urine or fæces. A large tube was inserted into the depth of the pelvis. Death occurred on the fourteenth day.

In this case a Mauser bullet had traversed the small intestine, wounding it high up judging from the contents, the bladder and rectum, and out through the buttock. All the palpable holes were small and clean cut; the immense sloughing was secondary and due to sepsis.

CASE 28. *Bullet wound of the small intestine.*—The patient was wounded forty-eight hours before admission. There was a double wound in the right groin, the holes of entry and exit being respectively 2 in. above and below Poupart's ligament. There was another wound, due to a separate bullet, 2 in. above and internal to the left anterior superior spine, surrounded by reddened skin, and from this fæces were running. There were marked signs of general peritonitis with constant vomiting and his general condition made operation impossible. He lived till the eighth day.

Another case (Case 24) in which the liver was wounded with formation of an abscess has been already described under "The Chest."

CONCLUSIONS.

The Roentgen rays should always, if possible, be available at that hospital nearest the front in which the wounds can be first properly examined and dealt with.

The electricity should be derived from a secondary battery consisting of separate covered cells charged from the nearest town, a man-of-war or other steamer, or by means of a cycle motor, as has been recently done in the Soudan by Major Battersby, R.A.M.C.

The skiagrams should be taken on to Eastman's positive paper which is sufficiently satisfactory for the detection of foreign bodies.

The apparatus is of no use on the field where the detection of bullets can only be an incentive to premature exploration.

The less wounds are tampered with before satisfactory surroundings are reached the better. All difficult bullets should be removed by a fresh incision and the track ignored.

The modern bullet from its greater penetrating power will be much less frequently found in the body than its predecessors. It is practically aseptic and there is no urgency for removal.

The hole of entrance is often extremely small. Suppuration is generally due to pieces of clothes carried into the tissues. Superficial septic sinuses should be excised. Wounds of lung by modern bullets run a comparatively favourable course.

Small-bore bullets may bore through a bone without causing any line of fracture whatever and every degree of injury from this up to the most extensive comminution may be met with.

Passive movements and massage when possible should be begun early in bullet wound fractures.

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NOTE ON A CASE OF BILHARZIA DISEASE.

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AND

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A RESIDENT of Shrewsbury, aged forty-one years, who was occupied as a scavenger, died suddenly on Oct. 5th, 1898. He had suffered for some time from shortness of breath and from attacks of the nature of angina, but had not had any medical advice. An examination of the body twelve hours after death revealed a few old pleuritic adhesions, the lungs being otherwise normal. A white patch was noted on the anterior surface of the left ventricle. There was old-standing disease of the aortic valves and an aneurysm admitting the whole thumb occupied the posterior left aortic sinus extending into the adjacent coronary artery. The left ventricle was hypertrophied. The liver was somewhat enlarged and hard. The spleen which was about twice its usual size was very dense, hard, and dark coloured. The right kidney was enlarged, being

double the size of the left one and showing signs of chronic congestion. On removing the intestines nothing abnormal was noted until the head of the cæcum came in view, when the large size of the appendix arrested attention. It was twice the size of the natural part and was bulbous or distended at its extremity which had a gritty feeling. It was non-adherent, bluish in the middle, and yellowish at the extreme end. Several hard nodules of the size of a mustard-seed projected slightly beneath the peritoneal surface of the part. The heart, portions of the liver and spleen, and the appendix were removed for examination. The liver was congested as also was the spleen. On making sections through the nodules or tubercles of the appendix each nodule was found to consist of several areas of dense connective tissue the fibres of which were arranged in a more or less circular manner so as to surround and include certain peculiar bodies, apparently parasites. These lay in groups of 3 or 4 but in some places 15 or 20 could be counted in one space. They varied greatly in shape but were mostly oval, one end bluntly rounded and the other more or less pointed and often terminating in a distinct spike. The average length was about 0.06 mm. In some places only the shrunken capsules of the parasites were seen, in which case the appearances were very puzzling and at first slightly suggestive of some kind of crystalline deposit. Staining was difficult and only effected by a prolonged stay in strong carbolic fuchsin. In this way it was possible to distinguish a transparent capsule which only stained very slightly and coarsely granular contents which were more deeply coloured. The parasites were exceedingly brittle and fragile, so that the slightest pressure on the cover-glass caused fracture of the capsule. Many of them were so shrivelled and altered in shape as to be unrecognisable and it was only by finding one here and there still retaining the shape characteristic of the ova of bilharzia that it was possible to be sure that this was a case of old-standing distoma disease.

Upon inquiry it was ascertained that the deceased had been in the army from June, 1883, to 1889. He was in South Africa, at Pietermaritzburg, in 1886, and in Egypt and Malta in 1889. He had had fever and ague when in Egypt and had also had a "touch of the shakes." No doubt he became infected by the parasite whilst in Egypt.

Professor Sheridan Delépine of Owens College, Manchester, has kindly examined some of the sections of the appendix. He considers the appearances to be characteristic of distomatosis.

AN INTERESTING CASE OF CÆSAREAN SECTION IN PRIVATE PRACTICE.

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AT 2 A.M. on Oct. 23rd, 1898, I was called to attend a patient in her fifth confinement. She was thirty-three years of age and had had three living children and one (premature) stillbirth. The labours had all been tedious affairs and the children big, but in no case had instruments been required. On this occasion pains had started about the 17th, had continued then some few hours and ceased again, to reappear at intervals on succeeding days. During the 22nd the pains had been present nearly all day, though not severe enough to make it necessary to send for me till early next morning. On my arrival at about 3 A.M. the pains were recurring every five or ten minutes. The membranes were unruptured; the presentation was right occipito-anterior, and the os was soft and dilatable, of the size of half-a-crown. At 6 A.M. the membranes were tense and bulging, the os was softer and admitted four fingers readily, while the head had made no advance; the pains continued vigorous, so I ruptured the membranes. At 7.30 A.M. the head, which lay rather forwards over the pubes, had not descended at all; the os was thick and oedematous and the patient was becoming exhausted. I noted at this time that the promontory was very easily reached with the finger, the conjugate diameter being about 3½ in. I applied the Barnes-Simpson forceps, but the head was too high to permit of easy locking and the patient too fidgety to allow of their use without an anæsthetic. I got the patient under chloroform, the continuance