The skin was moist, the temperature 100·8° F., the pulse 80, and respiration 30. The abdomen was extremely tender to palpation, but there was no distension and no dulness. On turning the patient on her side and examining the back no bruising was recognisable anywhere. There was tenderness on pressure over the lower cervical and upper dorsal regions, but no sign of fracture or dislocation. There was no paralysis of the limbs or face, and the patient moved in bed from one position to another freely. On testing sensation I found very definite impairment of common sensation over the limbs and trunk up to the level of the nipples. The knee-jerks were normal on each side. She lay on her right side, groaning with pain at intervals. During the afternoon she became unconscious of her surroundings and could not be roused to answer questions, but lay frequently screaming and writhing with pain. She had a hypodermic injection of a quarter of a grain of morphia. The temperature in the evening was 99°, the respiration 21, and the pulse 96. On the next morning her temperature was 97°, the respiration 31, and the pulse 96. She was very restless, frequently turning and throwing her arms about and screaming at the top of her voice. There was very little motor paralysis, but it was impossible to make her understand anything. She seemed to be quite unconscious of her surroundings and passed urine into the bed. The hypodermic injection of morphia was repeated. She gradually became worse and more deeply unconscious, and died at 9 P.M. somewhat suddenly, the temperature having risen to 102·2°.

Necropsy.—There was no bruising of the scalp and no fracture of the skull. The sinuses of the dura mater were distended with fluid blood. There was nothing noticeable on the surface of the brain. When the brain was removed blood was noticed to issue through the foramen magnum from the spinal canal. This was sponged dry, but on moving the body so as to depress the head and elevate the trunk about an ounce and a half of fluid blood ran out of the spinal canal. A careful examination of the brain showed no coarse lesion. On making an incision into the soft parts preparatory to removing the spinal cord much deep bruising was seen in the cervical and upper dorsal regions. There was considerable hæmorrhagic effusion into the deeper muscles, but no fracture or dislocation of the vertebræ was discovered. On opening the spinal canal a thick layer of blood-clot was seen covering the dura mater and extending from the medulla to the mid-dorsal region. After removing the clot and opening the dura mater there was no blood remaining on the cord, the whole having presumably drained out into the cavity of the cranium, as previously described. There was no softening or laceration of the cord visible to the naked eye, and unfortunately no microscopic examination was made. Nothing was found in the other organs at all bearing upon her fatal illness.

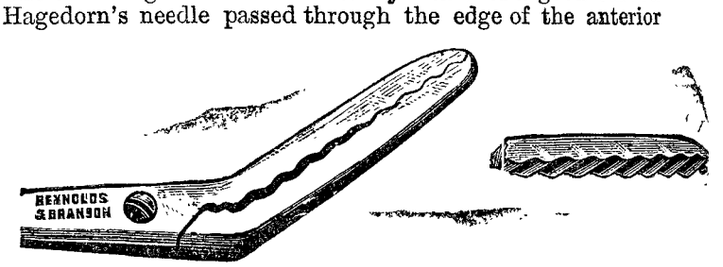
Recapitulation.—A robust girl of nineteen years of age fell backwards and was able to continue her work for several hours. For the next four days she was only partially confined to bed. Vomiting and pain on movement were the prominent symptoms, followed by incomplete anæsthesia up to the level of the nipples. Unconsciousness supervened, and death took place on the tenth day. At the necropsy extra-dural and intra-dural spinal hæmorrhage was found, but no fracture of the spine, or coarse lesion of the brain or cord.

Nottingham.

A POINT IN THE TECHNIQUE OF VAGINAL HYSTERECTOMY.

BY JAMES BRAITHWAITE, M.D. LOND.,
OBSTETRIC PHYSICIAN AND SURGEON TO THE LEEDS GENERAL INFIRMARY.

PERHAPS the most important points in the operation of vaginal hysterectomy for cancer are: (1) the rapidity and ease of the operation; (2) the perfect arrest of hæmorrhage; and (3) the making the ends of the stumps of the broad ligaments extra-peritoneal—i. e., contained in the vagina and not in the peritoneal cavity. All these points can be gained in one way—viz., by the use of an efficient clamp, or rather of two—one for each broad ligament. An instrument of this kind, which was made for me by Messrs. Reynolds & Branson of Leeds, has now been in use for six or seven years and has never failed me once in between twenty and thirty operations. It is stronger than the somewhat light pedicle clamp commonly used in oöphorectomy and is not so broad in the gripping edge as Wells' long compression forceps with blades bent at an angle on the flat, otherwise it exactly resembles them, except in one other point to be named. It is strong enough for anything and yet occupies little space. Wells' forceps were not intended for this purpose and are too bulky to lie in the small space nature has allotted to the vagina. The other point in which these clamps differ from Wells' is that they meet closely at the points, whilst a small space exists between the blades at the end near the joint. As the broad ligaments are much thicker at one edge than at the other, this allows of the whole ligament being compressed accurately, whilst without this modification one part is crushed and another is hardly compressed at all. A clamp of this kind can be put in position much quicker than one which has to have a screw adjusted, and the diagonal deep serrations on the gripping edge make it impossible for anything seized by it to escape. The length from the handle end to the joint is six and a half inches, and of the whole instrument nine and a half inches. The clamp is bent on the flat at an angle of forty degrees. As soon as the posterior incision opening into the peritoneum behind the cervix has been made, exactly in the middle a silkworm gut or silk ligature is passed in at the raw or peritoneal surface, through to the mucous, and then back again to the raw surface, so that the loop is on the mucous side and the loose ends at the raw side. These ends are then brought into the vagina and pulled out externally. A clip is attached to them, and they hang down out of the way until later in the operation the clamps have been applied and the uterus removed. One of the ligature ends is then by means of a good curved Hagedorn's needle passed through the edge of the anterior



vaginal wound, entering at the raw side, then passed through, and back to the raw side. It is thereupon firmly tied to the other end of the ligature, bringing closely together the anterior and posterior vaginal walls by their raw surfaces and fixing the stumps in the vagina. In order to effect this the stumps are brought well into the vagina just before tying the ligature, which of course is done between the two clamps. This ligature is never removed and becomes in time absorbed. Nothing more has to be done except to remove the clamps on the third morning. As there is no screw to be undone there is no disturbance of the parts. As this operation is now, I believe, performed pretty frequently—and I gather that great difficulty is experienced in making the stumps extra-peritoneal—I submit these points, as their observance should shorten the operation to half an hour at the outside. In conclusion I would draw attention to an article by Dr. E. L. Montgomery, Professor of Gynæcology, Jefferson Medical College,[1] in which he states that he passes a piece of gauze in order to prevent contact of loops of intestines with the ends of the clamps, and to "prevent the intestines making unfortunate adhesions." All this, by my plan, is quite unnecessary. The tedious fixture of the broad ligament stumps by ligatures passing through them in order to fix them in the vagina is also unnecessary. As the only death I have had to record was from shock, in a patient already in a bad condition from hæmorrhage, it seems to be a great point to shorten the operation as much as is consistent with safety. I may add that the makers supply these clamps at a reasonable price and that the instruments do for every abdominal operation in which clamps are required. They are light and yet exceedingly strong.

Leeds.

[1] American Journal of Obstetrics, November, 1893.

FEVER IN LONDON.—The report of the Metropolitan Asylums Board on the 6th inst. stated that fifty cases of fever (mostly scarlet fever) had been admitted into the hospitals on that day. The number of patients under treatment amounted to 2492. Of these, 2143 were patients suffering from scarlet fever, 226 from diphtheria, and 114 from enteric fever; three were cases of typhus fever and six were suffering from other diseases.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Prœmium.

WEST LONDON HOSPITAL.

OBSTRUCTION OF THE BOWELS; DIVISION OF BAND; RECOVERY; REMARKS.

(Under the care of Mr. PAGET.)

CONSTRICTION of some part of the small intestine by the pressure of a band is one of the commonest causes of acute intestinal obstruction. The band is usually of inflammatory origin, though the exact way in which it has arisen is not always apparent, especially in the male. There can be no doubt about the necessity for early operation in these cases, and the percentage of recoveries (41 per cent.—Curtis), although favourable now compared with that for operation for other conditions, will be much improved in the future. The closing of the wound is, we think, best performed by sutures passing through all the layers at once. This method is speedy and gives very good results. There should be no likelihood of including intestine, and if the omentum is carefully drawn down towards the pelvis, as in ovariotomy, subsequent adhesion of the bowel to an imperfectly sutured wound is improbable. For the notes of this case we are indebted to Dr. Causton, in whose practice it occurred, and for those taken in the hospital to Mr. E. W. Lewis.

A young man twenty-five years of age was admitted to the West London Hospital on Jan. 8th, with signs of acute obstruction of the bowels. He had always enjoyed good health, save for an attack of typhoid fever in early childhood. His bowels had always acted regularly, and he had never felt pain in the region of the appendix vermiformis. His illness began on New Year's Day. He was in his usual health, his bowels having acted well in the morning. He had not been exposed to any chill and had not taken any unwholesome food. He was seized with pain, which began at the umbilicus and then became more diffused, and he vomited. He came to the hospital, but was not admitted. From Jan. 1st to 7th he was under the care of Dr. Causton. The abdomen at this time was very tender, but soft; no coils of intestine were visible, and no noises were heard save a slight gurgling on the right side. There was at first no distension, or very little. He vomited once or twice daily. On Jan. 4th an enema brought away some large lumps and some undigested food. This gave him relief, and the vomiting stopped for a time. His temperature was always found to be normal, and he would insist on leaving his bed for an armchair. Mr. Paget saw him first, with Dr. Hood, on the afternoon of the 8th. He had walked into the hospital the day before, not seeming to be very ill, but on this day his condition had taken a great change for the worse. An enema had been given without any result. He had just brought up nearly a pint of thick brown, lumpy, fæcal vomit. The face was pinched and haggard, and the eyes were sunken. He was in pain, restless, depressed, and weak. There was frequent hiccough; the tongue was moist and fairly clean, with a thin white coat all over it. The pulse was 100, regular and fairly strong, the temperature was normal, and the breathing quiet. The urine was loaded with urates, but there was no albumen. The abdomen was slightly distended, but not more in one part than in another; there were no dilated veins. A high-pitched note was heard everywhere, but it was not tympanitic. There were no visible coils of intestine, no movements, and no noises; there was also no marked tenderness. The legs were not drawn up. Nothing was to be felt in the right iliac fossa, or by the rectum. It seemed to be certain that the patient was not suffering either from inflammation round the appendix, or from intussusception, or from impacted gallstone, or from volvulus. The diagnosis lay between acute inflammation of the bowels, arresting their action at the inflamed part, and internal strangulation. The following considerations were in favour of internal strangulation: 1. He had not been exposed to cold or wet, he had taken no unwholesome food, he had kept quiet all Sunday, and had been seized with sudden pain on Monday morning. 2. He had felt no previous uneasiness in his bowels; they had acted properly just before he was attacked with pain. They had never given him any trouble in his life, and he had never had attacks of pain in them. 3. He had been ill a whole week. Acute inflammation of the bowels would surely either have proved fatal within the week or would have abated under treatment; and there would have been large, motionless coils of distended bowel plainly visible, lying inert beneath the abdominal wall. With Dr. Hood's approval Mr. Paget operated at once. Two coils of intestine presented through the wound, distended and inflamed, one of them slightly rough with lymph. Mr. Paget first made sure that the appendix felt healthy; then he took the coil that had the lymph on it and followed it downwards and to the right for eight or ten inches. Here it was fixed and could not be drawn forward, and began to bleed a little, and something could be felt holding it down. The wound was enlarged to five inches; the bowel could then be drawn forward a little, and was found to be constricted by a tough, rounded band about an inch long and about the thickness of a No. 7 catheter, attached at either end to healthy coils of small intestine. It was easily divided, and the constricted bowel at once became distended. The wound was quickly closed, the vomiting ceased, and the patient made a good recovery. On the tenth day after operation an enema was given and acted well. It was repeated on the twelfth and fifteenth days, and on the eighteenth day he had some castor oil. The bowels now act regularly without medicine and the patient is in good health.

Remarks by Mr. PAGET.—The diagnosis in this case was helped more by the negative evidence against inflammation than by any positive evidence of strangulation. The operation was happily free from difficulty. The prolonged inaction of the bowels after strangulation is worthy of note. The origin of the constricting band must remain a matter of conjecture; possibly it was due to the attack of typhoid fever in childhood.

THE ENGLISH HOSPITAL, HUELVA, SPAIN.

EXCISION OF THE LARYNX; THE AFTER-TREATMENT OF THE PATIENT; REMARKS.

(Under the care of Dr. MACKAY.)

THIS case of tumour of the larynx not only shows the result of a case of extirpation of the larynx, but is also a good example of sarcoma affecting that region. As a rule, sarcoma of the larynx is of slow growth; in this instance it was rapid, and death threatened to occur from suffocation. Mr. Butlin[1] writes of these cases: "Partial or complete removal of the larynx appears to be a suitable one for cases of sarcoma. The more extensive the disease and the more extensive the consequent operation the less satisfactory is the result likely to be in every respect, not only with regard to the probability of recurrence of the disease, but on account of the after-condition of the patients." The results of operations for sarcoma are much better than similar ones for carcinoma. Hahn collected a series of sixty-five cases of operation for carcinoma; of these, twenty-eight died within fourteen days and five within six or seven weeks from pneumonia or broncho-pneumonia. He also gives records of six complete and two partial excisions for sarcomatous tumours. Of the complete operations two died with recurrence of the disease at the end of seven and fifteen months respectively, one was quite well six years after operation, another two years afterwards, and the fifth died from phthisis eighteen months afterwards with evidence of recurrence of the disease. Mr. Butlin has pointed out that in the second half of the series the results were better than in the first half, and we have no doubt that the future published results will be even better. It must, however, be recollected that it is almost impossible to arrive at the exact truth, for so very often the unsuccessful cases are not recorded. When each hospital is obliged to publish a yearly statistical account of the patients under treatment, according to an approved standard, we shall perchance be able to give a more definite and trustworthy opinion on many similarly obscure questions.

The patient, a man aged forty-four years, was admitted to

[1] Operative Surgery of Malignant Disease.