with great pleasure these weighty words of Professor Simpson: "I do so (viz. invite attention to "the backward displacements of the uterus") all the more urgently that the subject of uterine dislocations is one which a certain group of respectable gynecologists pride themselves in slighting, or even trying to teach the profession to ignore. Reviewers may load the pages of our journals till they are ready to sink under the length if not the weight of their strictures on physicians who recognise the existence of these mechanical disorders and remedy them by mechanical means; but the man who has seen one such case as this which we are considering will be apt to suspect that these review-writers are more skilful in handling the critic's pen than the practitioner's probe. I have seen many such cases."⁵ So have I.

Granville-place, Portman-square.

CHRONIC STARVATION AND FATTY DEGENERATION AS CAUSE AND EFFECT:

A CASE OF FATTY DEGENERATION; WITH REMARKS.

BY JOHN C. LUCAS, F.R.C.S., &c.

THAT fatty metamorphosis not unfrequently occurs without the previous advent of chronic tuberculosis there can be little doubt, and that this is the effect—although a remote one—of depraved nutrition, extending over a more or less lengthened period, during which the food taken into the system has been much below par, must also be *à coup sûr* to most average observers.¹ It is true that fatty changes (conversion into fat of muscular, nerve, osseous, and other tissues, including the complex placental structure) do take place *pari passu*, but as the result of the reverse cause—over-feeding, perhaps in most cases combined with inadequate bodily activity. And, again, thirdly, some (like Moorhead, p. 254 *et seq.*, vol. i.) even believe that the poison called malaria causes atrophy, with fatty degeneration and infiltration. But this latter mode of causation, although quite true *per se*, I may here venture to explain in a different way, as follows: A person suffering from malarial cachexy can, in the first place, take in very little nourishment, owing, obviously, to the impaired appetite. Then, as Dr. MacDowall and myself endeavoured to show elsewhere, there are the effects of malarial influence on hepatic and splenic functions, and consequent spanæmia and general debility. "Admitting that inflammation of the liver not unfrequently results from vicissitudes of temperature, and consequent chills,² excessive heat, alcohol, dysentery, embolism, and traumatic cases, including cerebral injuries ("wunden des Schädels," Niemeyer); yet we cannot help believing that by far the most potent cause in India is malarial influence, and its cachexy, which soon develops itself. There is a spanæmic condition of the system thus produced, by which a greater onus is thrown on the spleen, and this organ soon enlarges and aggravates the spanæmia; in other words, the spanæmia is both the *vera causa* and effect of the splenic enlargement. There is an excess of colourless corpuscles found and formed in this organ; these are carried to the liver, and the collection and migration there of such an abnormal quantity of white cells or leucocytes (there being also a greater determination of blood to the liver), invite suppuration, which does occur. On the other hand, it may be logically inferred that—as simply an enormous increase of colourless cells in leucocythæmia, chlorosis, &c., never causes abscess of the liver or spleen—some other grave imperfection in their elaboration must take place everywhere, but especially in the liver, where Bernard, Lehmann, and M'Donnell ascertained that the white discs of the blood of

the hepatic vein are five times more numerous than in that of the portal vein. Besides, enlargement of the spleen in this case is not always observed. We therefore hold that the faulty elaboration of the white cells, especially in the liver (for abscess of the spleen is not always concurrent), is the true cause of malarious liver abscess. The crowding of leucocytes from the spleen largely promotes the mischief; in fact, to this we may ascribe the sole origin, since, even with an inferior microscope, the amœboid movements of these white cells were unmistakably seen, thus corroborating the fact originally inculcated by Professor Cohnheim."

Then, again, in the case of women,³ there is actual menorrhagia, if not leucorrhœa—additional channels of bodily waste, which in the existing state of morbid physiology cannot be made good. Again, there is also proportionately increased waste and combustion of albuminoid tissues from the periodical pyrexia. We have, therefore, from the causes noticed above, poor nutrition of the body, which appears to me to be *ipso facto* the *vera causa* of the fatty degeneration.

This explanation of the etiology of fatty transformation, and more particularly of the normal muscular structure of the heart, I think is illustrated in a paper published by me in THE LANCET.⁴ Since then another case came under my observation, and proved fatal. Now, in this more particularly the fatty changes in the viscera, seen in the dead-house, are capable of explanation, and both according to Dr. Moorhead's and this other view of mine.

The case upon which I would make a few brief remarks was also that of a native soldier, a Hindoo, aged thirty-three years, and of fifteen years' service. Immediately before he came under my care he had been quartered at a notoriously unhealthy station, where he had repeatedly been under treatment for ague. On the 17th of February he was admitted into hospital. He was then very anæmic, and the body was badly nourished; muscles wasted and flabby; spleen enlarged; the liver, on palpation and percussion, did not seem very large (although in reality it was enlarged); his pulse was small and quick, but compressible; the heart's sounds were feeble (I could not tell that the organ was fatty), but regular. I had not percussed, unfortunately, to make out the area of cardiac dulness. The patient had never complained of angina pectoris, nor even of any pain or uneasiness in or about the chest to arouse the slightest suspicion. In fact, he was admitted as an ordinary case of fever. On the evening of the 18th (day after his admission) his axillary temperature was 106° F., followed by a morning fall to 97°, then an evening rise to 103·2° F., falling in the morning to 97·6°; evening of same day, 105°. On the 22nd the morning temperature was 100°, evening 103°. From this time the pyrexia assumed a continued aspect, with the same morning remissions and evening exacerbations (viz., 100° and 103° respectively), until the 25th; then, on the morning of the 26th, his temperature was registered 100·8°, and was followed by an evening rise to 103°. Death took place suddenly on this evening at about eight o'clock. The patient was seen conversing with his wife, who had visited the hospital to see him.

At about 9 A.M. next morning I examined the body, which certainly was very emaciated. The pericardium was all over adherent, and contained about two ounces of clear serum. The heart was large, of a leaden hue, with yellow patches in places; near the apex, and over the anterior surface generally, there was a fatty transformation, visible to the naked eye. The organ was of a soft and yielding consistence, and weighed 7½ oz., or about 3½ oz. below the average normal weight. The right auricle and ventricle were filled with hard discoloured clots; both these cavities were distended, and the former in some parts appeared thinned, not unlike an oily piece of paper, and almost transparent. These changes were much less marked on the left side; the valves were competent. At the mouth of the ascending aorta, outside the valve, there was a tolerably firm fibrinous clot. Lungs: right, 3 lb. and 6½ oz. in weight, consolidated throughout, but no tubercles or vomica; left, 1 lb. and 4 oz. in weight, cedematous, also free from tubercular deposits and cavities. Spleen enlarged slightly,

⁵ Ed. Med. Journal, March 1879, p. 776.

¹ See for proof "Manual of Pathological Histology," by Dr. E. Rindfleisch (English Translation from German), p. 29, vol. i. And for contrary view, that this is not accomplished, see "Der Stoffumsatz bei der Phosphorvergiftung." Von Dr. Jos. Bauer, Zeitschrift für Biologie, Band vii., S. 62—86.

² I do not in the least imply that I countenance the "chill theory" (which can be disproved from the very data furnished ably by the author, who seemingly discards all the more weighty evidence opposed to his view). See for details "What is malaria? and why is it most intense in hot climates?" by C. F. Oldham, M.R.C.P.E.

³ Indian Medical Gazette, 1876, vol. xi., p. 297. Professor Wharton Jones, F.R.C.S., F.R.S., denies the penetration of white cells through capillary walls (Brit. and For. Med.-Chir. Rev., 1852, vol. ii., p. 195); and since then he has not altered his views (vide THE LANCET, 1879, vol. i., p. 74.)

⁴ Fatty Degeneration of the Heart (THE LANCET, 1878, vol. ii., p. 917).

⁵ This is about the average temperature of a native in health.

and 11 oz. in weight; not congested. Liver enlarged, congested, and fatty, weighing 3 lb. and 4½ oz., or about normal; small pieces floated on the surface of water. Kidneys both congested; the right weighed 5 oz., and the left 5½ oz. The stomach, bowels, and the head were not examined.

Remarks.—With regard to the pericarditis it may be observed that the man during the past ten years was never under treatment for rheumatism, nor did he during his fatal illness complain of symptoms of pericarditis, which in this case was no doubt of a chronic nature. The next point of pathological interest is the cause of death by syncope, and which was revealed at the autopsy—namely, a very fatty condition of the heart. The pneumonia, I believe, was set up, and which, although caused by the fatty heart, in its turn embarrassed that organ in its feeble action. It may also be remarked that in this case salicin had little or no effect in reducing the temperature.

Agar, India.

SEVERE WOUND OF ABDOMEN, WITH PROTRUSION OF THE BLADDER AND INTESTINES; RECOVERY.

By RIDLEY DALE, L.R.C.P. Ed., M.R.C.S.E., &c.

ON Saturday, April 4th, 1879, I was hurriedly summoned to attend Mrs. P—, aged sixty-five. It appeared that she had been standing on a broken chair, the back of which was off, leaving two sharp uprights. Her foot had slipped, and in falling one of the uprights had entered her abdomen.

On examining the patient, I found a large contused and lacerated gaping wound, twelve inches long, extending from half an inch internal to the left superior iliac spine to within two inches of the right superior iliac spine, laying open the cavity of the belly along its whole extent. The wound was semilunar in shape, the lowest part of the crescent being two inches above the pubes. A large mass, the size of an adult's head, protruded from the wound, hanging down in front of the pubes. This consisted of the bladder, a portion of the small intestines, and the omentum; and on careful examination no wound either of the vesical or gut could be detected. The protruding organs were returned with some little difficulty, and the wound closed by carbolised silk sutures, merely embracing the skin and subcutaneous tissues, placed at intervals of three quarters of an inch, and a pad of dry lint and a bandage applied, the limbs being retained in a flexed position by means of a pillow. A mixture, containing opium, ether, and aromatic spirit of ammonia, was ordered to be taken every four hours, ice to be sucked frequently, and her diet to consist of brandy and milk. The patient was somewhat collapsed, but perfectly conscious; pulse weak, but regular; little or no hæmorrhage.

At 7.30, two hours after the accident, she had recovered from the effects of the primary shock, her pulse being regular and strong. Had passed urine easily, and without pain, and expressed herself as feeling very comfortable. Temperature 99° F. At 12 o'clock the bandages were slightly stained with blood, but the patient's voice was perfectly strong, her pulse was good, and she had taken her iced milk and brandy easily. No vomiting.

April 5th.—On visiting my patient to-day I found her smoking a pipe. Slight pain in the wound; no vomiting. Has passed urine three or four times perfectly free from blood. Takes nourishment freely. Temperature and pulse normal.

7th.—To-day there is more pain in the region of the wound. Pulse 100; temperature 101°. Tongue dry and furred. Has had some retching. To take a calomel and opium pill every four hours, and five grains of compound soap pill at bedtime.

8th.—This morning the patient has vomited her brandy. Complains of tenderness in the wound. Temperature 100°; pulse 92. On removing the dressings the deep parts of the wound were found to have united, but the skin and superficial parts were exuding healthy pus. A bright-red blush encircles the wound, fading gradually away about three inches from the margin. Sutures removed, except one in the centre and one on either side; dressed with dry lint. To discontinue brandy.

9th.—There is still some tenderness at the seat of the wound, but the reddish blush is disappearing. Dressings stained with pus, which is quite sweet. No further vomiting. Temperature 99·8°; pulse 96. Bowels moved once during the night.

10th.—Patient has passed a restless night; her bowels having been relaxed five times. Wound dressed; edges are sloughing to the left of the middle line and suppurating freely; dressing smells fetid. Abdomen not tender. The remaining sutures removed. Temperature 99·8°; pulse 88. To discontinue calomel and opium pills. Linseed poultices to be applied to wound.

11th.—Patient has passed a much better night; but wound is still painful. Temperature 100·2°; pulse 88.

12th.—Wound dressed; skin sloughing along whole extent of margin of wound; tongue very furred. Temperature 99·8°; pulse 84.

13th.—Patient is much brighter and expresses herself hopefully. Wound discharging freely and commencing to granulate. Temperature 99·8°; pulse 88. To take beef-tea and a saline mixture, and discontinue compound soap pill.

16th.—Wound healing rapidly at the right extremity. Temperature 99°; pulse 84. To discontinue poultices and use a lotion of sulphate of copper.

From this date she progressed rapidly without an untoward symptom, and on May 8th the wound was perfectly cicatrised, and she was convalescent and able to get about.

Remarks.—Proof is hardly needed in the present day, when ovariectomy is so frequently performed successfully, that our ancestors' dread of an injury to the peritoneum was considerably greater than facts warrant. In the present case the abdomen was torn completely across in its transverse diameter, and the peritoneal cavity exposed for that extent. Yet, when we consider the age of the patient, the absence of all antiseptic applications, which were not at hand, and the contused state of the wound, the result must certainly be pronounced most successful; the patient being perfectly well in little over a month, with scarcely a bad symptom.

Sunderland.

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. Proœmium.

MIDDLESEX HOSPITAL.

SARCOMA OF BREAST; HÆMORRHAGE; RECOVERY.

(Under the care of Mr. ANDREW CLARK.)

J. B—, a woman aged fifty-eight, was admitted March 20th, on account of a large tumour involving the left breast. It first appeared nine months previously as a small painless enlargement, and the patient neither sought any advice nor adopted any treatment. Soon after last Christmas it began to increase rapidly in size, and continued to do so till the beginning of March, when, being considerably larger than at present (according to the patient's statement), it burst, and discharged a large quantity of sanious fluid, which has continued ever since, varying in quantity from day to day. Being now inconvenienced by the weight of the tumour, and the pain in it being considerable, she was induced to apply for relief.

On admission, the tumour extended laterally from the middle line of the body to the axilla, and vertically from two inches below the clavicle to three inches above the lower border of the ribs; its circumference was 24½ inches; and its size laterally 17 inches, vertically 13 inches. It looked about the size of an adult's head. The breast itself was situated on the outer aspect of the growth; and just round the nipple, which was nearly in the axilla, there was normal breast tissue; the remainder was nodulated and irregular, varying in consistence—hard in some parts, soft and fluctuating in others; and in the upper part was a sinus, from which more or less sanious fluid was constantly exuding. It was freely movable on the subjacent structures, but the skin