived at about 5.30 A.M. on June 1st I was told that the labour pains had commenced at about one o'clock in the morning and had since then been strong, regular, and frequent. On examination I found the os fully dilated and the brow presenting at the brim. I gave chloroform and tried to convert the brow into a vertex and as this was not successful made an attempt to get the face to engage but did not succeed. As the parents were exceedingly anxious to have a living child I sent and got the assistance of my partner, Dr. C. L. Lander. He arrived very soon and under full anæsthesia I introduced my hand with the intention of turning but found that there was a well-marked retraction ring round the neck, so I did not persevere in the attempt. I then tried to pull the head down with forceps but was unsuccessful so I asked Dr. Lander to try. He first attempted to get the head into a more favourable position and then applied axis-traction forceps but his efforts were also of no avail. I thought it best to make no further attempt to save the child so I sent the husband to my house for a cephalotribe and perforator. Whilst he was gone there was some hæmorrhage from the vagina and on examining I found that the presenting part had receded and on further examination found an extensive laceration of the uterus through which the hand could be easily passed into the abdominal cavity. The patient was under the influence of chloroform so, of course, did not feel pain but there was a surprising absence of shock and the pulse was 80 and regular. We thought in the circumstances that laparotomy offered the best chance of dealing with the condition and the sooner we could carry it out the better. Accordingly, whilst Dr. Lander prepared the patient I got ready what few instruments my pocket-case contained and proceeded to operate. The nurse gave the chloroform and Dr. Lander assisted me. I made the ordinary incision in the middle line from the umbilicus almost to the pubes, at once exposed the rent in the uterus with the back of the child presenting, and delivered the child through the rupture. The placenta was also removed through the rupture. I then brought the uterus out of the abdominal cavity and thoroughly exposed the rent, which was situated on the lower and anterior surface running obliquely right across from left to right. I sutured the rent as carefully as possible, using a blanket stitch with thick catgut for the deep sutures, and brought the peritoneum carefully together with fine catgut. The uterus contracted well. There was no hæmorrhage from the placental site but some rather free bleeding from one corner of the uterine wound which however, was stopped by a deep suture. The uterus was returned to the abdominal cavity and the parietal wound was united by silkworm-gut sutures.

As in the case recorded by the late Dr. R. Milne Murray¹ no attempt was made to cleanse the peritoneal cavity. The whole operation was very quickly performed and the condition of the mother at the end was wonderfully good. The child, a boy, was living and apparently healthy. He weighed eight and a half pounds; his head was long and firmly ossified. There was some enlargement of the thyroid gland, so much so that the nurse called my attention to it again the next day, and I think this enlargement was, at any rate in part, a cause of the extreme difficulty in getting the head into a more favourable position. The after-history of the case does not call for much comment. The urine was drawn off by catheter on the first evening and afterwards

was passed naturally. On the second and third days there was considerable abdominal distension and great difficulty in getting the bowels to act. Sickness also was very troublesome. The distension was relieved by turpentine enemata given with a long tube and the bowels acted freely after ten one-hourly grain doses of calomel. There was practically no temperature throughout, the highest recorded being under 100° F. The abdominal wound healed well and the stitches were removed on from the tenth to the fifteenth day. The patient was up at the end of three weeks and is now quite well. The baby also is thriving. The nursing was carried out by the usual monthly nurse as trained nurses were out of the question.

I have ventured to record this case in the hope that it may prove of interest. Of course rupture of the uterus is a calamity which is supposed not to occur in a well-regulated midwifery practice. In this particular case I do not know how it could have been avoided as both my partner and myself were extremely careful to use no more force than was absolutely necessary and no length of time was allowed to elapse after the recognition of the unfavourable position of the head. I think the history of the previous confinements affords an explanation of the extreme weakness of the uterine wall. With regard to the treatment adopted, there may be room for different opinions. I know the usual text-book advice is in a case of rupture of the uterus to deliver the child per vaginam either after turning or after perforating, but if the abdomen has to be opened to deal with the uterus later it seems much simpler to do it in the first place. Dr. H. Spencer² in an address delivered at the Obstetrical Society of London in 1900 strongly advocated gauze plugging and said that in his experience all patients treated otherwise had died. If laparotomy is performed the question arises whether to suture the wound or to remove the uterus. Wiener³ says that the rule in his clinic is in all serious cases of rupture to perform laparotomy forthwith and with a clean tear to suture, and with lacerated wounds to perform supravaginal hysterectomy. Amann, Jun.,⁴ summarises the operative methods of treatment in the following way. 1. Suture of the tear: (a) by the abdominal route; (b) by the extraperitoneal method; and (c) by the vaginal route. 2. Supravaginal amputation of the ruptured uterus: (a) with extraperitoneal treatment of the pedicle; and (b) with intraperitoneal treatment of the pedicle. 3. Total extirpation of the uterus: (a) by the abdominal route; and (b) by the vaginal route. So that there is apparently a fair range of choice. It is very difficult to get any clear or reliable statistics either as to the frequency of occurrence of rupture of the uterus or as to the success of any particular method of treatment. I think in the case forming the subject of this note the successful result was largely due to the rapidity with which the operation was carried out and to the small amount of disturbance of the patient afterwards.

Devonport.

ON A CASE OF TUMOUR OF THE CENTRUM OVALE WITH CEREBELLAR SYMPTOMS,

WITH REMARKS ON THE DIFFICULTIES OF DIAGNOSIS.

BY W. L. ASCHERSON, M.B., B.C. CANTAB.,
M.R.C.P. LOND.,

MEDICAL REGISTRAR TO ST. GEORGE'S HOSPITAL.

It is incontestable that, even though we are armed with a host of criteria for determining the localisation of cerebral lesions, these, in the case of tumour, may often prove fallacious. Sir William Gowers,¹ commenting on this difficulty, states that although the general region in which the growth is placed may be determined in the majority of instances it is not often that its exact situation can be confidently affirmed. Professor Raymond² speaks with even more

² THE LANCET, Jan. 13th, 1900, p. 100.

³ Gustav Wiener: Beitrag zur Therapie der Uterus-rupturen, Münchener Medizinische Wochenschrift, January, 1902.

⁴ Amann, Jun.: Die Abdominale Totalexstirpation bei Kompletter Uterus-ruptur, Münchener Medizinische Wochenschrift, March, 1902.

¹ Diseases of the Nervous System, vol. i., p. 523.

² Clinique des Maladies du Système Nerveux, Année 1836-97, troisième série, p. 43.

¹ Milne Murray: British Journal of Obstetrics and Gynaecology, vol. i., part ii.