eighteen months before the present one. She never had any miscarriage or other symptom of syphilis. I find the following note in my case-book relating to her last confinement: "Long and tedious first and second stages; pelvis roomy; presentation first cranial. Ergot was of decided benefit in arousing uterus to stronger action during second stage. On the fifth day I found on visiting my patient that she was dressed and downstairs, so I immediately ordered her back to bed, where she remained until the tenth day. No ill effects apparently followed this early rising beyond slight increase of discharge. This, her eighth, confinement commenced in the following unusual manner. She and her husband went to bed as usual about 11 P.M., she feeling perfectly well at the time. Very shortly after they had been in bed she said to her husband, 'I believe my confinement is coming on.' A few minutes after that she said, 'I am sure it is so; you had better get up at once.' After he had got up she hurried him off, saying it was coming on quickly. As I was not at home when the message arrived my assistant went immediately. On his arrival he found the nurse there, and was told by her that shortly after the husband had left a smart hæmorrhage had occurred from the vagina; there was ample evidence of this in the condition of the bedclothes near the patient. But one pain occurred and was followed by a gush which she thought was the liquor amnii following the sudden rupture of the membranes. The hæmorrhage ceased when the nurse changed her from the right to the left side; continuous pain was from this time felt on the left side of the abdomen. After waiting about three-quarters of an hour, as labour pains did not come on, I was sent for. On my arrival I found the patient had rather an anxious look on her face. The left-sided pain, though not severe, became so if the abdomen was handled or if she was moved or attempted to move herself. She appeared very nervous and upset, so that it was difficult to tell definitely whether the pain was very acute or the tenderness very great, as she cried out as soon as the vulva was touched in making a vaginal examination. There was practically no collapse, and the depression was only such as might have been produced by a slight hæmorrhage. Her pulse was fairly good, 80 beats to the minute. The patient appeared very much disturbed at the prospect of being touched or examined. The pain was confined to the left side and was not severe, the patient talking in an ordinary way and not complaining unless she attempted to move. On vaginal examination I at first failed to reach the presenting part or, indeed, the os; on inserting the whole hand into the vagina, however, I could get my middle finger inside the os only about one-third of an inch, but felt nothing definite. Though the patient said she had felt movements of the child shortly before labour I could not hear the fetal heart sounds. Abdominal palpation yielded no definite result as the patient could not bear its being done properly. Nothing definite was thus made out by either examination. The patient now begged to be left alone for a time, and as her pulse remained fairly good and there was but little pain we did so. Neither labour pains nor hæmorrhage occurred for the next hour; her pulse remained about the same, and she became rather more comfortable. At this stage the case looked like either a placenta prævia or slight accidental hæmorrhage, the pulse keeping good, and the patient not complaining of feeling faint or exhausted appeared to place concealed hæmorrhage or ruptured uterus out of the question. As at this time the patient's condition appeared to be improving rather than going back I decided not to use any means for bringing on labour, at least for a time, other than plugging the vagina and orifice of the womb, which latter would answer the double purpose of preventing further external hæmorrhage and keep up a slight reflex stimulation on the womb. This was carefully done with iodoform wool pellets. A few hours after this the patient did not appear to have altered much. She took nourishment and kept it down; her pulse was, however, quicker, her face looked more anxious, and a feeling of sickness was complained of. Her temperature in the mouth was 101°F. I now decided to endeavour to accelerate labour by resorting to more active measures. No hæmorrhage followed the removal of the plugging. On

making a vaginal examination a hard indistinctly fluctuating mass was found in front of the anterior vaginal wall and remained after the bladder was emptied. A Barnes' bag was with difficulty passed through the os, the difficulty not arising from the rigidity of the os or any malposition of it, but from its great height. Ergot was given by the mouth freely. No real labour pains followed, though about an hour afterwards the bag was found in the vagina and the os readily admitted two fingers. Still no presenting part could be definitely made out. The next size Barnes' bag was easily passed, and after a time, on its removal, three fingers could easily be passed through the os, and a shoulder was found presenting. Without much difficulty, by means of the bipolar method of version, a foot was brought down into the lowest and posterior part of the uterus. The child was found to be dead, skin peeling off the foot. The passive condition of the uterus during removal of the child was noticeable. No blood or liquor amnii up to this time had escaped. A rupture in the anterior uterine wall could now be detected. The placenta, which was found to be quite free in the uterus, was easily brought away, the uterus remaining flaccid. Hypodermic injections of ether and ergotin were now given, as the patient complained of feeling faint. She quickly revived. The uterus could not be made to contract, though not even an ordinary amount of external hæmorrhage occurred. An iodoform and eucalyptus suppository was left in the upper part of the vagina with its apex passing through the external os, and repeated every six hours. Sickness gradually increased, and the patient died thirty-six hours after the birth of the child with symptoms of peritonitis and exhaustion. No post-mortem examination could be obtained."

The points worthy of particular notice in this case appear to be (1) the very early stage at which rupture occurred; (2) the absence of any other exciting cause than the faulty position of the child (no marked anteversion of the uterus being made out); and (3) the comparative mildness of the first symptoms occurring after so grave an accident.

Ilford, Essex.

NOTE ON THE RELATION BETWEEN DYSENTERY AND LIVER ABSCESS.

By A. W. D. LEAHY, M.D. DURH., F.R.C.S. ENG.,
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SOME observers have of late gone the length of denying that any connexion exists between dysentery and abscess of the liver. It is possible, therefore, that notes of the following case may prove of interest to the profession, for I think it demonstrates the connexion which existed between an attack of subacute dysentery and the subsequent formation of an abscess in the right lobe of the liver.

A European male, aged twenty-nine years, was attacked by dysentery on June 18th, 1894. The actual dysenteric attack was comparatively slight in character, confining him to his

bed for five days only; but after the disappearance of the more urgent symptoms he continued to suffer from diarrhoea until the end of July. He was under the treatment of Dr. J. F. P. McConnell and was quite well by July 23rd. On the last day of August, 1894, he began to suffer from fever, his temperature going up to 102°F. in the evening and falling to 99°6' in the morning. To get rid of this fever he went to Darjeeling on Sept. 8th, and returned

thence to Calcutta on Oct. 1st free from fever. The patient consulted me on Oct. 26th for a recurrence of the fever, and, though I carefully examined his liver on that day, there were no physical signs of anything being amiss with the organ. I saw no more of him until Nov. 29th last, when he sent for me, and I found him in bed suffering from great pain in, and with some tenderness of, the hepatic region. His temperature showed a daily rise of from two to three degrees, and never reached the normal limit in the morning. The symptoms during the earlier days of his illness were somewhat masked, but their obscurity gradually cleared up, and on Dec. 12th distinct enlargement with slight bulging of the liver was made out just below the right costal arch. On Dec. 16th this swelling was aspirated and ten ounces of typical hepatic pus were withdrawn. This pus was immediately examined under the microscope by Professor D. D. Cunningham, and was found to contain *amœbæ coli* in abundance. Four days later the abscess was freely opened and a large drainage-tube inserted. The patient made rapid strides towards recovery, and at the date of writing this the wound in the liver has healed and he is able to take carriage exercise daily. As regards the rapid cure it is needless to say anything, for it is an ordinary successful case of liver abscess treated by free incision and drainage, without washing out the sac with any of the numerous antiseptic solutions. The interest of the case appears to me to lie in the following. A young man, hitherto perfectly well, is attacked by dysentery in the month of June. The dysenteric attack lasts until the latter part of July. In the month of November, after an interval of four months, more or less pyrexial in character, he develops distinct symptoms and physical signs of an abscess in the right lobe of the liver. This abscess is aspirated under precautions that prevent the admission of any air, and the pus thus obtained is immediately subjected to examination under the microscope and found to contain the *amœbæ* of dysentery. It is known that in cases of dysentery these *amœbæ coli* are present in the stools and in the walls of the gut which are undergoing dysenteric ulceration. It is also known that one property possessed by these organisms is motility and the power of transporting themselves. May it not then be assumed, looking at this case, that the organisms found in the pus from the liver abscess have had their origin in the previous dysenteric process and have travelled from the ulcerated gut to the liver? Their presence in the liver in this case was a *fact*, and the observation of this one fact is worth many theories. Kartulis, Councilman, and Lafleur have all observed the presence of these *amœbæ* in cases of abscess of the liver. How the *amœbæ* get to the liver from the diseased gut must at present be largely a subject for speculation. Do they travel up through clots which block the lumen of vessels opened up by the ulcerative process of dysentery? Or do they reach the liver by way of the lymphatic system? We also know but little as to the part played by them in causing the abscess. They are comparatively large motile bodies, and it cannot be said whether they, by their presence, cause the breaking down of the liver substance, or whether they only act as carriers of some septic poison, which by its irritant properties gives rise to the abscess.

The practical value of the case I have recorded rests, I think, upon three points—viz., (1) the known date of the previous attack of dysentery; (2) the subsequent formation of the abscess in the liver with the pyrexial interval; and (3) the presence in the pus from the abscess of the *amœbæ* of dysentery. These three points are so closely connected that I think it may safely be affirmed that so-called single tropical abscess of the liver does in some cases owe its existence to a previous attack of dysentery and is due to the *amœbæ* finding their way from the diseased part to the liver.

Annexed is a chart showing the patient's temperature during the progress of the case.

Calcutta.

FOREIGN UNIVERSITY INTELLIGENCE.—Vienna: Professor Max Gruber, who is already on the Council of Hygiene, has been elected a member of the municipality. Dr. Max Salzmann has been recognised as a *privat-docent* in Ophthalmology. Prague: Professor Wilhelm Czermak has been appointed to the chair of Ophthalmology in succession to Professor Schnabel.

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.

THE series of cases of diphtheria treated by antitoxin which appear in the subjoined reports form a valuable contribution to the subject, and confirm the opinion that the remedy is one of considerable efficacy. The cases, being all treated in hospital and the diagnosis in each controlled by the bacteriological test, were observed under conditions favourable to the formation of a just appreciation of their character and of the influence of antitoxin upon them. We would draw particular attention to the fact that no less a proportion of the cases reported from University College Hospital than six out of thirteen necessitated tracheotomy, and that of these tracheotomised subjects only one succumbed. Another fact of interest is that of death from suppression of urine after seven weeks' illness in a case of pharyngeal diphtheria, and a clue to this exceptional course is probably afforded by the fact that one of the kidneys was atrophied and cystic. It might be also suggested that the defective renal elimination in this case had some relation to the roseolous rash which appeared on the skin during treatment. In his remarks on these cases it will be seen that Mr. Bunch notes that a rash appeared in three cases, in each case accompanied by a rise in temperature. His suggestion as to the possibility of the fluid containing some impurity is one deserving of the most careful scrutiny. We publish in another column (p. 949) the judgments of several well-known German physicians, and the motion adopted by the Congress of Internal Medicine, meeting now at Munich, on the subject.

UNIVERSITY COLLEGE HOSPITAL.

THIRTEEN CASES OF DIPHTHERIA TREATED WITH ANTITOXIN; REMARKS

(Under the care of Dr. FREDERICK ROBERTS.)

EVIDENCE as to the value of antitoxin in the treatment of diphtheria is being accumulated, and there is no doubt that this remedy has proved successful in many cases. At the recent discussion at the Royal Medical Society of Vienna, Dr. Monti, Dr. Hein, and Dr. Unterholzner gave statistics of eighty-three cases which had been treated by them, with a mortality of only 18.07 per cent. Dr. Kolisko at the same meeting reported that from post-mortem examination of fatal cases in which the serum had been used he had found the membrane much less firmly attached to the mucous membrane than in the fatal cases treated by other methods. Many of the accounts of patients who have died show that they were treated at a late stage; in fact, when almost dying—at a period, in fact, when no improvement could be expected from any treatment. The following thirteen cases of diphtheria were taken into University College Hospital during the months of December and January last, and were all injected with antitoxin within a short time of admission. Of these cases two were fatal—one on the third day through broncho-pneumonia, and the other through suppression of urine after seven weeks' illness. During the same period another case of diphtheria was admitted, but in a moribund condition, the child dying before antitoxin could be injected. Six cases out of the thirteen had tracheotomy performed, and of these one was fatal, the other fatal case being one of pharyngeal diphtheria in which the larynx was not affected. The antitoxin injected was in every case that obtained from the British Institute of Preventive Medicine. The bacteriological examinations were made by Dr. H. R. Smith, Dr. Paul, and Mr. Watts. For the