lower uterine segment, and the almost certain necessity of perforating the after-coming head, it was thought best to do craniotomy. Even then, delivery was very difficult, and the shape of the head when born left no doubt regarding the impossibility of delivering it through the natural channel in any other way. The patient left the hospital on the sixteenth day, well.

The third and last case differs from these, in so far as there was no obstacle to delivery in the pelvis or vagina; the whole trouble being with the uterus.

The patient was admitted on the 16th of September. She had been at the hospital two days before this, but was not supposed to be in labor. She said, however, that she had had pain off and on ever since she was first seen. Fifteen hours after entrance, the os was fully dilated, and the membranes ruptured. The head was high, position posterior. The pains were very severe at intervals of about five minutes.

No advance being made, I was sent for; ether given. The head was found movable above the superior strait; was rotated to an O. L. A., and after some difficulty, forceps and rods applied. Steady traction failed to produce any result. After several attempts, I sent for Dr. Townsend. Forceps with him resulted as they had with me, in failure; the head would not budge; the uterus being simply drawn down somewhat into the pelvis.

We now attempted version. There was a dense contraction ring which held the child firmly between the head and shoulders. The head was held exactly as it would be in a pillory.

We endeavored for hours to dilate this ring sufficiently to pass the hand through and by the head; but the most we could do, was with great difficulty to touch a knee with one finger. The feet were evidently high up in a contraction pocket. We then endeavored to shove the head back through this ring, but without success. A pulseless cord was found, and craniotomy resorted to. Powerful traction with the cranioclast merely served to pull away the skull piece by piece, until finally there was nothing left but the atlas. The hand could now be introduced, and the foot was finally brought down. Extraction was most difficult. With a blunt hook in the groin, and with traction upon the legs sufficient to break the bones, delivery was finally accomplished.

The first two of these cases, I think, could very properly have been treated by Cæsarian section, and in the first one, it seemed to me at the time the operation of election, and does so still. If the tear had extended through the anterior vaginal wall, and so into the peritoneal cavity, a fatal result would have been probable. As it was, the tear went in the most favorable direction; namely, towards the rectum. It does, however, seem to me that the mother's chances were better with Cæsarian section than with craniotomy. I have not seen her since she left the hospital; but, with the tear which she had, and with the history of having undergone several previous operations, much tissue having at each time been lost, I think that her outlook for a perineum and sphincter is very dubious.

In the second, we had to do with a pelvis through which a fair-sized child at term could not be born, and the question here is, what was the best operation for the mother? Sænger's results have been so brilliant, that it seems to me the time has come for us to think pretty seriously of his operation. Statistics are only reliable when the operation has been done by a good

operator, under the most thorough aseptic precautions, and before all other methods of delivery have failed. These statistics Dr. Reynolds and myself hope to present in another paper.

The third case was very peculiar. The woman had probably been in labor for forty-eight hours before entering the hospital. The uterus was in a state of tonic contraction, which ether and hours of labor failed to overcome. The cord had become pulseless, and craniotomy was certainly indicated. The body was, however, so firmly held by the uterus that traction merely served to pull the head to pieces without budging the trunk. Version, if possible, seemed the best thing to try. If we could bring a leg down, it gave us a wedge; and continuous traction for a length of time, would probably allow the body to pass the barrier. This proved true, but how difficult it was, can only be realized by those engaged in the case. Dr. Townsend succeeded in getting one leg, but not until he had brought down the other could any advance be made and even then not without the help of a blunt hook which I inserted in the groin.

I sincerely hope that these cases will provoke a discussion on this subject. If they do not do so, I shall have failed in my object in reporting them.

Clinical Department.

TWO CASES OF APPENDICITIS WITH ABSCESS, SUCCESSFULLY TREATED BY RECTAL PUNCTURE.¹

BY MAURICE H. RICHARDSON, M.D.

ON Wednesday, November 18, 1891, I was called by Dr. Porter, of Auburndale, to see Mrs. H. S. P., aged about thirty. Dr. Porter gave me the following history:

"Last Friday night I first saw her. She was suffering with colic and indigestion. She was in pain and was out of her head. She vomited once or twice. I tried to move the bowels with enemata without success. The next morning the pulse was 125 and the temperature 101.5°. I gave her an anodyne. She had pain in different parts of the abdomen. On Sunday she began to complain of pain in the right iliac fossa. With the movements of the bowels we got various seeds in large quantities. Day before yesterday it looked like appendicitis. I began to give her small doses of calomel, which moved the bowels. On Monday night she passed about a drachm of various kinds of seeds. Yesterday she began to have tympanites. The pulse yesterday came down to 100, and the temperature to 99.6°. This morning she had two movements of the bowels. On examination of the abdomen I found that it was dull in the right flank, and by rectal examination there was a bunch which could be felt also by the vagina."

I found the patient lying in bed looking fairly well. Tongue was coated and white. There was no distension of the abdomen, though it was everywhere tympanitic, and nothing could be felt by external examination. By the vagina, the uterus seemed to be somewhat fixed, and there was a resistance to the right. I found a great prominence in the rectum behind the bladder, caused by a tumor, which was soft and evidently con-

¹ Read before Boston Society for Medical Improvement, January 11, 1892.

tained pus. The general condition of the patient was good. After careful consideration, I advised that the tumor be punctured and drained through the rectum.

On the following day Dr. Porter, under ether anaesthesia, punctured the abscess through the rectum, and left in a drainage-tube. This was followed by perfect recovery in about three weeks. She has remained well ever since.

On Monday, December 14, 1891, I was called to see a young man, living in South Boston, by his physician, Dr. W. J. G. Fogg, from whom I obtained the following history:

"James W. B., aged twenty-six, brass-finisher, was perfectly well up to a week ago last Friday night. Then, about bedtime he began to feel uncomfortable, and complained to his wife of distress in the bowels, with a slight bellyache. He slept fairly well that night. Took some breakfast the next morning, and went to work. He had a good operation of the bowels. In the middle of that forenoon he was taken with severe cramp in the belly (indicating the place by putting his hand over the lower part of the abdomen, below the navel). He did not pay much attention to it at that time. The pain lasted all the forenoon, and he was not able to get back to work. On Saturday he stayed at home. He had great pain in the lower part of the abdomen on the right side, accompanied by vomiting. His tongue was dry and red. Respiration was difficult and increased in frequency. Pulse was 88 and temperature 101° . Had had a slight chill. That was on Sunday morning. On Monday his pulse went up to 130 and to 128 in the evening. The pain was somewhat controlled by Squibbs opium, fifteen drops every two or three hours. The belly was increased in size and somewhat tender. Respiration seemed difficult, and he vomited continually. The next day the pulse dropped to 98, and there was a little less tenderness. He was stupid and heavy from the opiate. Vomiting and nausea the same. The next day, Wednesday, pulse was 94 in the morning, and rose to 103 in the evening. General symptoms about the same. On Thursday the pulse was 105 in the morning and 100 in the evening. During this time we were giving him very small quantities of milk with carbonated water. He could not take any stimulant, although lately he has taken some. The next morning the pulse was 90, but otherwise he was about the same. On the 12th, that is, two days ago, his pulse was 98, and the treatment the same. There was vomiting all this time. Yesterday the pulse was 105 and in the evening 100. He was vomiting hard, retching and straining all day. There was a little oozing of fluid from the bowels. During this time he was passing gas at intervals. There was a little hesitancy in making water yesterday, which amounted to retention last night. He was catheterized this morning. The last twenty-four hours ending this morning, we have made no attempt to give any nourishment at all. He cannot retain it. During his whole sickness he has not taken a pint of milk in twenty-four hours, though milk has been the main-stay. The distention reached its maximum within the third day. There has been no discharge of pus at all. In regard to the pain he said that there has been no very severe pain since the third day. There has not been as much pain as one would expect to find, and there has been no chill. Respirations are much better now. They were nearly sixty a minute at times. The vomiting

has ceased since morning and he has had a large defecation."

On physical examination I found the young man's general appearance good. His face was rather flushed, pupils large, abdomen slightly distended. There was a dulness in the right iliac fossa. Bladder was full. Pulse 104. Tongue a little red. No special tenderness except on deep pressure in the right iliac fossa. Tympanitic everywhere except in this place, where it was a little dull. Nothing could be felt by the rectum.

In this case it seemed to me best to wait, because the symptoms had taken so decidedly favorable a turn. Everything went on well for a week, when vomiting returned with renewed violence, accompanied by increased pain, tenderness and distention. He was sent into the Massachusetts General Hospital on the evening of December 23d, and I saw him at about eleven o'clock that night. I found him vomiting constantly, with a high pulse and temperature, and in a very bad general condition. There was a large tumor occupying the lower part of the abdomen, filling the whole right and extending far into the left side. There was a large, tender mass pressing upon the rectum just back of the bladder. The patient's condition was so bad that anaesthesia and laparotomy were out of the question. I therefore introduced a long rectal trocar of small diameter into the tumor. There was an immediate discharge of fetid pus. The canula was fastened into the mass and a large antiseptic dressing applied. During the night the vomiting ceased and about two quarts and a half of pus escaped through the canula. At the dressing in the afternoon the canula became displaced. From that time to the present the temperature has been normal and the physical signs have entirely disappeared. Nothing can now be felt by the rectum.²

I think there is no doubt that I was wrong in advising delay in this case. It was not evident at the time, however, and it is only in the light of subsequent events that an error of judgment becomes manifest.

Several times before I have been inclined to open abscesses pointing in the rectum by that channel. It seems to me that it is often more dangerous to open such abscesses by laparotomy and that the drainage is not so good. While as a general principle I believe it is far better to open from above, for obvious reasons, yet at times it seems to me that this procedure cannot be adopted. If the patient is in a very bad condition, the necessary shock of a laparotomy is often sufficient to cause a fatal termination. If the abscess has not become definitely adherent to the anterior abdominal wall, it is undoubtedly very dangerous to drain the cavity upwards.

In the first case quoted there was everywhere tympanitic resonance, and there was no reason to suppose that the tumor had become adherent to the abdominal wall, nor was it possible by this route to drain the abscess except by going between the healthy intestines. In the second case the patient's condition was too serious to entertain for a moment the question of laparotomy, no matter how quickly or how skilfully performed. I recall several cases in which I have no doubt whatever that the patient died from the shock of an operation performed at this time.

In both the above cases pus was about to break into the rectum, and the operation hastened by a few hours the process of Nature. The chief objection to this

² He remains perfectly well at the present time, March 9, 1892.

method is the infection of the abscess cavity by the rectal contents. In these two cases nothing of the kind took place, and it is a well-known fact that abscesses break into the rectum without any subsequent trouble. We must bear in mind, however, that at times long-continued suppuration, general wasting, and death result from the breaking of an appendicular abscess or from the rupture of a pus-tube. Such cases, which are most disastrous and distressing, have led us, when possible, always to open large collections of pus in the pelvis by laparotomy, notably in cases of appendicitis and salpingitis. In the latter condition, with which I have had considerable experience, I have yet to see any ill results following vaginal puncture and drainage. It is obvious that while we have in rectal puncture the most dependent drainage, this method should be selected only in very exceptional cases. In vaginal drainage I think we have a less dangerous method, although in my experience it is very difficult to make the utero-vaginal canal aseptic. I believe in avoiding both as far as possible, but that occasionally we must resort to this procedure.

In a case very similar to the second, which I saw with Dr. Goss two years ago, and which I sent to the Massachusetts General Hospital, Dr. Warren drained by the supra-public method. The rectum was compressed by a large abscess situated directly behind the bladder. This case made a good recovery, although in the light of my recent experience I am quite convinced he would have done just as well by rectal drainage.

While there is no definite rule to be laid down in these cases, it seems to me that a certain number of them may be more safely drained in the manner described.

WOUND FROM WHIP-LASH SIMULATING BULLET-WOUND.

BY FRANÇOIS C. MARTIN, M.D., ROXBURY, MASS.

I HAVE had a case recently, which is certainly an amusing curiosity. A wagon-driver presented himself, with an enormously swollen under lip, and the following history: Late in the evening, he was driving through Dover Street, past a dense crowd of people. He struck his horse with the whip, and, at the same instant, there was a sharp report, and he felt a stinging pain in the chin. He found a wound in the lower part of the chin, and another smaller one inside the mouth at the base of the lower lip. The next morning the whole lip was very much swollen.

On passing a probe inwardly, from the outside of the face, I found a passage through into the mouth at the smaller wound. The probe rubbed against some hard substance *in transitu*. All the appearances indicated a severe bullet-wound. On making a free incision from the inside wound, I cut down on the foreign body, and with bullet forceps removed a black mass, about as large round as a lead pencil, and over half an inch long. I at once exclaimed, "You were shot from the crowd!" On dropping the object, however, from the forceps, into a basin of water, it went rather slowly to the bottom, without any "thud." I then examined it carefully, and found it was a piece of the whip itself.

I have often seen the power of the long snake-whips of the freighters in Montana, in taking out the skin in

minute pieces from any part of a mule, with unerring accuracy, but never heard of any such catastrophe as the one I have described.

Medical Progress.

RECENT PROGRESS IN DERMATOLOGY.

BY JOHN T. BOWEN, M.D., BOSTON.

AN EPIDEMIC DERMATITIS AT PADDINGTON INFIRMARY AND NEIGHBORING INSTITUTIONS.¹

IN view of the probability so often expressed, that many forms of cutaneous inflammation heretofore classed as eczema or dermatitis simply, are due to the action of a parasite or its products, the following epidemic of dermatitis is interesting and suggestive.

At the meeting of the Medical Society of London, held on November 30, 1891, Dr. Thomas Savill read a paper on "A Recent Epidemic at Paddington Infirmary." Between July 1st and October 23d, 163 of the 846 inmates of the infirmary were attacked by the disease, or twenty per cent. Only two cases occurred among the staff, the author himself and a housemaid. The disease is described as a universal dermatitis always resulting in a desquamation of the epidermis, attended by a certain amount of constitutional disturbance but no essential rise of temperature, running a course of about six weeks, and attacking males slightly more often than females. The disease sometimes began as a papular or papulo-erythematous eruption, sometimes as elevated macules, in rare instances in ring forms; in either case becoming confluent in a week's time, and presenting then the features of an acute, desquamating dermatitis. In a majority of the cases there were vesicles also, which caused much serious exudation when broken. The eruption started most frequently on the upper portion of the body, although the lower portions were affected first in a considerable number of instances. It seemed to spread by contiguity to the adjacent parts from those first affected. Burning and itching were constant features throughout the attack. Convalescence was slow, and 38 of the patients had relapses. Anorexia and prostration were the chief constitutional symptoms. In about a quarter of the cases there was vomiting, diarrhoea, or both. Temperature normal excepting occasionally at the height of the inflammation. The conjunctivæ were inflamed in all of the severe cases, and the hair and nails were often lost in the later stages of the disease. Albumen was found in the urine in fifty per cent. of the cases, but no serious renal disease was recorded. Some cases ended fatally [proportion not stated, nor whether these were the old and enfeebled. — RER.] chiefly from "the extreme weakness produced by the eruption," in other instances from collapse following the vomiting and diarrhoea. Some died comatose as in uræmia. In several cases boils and carbuncles were seen scattered over the surface. The disease bore, on the whole, the most resemblance to an acute general eczema, differing from it, however, in the extent of the inflammation and thickening, in the profuseness of the exfoliation, and the definiteness of the course. Germicides externally and stimulants, afforded the most relief. With regard to the etiology, age was found to be a predisposing condition, the largest pro-

¹ Lancet, December 5, 1891.