be rolled too tightly on the plates. A coil of ninety inches long will lose from half an inch to an inch of its length during its preparation, so that if it is rolled too tightly at first it will be very much weakened, and also will be extremely difficult to unwind from the plates. It should be very loosely rolled on the glass plates and placed in a jar containing absolute alcohol for three or four days in order that the contained water may be perfectly removed. The plates are then transferred to the brass box, which is three-quarters filled with alcohol, and after screwing on the lid it is placed in a saucepan in cold water and boiled over a stove, being removed a quarter of an hour after the water has begun to boil. The water in the saucepan should at first be cold, or nearly so, because when it begins to boil the brass box and its contents have reached the same temperature as the water and, therefore, the catgut is kept for fifteen minutes at 212° ; but if the water were boiling at the commencement some little time would be required for the heating of the box and its contents, and the catgut might not be kept long enough at the required temperature. When the box has cooled the plates are removed to a jar filled with a mixture of alcohol and glycerine, containing from 5 to 20 per cent. of glycerine according to the degree of stiffness required in the catgut. This mixture of alcohol and glycerine should be changed every week or ten days, for alcohol has an extremely small germicidal action and bacteria fall into the jar during the removal of pieces of the catgut from the plate.

Whilst the primary object of this steriliser is to prepare catgut it can be used for sterilising by heat anything which cannot be placed in boiling water, such, for example, as sea-tangle tents. It can also be used to re-sterilise the mixture of alcohol and glycerine in which the gut is kept. The steriliser is made by Messrs. Fannin and Co., Grafton-street, Dublin.

Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

"TRANSIENT AMBLYOPIA DURING LACTATION."

BY CHARLES E. S. FLEMMING, M.R.C.S. ENG.,
L.R.C.P. LOND.

IN THE LANCET of July 18th there is an annotation with the above heading, and as these cases are not common I venture to send notes of a case which lately occurred in my practice.

A healthy woman aged forty-two years was confined on the morning of April 10th, 1896. The labour was normal and she seemed to be doing well until the morning of the 13th, when she became almost blind, had marked photophobia, and severe frontal headache. Her pulse was full and her temperature was 100° F. The bowels had acted freely during the night. The next day the temperature was 99.2° , but the headache and photophobia continued as severe and she had merely perception of light. I thought I detected some swelling of the disc, but it was not marked and there was much difficulty in examining the eye. There were no other signs then or later of septic mischief, and on the following day the temperature was normal. On the fourth day the pain began to subside and vision improved a little, but it was a fortnight before the headache and photophobia quite disappeared, and then, although vision had much improved, the patient described it as much worse than it used to be. She informed me that she had had "weak" sight since childhood, and that her left eye had always squinted, and that she had never been able to see more than light with it. After each of the two previous confinements she suffered in the same way from pain and blindness only in a less degree. Her health had otherwise always been good. Six weeks later I examined her eyes under atropine and found: left internal strabismus fixed; right disc normal, left small; mixed astigmatism in both eyes; right vision = $\frac{6}{60}$ with correction $\frac{6}{15}$, and left vision = perception of light.

Freshford, Bath

ACEPHALOUS INFANTS.

BY J. L. KERR, M.D., C.M. ABERD., F.R.S.E.,
LATE EXAMINER IN CHEMISTRY AND IN MEDICAL JURISPRUDENCE,
UNIVERSITY OF ABERDEEN.

I HAVE lately attended two women who gave birth to acephalous infants. One was a young woman and the other a middle-aged woman. In each case the child was of very large proportions and otherwise of normal conformation and very well nourished; both would have been living if the parturition had been easy and uncomplicated. The portion of the skull which was absent was in each case occipitoparietal, an oblique line passing downwards and backwards from above the middle of the forehead above the ears to the occipital protuberance being the boundary. The conclusion come to by me from inspection of the parts is that each was a case of intra-uterine amputation, the same as is seen in children born without a portion of some limb. Any further observations by others may confirm or correct my theory and are hereby solicited.

Crawshawbooth, Manchester.

AXILLARY VERSUS RECTAL SALINE INJECTIONS.

BY GEORGE HENRY BUTLER, L.R.C.P. IREL., L.R.C.S. EDIN.

THE case of injection of normal saline fluid into the axilla for severe loss of blood lately recorded in THE LANCET leads me to think that a report of the following case, which occurred in my practice recently, may be of interest to some of my fellow practitioners.

On June 29th last, about 2 P.M., I received an urgent message to visit a woman. On my arrival I found her in bed, blanched from loss of blood, the pulse imperceptible, respiration sighing, and nearly constant vomiting. In fact, the symptoms and appearances were those of impending death from hæmorrhage. I found she had gone nearly her full term in pregnancy and had been losing blood very freely for some hours. There had also been slight loss of blood at intervals for about a month past. It being impossible to give nourishment or stimulants by the mouth on account of the constant sickness I injected strychnine and brandy hypodermically, and as soon as the patient had rallied somewhat proceeded to make an examination. The pains were very slight. I could feel the edge of the placenta through the os, which was dilated just sufficiently to pass a finger, and separated it from the uterine wall as far as I could reach. The membranes could not be reached. I then plugged the os and vagina thoroughly with wool gauze and injected ergotinine. The patient at this stage and for about two hours was in a desperate condition, and I resorted twice to the injection of normal saline fluid into the rectum with extremely good results. It was necessary to press a pad firmly against the anus in order to retain them, on account of the violent retching at frequent intervals. After waiting three hours, and having injected ergotinine again, the pains being stronger, I removed the plug in hopes of being able to rupture the membranes. I found the os very little larger and bleeding coming on very freely I plugged again. The patient having somewhat improved, I left her at 6.30. On visiting her again at 8.30 I found her better, the pains much stronger and more frequent. There had been no further loss. I now removed the plug and found the os dilated to the size of half-a-crown. The presentation was cranial, first position, and I was now able to rupture the membranes. At the patient's urgent request I gave a little chloroform and in about an hour delivery was effected by the natural powers. The child was stillborn. The woman has made a good recovery. I think this mode of introducing saline fluid into the system is quite as effectual and much less painful than the other. I had no apparatus for transfusion with me. The case was much handicapped by the sickness. No nourishment could be retained till after delivery was effected; only small pieces of ice sucked frequently. I cannot help thinking that the woman's life would have been lost had any violent measures for effecting immediate delivery been resorted to. The only chance seemed to be to stop the loss and give her time to rally.

Wealdstone, Middlesex.