to bear the brunt of being the sole cause of the mischief. Under all the manifestations of disease there are hidden agencies at work whose presence eludes the most vigilant. It is a fine thing, no doubt, to go around the wards and "spot" the cases, to use the expression one so frequently hears. In this connexion, perhaps, I may be allowed to mention an anecdote of the late Sir Andrew Clark. A year or two before his lamented death a lady went up from Glasgow to consult him. When the examination was over the patient said: "And what do you consider to be my disease, Sir Andrew?" The reply was: "Well, if I were a young man, I should certainly give your disease a name, but being an old man I prefer not to apply any name to it." There is a good deal of food for reflection in this. In reference to the treatment in this case it is incumbent on us to give as prompt relief as we can to the condition of the circulation. To this end we gave medium doses of digitalis, and for the condition of his lungs a stimulating expectorant is clearly indicated. Carbonate of ammonium in fairly large doses, together with the compound spirits of ether, was therefore used in conjunction with the digitalis, and we are pleased to find a marked improvement since this was begun. We endeavoured in this way to obtain diuresis, and the result has been that his urine has risen in quantity from 31 ounces on admission to 118 ounces to-day. With regard to carbonate of ammonium I may mention that it is sometimes very serviceable when given in large doses, even as much as ten grains, and glycerine is an excellent medium wherewith to administer it. Should, however, the time come when these remedies fail us, we may resort to the inhalation of oxygen, and should cyanosis become an urgent symptom venesection is often followed by much relief.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF GASTRO-INTESTINAL HÆMORRHAGE IN AN INFANT.

BY LOUIS E. STEVENSON, M.B. CAMB.

IN the columns of THE LANCET of April 22nd, 1893, I placed on record a case of this extremely fatal disease. A second case has recently come under my notice. The labour history of the mother is rather unusual and is briefly as follows. Liquor amnii drained away on Nov. 16th, 1894. The woman was assured by a neighbour that this was only the "womb slipping down," and I was not sent for. I happened to call on the Wednesday following, when I found the patient looking much smaller than one would expect at the end of gestation, and she complained to me that the waters had come away, but she had had no pain whatever. I wished to examine, fearing a mal-position, but the patient did not appreciate my anxiety. On the evening of Nov. 25th I was summoned, but found on my arrival that the child had been born one hour. I removed the placenta, which was extremely small, by expression. The child (female) was puny and emaciated-looking, there being apparently an almost entire absence of adipose tissue in her body and limbs; she had the appearance of being starved. The function of respiration was established with difficulty. The child was ordered to be wrapped in cotton wool and kept warm. Next day she breathed rather heavily, but on the following day took the breast eagerly and seemed to have improved. On the morning of the next day I found the child very ill, having passed a treacly motion of blood mixed with meconium. The skin was of a deep icteric tinge, more like the hue of true jaundice than that of the so-called icterus neonatorum. There was no bleeding from the umbilical cord. Later in the day a considerable amount of bright-red blood was vomited and several more dark-coloured motions were evacuated, the child dying at 2 A.M. the following morning.

Remarks.—There was no history of hæmophilia, though the child herself may have been a hæmophilic. More probably, I think, this was one of those cases where

visceral congestion follows difficulty in the establishment of respiration. Hæmorrhage would also be favoured by debility of the child and possibly by uterine compression before birth. The nutrition of a fœtus must depend, I suppose, on the relative size of the placenta, as it is hardly likely that partial compression of the cord for nine days could account for the extreme emaciation of the child when born. The mother, I may add, is a strong, stout, healthy woman. I could not elicit any history of syphilis in the family.

Temple Sowerby, Penrith.

SARCOMA OF THE OVARY IN A CHILD.

BY FREDERICK PAGE, M.D. EDIN., M.R.C.S. ENG.,

SURGEON AND JOINT LECTURER ON CLINICAL SURGERY, NEWCASTLE-ON-TYNE ROYAL INFIRMARY.

A GIRL aged six years with a large abdominal tumour was sent to me by Dr. Bishop of Wylam-on-Tyne for operation. The abdomen had been noticed to be gradually increasing in size for about four months, but, the child's general health continuing to be good, no anxiety was felt. On Nov. 2nd the abdomen was opened, and a solid tumour of the left ovary weighing three pounds and three-quarters removed. There were no adhesions, and only some two ounces of blood-stained fluid in the pelvis. On Nov. 25th the child returned to the country, having made an uninterrupted recovery. The tumour proved to be a fibro-sarcoma. Mr. Bland Sutton, in his work on Tumours, alludes to twelve cases of sarcoma of the ovary in children under fifteen years of age which have been operated upon since the year 1874. Seven of the children died from the operation. The youngest patient was three years and a half old; Dr. Cameron of Glasgow operated, and the case terminated fatally. The youngest patient who recovered was seven years old, and Dr. H. Croom was the operator. The case now reported would seem, therefore, to be that of the youngest child who has, so far, been successfully operated upon for sarcoma of the ovary.

Newcastle-on-Tyne.

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.

SEACOMBE COTTAGE HOSPITAL.

A CASE OF OVARIOTOMY; RECOVERY.

(Under the care of Dr. BOUVERIE McDONALD.)

THE patient was a woman aged forty-two years who had been operated on for ovarian tumour of the left side five years previously at the Hospital for Women, Liverpool. She complained of an abdominal swelling, free from pain, and in no way affecting the general health. Menstruation was irregular. The tumour was central and extended three inches above the umbilicus; it was smooth and fluctuating below, but somewhat lobulated and more solid above. A multilocular ovarian tumour was diagnosed and its removal decided upon. On June 4th, 1895, Dr. Bristow administered an anæsthetic, and with Dr. Craigmile's assistance Dr. McDonald proceeded to operate. The only difficulty met with was in the abdominal wall, the old cicatrix having made the respective layers dense and adherent. The lower portion of the tumour readily collapsed after puncturing with a Spencer Wells trocar, and the upper and more solid portion was easily drawn through the abdominal wound. A Staffordshire knot of Chinese silk was used for the pedicle, and the abdominal cavity was freely irrigated with boric acid solution. A Keith's glass tube was used in the lower part of the wound, which was closed by interrupted silk sutures.

The progress of the case was highly satisfactory. The temperature once reached 100° F. The tube was removed on the second day. All the stitches were taken out on the eighth day, and the patient was out of bed on the fourteenth day. By the twentieth day she was looking after some of the children in the hospital, and went out daily afterwards.

Remarks by Dr. McDONALD.—"Should ovariectomy be undertaken by the ordinary general practitioner?" is a question that may meet with as many "ayes" as "nays." It is, however, generally accepted that the operation—not only on account of the recognised experience of the operator, but also for the safety of the patient—is best performed by a specialist. My own private views have endorsed those of many of my medical friends that ovariectomy may present so many difficulties unforeseen that it is undoubtedly wise to leave the operation in the hands of one who is almost daily brought face to face with every contingency which may arise. I am fully aware that many cases have been undertaken by general practitioners, and also that a fair proportion have ended satisfactorily. Nevertheless, I consider that the operation should not be undertaken lightly—merely for the sake of having done an ovariectomy—but every consideration should be well weighed before proceeding to operate. It may, therefore, be of some interest to any who, like myself, are associated with a small hospital—where an occasional ovarian tumour presents itself—to give a few rules which might guide one—as they guided me—in deciding upon the operation. Firstly, the patient's absolute consent should be obtained. No general practitioner has any right to force his own services, or in my opinion even persuade a patient to submit to his limited experience in this direction. In the case described above I only consented to operate at the urgent request of the patient. Next in importance is the preparation of the patient by attending to rest, daily evacuation of the bowels, and giving plain wholesome food for three or four days before the operation. Thirdly, the preparation of the room. In this case I had the room fumigated with sulphur on three occasions. The walls and floor were carefully washed. The operating-table and chairs were also thoroughly disinfected, and nothing else but the bed occupied the room. All the instruments were, through the kindness of Messrs. White and Wright of Liverpool, new, and lay in carbolic solution (1 in 20) for eighteen hours before the operation. Skilful nursing is a necessity; as regards day work I was well off with the ordinary staff, but a nurse accustomed to such cases was procured for night work. Need I add to these primary rules the necessary confidence in one's own power to complete the operation? Granted that all the above conditions are present, then I consider that a general practitioner is entitled to undertake the case. The correct diagnosis of ovarian tumour is not to be passed over lightly, and here again the great advantage of a specialist is all-important. Even the differential diagnosis is not always easy, and, having satisfied oneself of an ovarian origin, the questions arise: Are there adhesions? Is the tumour solid or fluid? Is it unilocular? &c. One word of warning may not be out of place. I know of some young practitioners who, having successfully undertaken one case of a special kind, immediately allude to details of the case as "their invariable custom," but after one successful ovariectomy let no man be puffed up with his own prowess—rather let him, should he be called upon to undertake a second case, study every detail with the same anxiety which he showed in his first attempt. My thanks are due to Miss Collins and Nurse Hughes for their constant care and attention, also to Dr. Craigmile for his assistance at the operation.

Medical Societies.

NORTH LONDON MEDICAL AND CHIRURGICAL SOCIETY.

Abdominal Aneurysm.—Abdominal Suppuration.

A MEETING of this society was held on Dec. 12th, the President, Mr. CHARLES KING, being in the chair.

Dr. BEEVOR read an account of a case of Abdominal Aneurysm showing peculiar symptoms. The patient was admitted into the Great Northern Central Hospital under his care suffering from symptoms of pressure on the roots

of the upper lumbar nerves on the left side. Thus on carefully comparing the sensation of each thigh it was noted that there were areas of comparative anaesthesia on the left; the left knee-jerk was also diminished on comparison. A certain amount of reflected pain was complained of over the left great trochanter, and on percussion over the spines of the first and second lumbar vertebrae tenderness was found. It was then observed that there was a small abdominal tumour on the left side of the spine, but from the other symptoms it was thought to be malignant character. In a short time this tumour increased in size, occupied a large area on the left side of the abdomen, and showed expansile pulsation. Soon after this increase began to be observed, one morning, while moving in bed, the patient was seen to fall back, his face became blanched, and he expired almost immediately. On post-mortem examination there was found to be an aneurysm of the abdominal aorta which had caused erosion of the bodies of the first and second lumbar vertebrae and which had penetrated the left psoas muscle, dissecting through the soft muscular structure, and turning it into a secondary aneurysmal cavity. The blood had then passed upwards, and, passing below the diaphragm, had escaped suddenly into the left pleural cavity; death had resulted as the consequence of this accident. Dr. Beevor remarked on the importance of observing with care apparently insignificant physical signs as a means to accurate diagnosis, and especially the comparison of one side of the body with the other in the case of any symptoms involving sensation or any other interference with the nervous system.—In the course of the subsequent discussion Dr. GALLOWAY remarked on the absence of signs of referred pain along the course of the lumbar nerves, which must have been pressed on during the progress of the aneurysm.—Mr. MOWER WHITE pointed out the fact that from the anatomical relations the aneurysm must have perforated the strong iliac fascia on gaining access to the psoas muscle, and inquired whether it was not possible that the aneurysm might have originated in either the first or second lumbar artery instead of in the aorta itself.—After remarks by Dr. GLOVER and Dr. MORISON, Dr. BEEVOR replied, and said that there was no evidence that the aneurysm had originated in either of the two positions mentioned as possible by Mr. Mower White.

Dr. THOMAS HAMILTON then described a case of Abdominal Suppuration. The patient, a man in late middle life, had long suffered from symptoms of chronic dyspepsia, with gradual loss of strength. After a long period of illness he developed a tumour in the left side of the abdomen, about the iliac region. This increased in size, with rise of temperature, and presented much difficulty in diagnosis. The patient was seen in consultation by several physicians and the opinions formed differed, some being in favour of the diagnosis of abdominal suppuration and others of malignant disease. At length, on being seen in consultation with Mr. Langton, it was decided to incise the mass with the idea of exploration. On incision the tumour proved to be an abscess in connexion with the descending colon, and on microscopic examination of the wall of the cavity there was found to be no evidence of malignant origin. While the abscess was being drained there appeared in the discharge a coil of sausage skin and a bristle about 4 in. in length. Dr. Hamilton was of opinion that the abscess was associated with the presence of these foreign bodies as irritants. In spite of all efforts to prevent the spreading of the suppuration the abdominal wall became extensively involved and death resulted.—Dr. GLOVER, who had seen the case with Dr. Hamilton, remarked on the extraordinary manner in which the abscess had simulated a malignant growth, and stated that in the first instance he felt quite assured of the malignant origin of the obstruction that was produced.—Mr. CHARLES KING spoke of the case, and criticised Dr. Hamilton's supposition that the foreign bodies mentioned had been the immediate cause of the abscess. Mr. King was of opinion that it was more probable that there had been a faecal accumulation, possibly around the foreign bodies, which had caused ulceration of the mucous membrane, with a resulting pericolic abscess.

NORTHUMBERLAND AND DURHAM MEDICAL SOCIETY.

Exhibition of Cases and Specimens.

THE third meeting of this society was held on Dec. 12th, Dr. J. DRUMMOND, President, in the chair.