years, multipara, was attended by me in January, 1878. The patient was a small, anæmic, nervous woman, and informed me she had suffered from severe flooding after each of her three previous labours. This note was made at the time of her taking out her ticket from hospital. Her father was an epileptic, but she herself had never had a fit. She was an only child. Her labour commenced on the 13th at 6 P.M.; the os was fully dilated at 10 P.M., and the second stage was over at 2 A.M. There was nothing abnormal in her labour, but, bearing in mind her previous experiences, a considerable amount of care was given to the third stage, and after expulsion of the placenta the uterus was grasped and kneaded. It contracted well, was fairly hard, but continued large, and felt somewhat irregular. Then to my astonishment hæmorrhage set in. The bleeding was profuse and in gushes. The patient quickly became collapsed, her pulse failed, her skin became moist and clammy, and she fainted. During the hæmorrhage I followed the usual course of treatment, introduction of the hand into the uterus, clearing out its contained blood, the injection of hot and of iced water, and the placing of ice within the uterus, but these remedies failed. The bleeding continued in spite of the uterus being grasped both externally and internally, and I noted that its walls were hard. The patient I believed to be on the verge of death, and as she fainted I felt the walls of the uterus first relax and then rapidly and regularly contract, forcing my hand from within its cavity into the vagina. The contraction was sustained and the woman recovered, but was weak for weeks afterwards.

CASE 2.—A woman aged thirty-two, married four years, multipara, was confined on Aug. 9th, 1892. After each of her two previous labours she had nearly died of post-partum hæmorrhage. She was a fair, delicate-looking woman of an extremely nervous disposition, and looked forward with great dread to the ending of her present pregnancy. She was attended by Dr. Harvey in her first labour and by Mr. Joubert in her second. In this case, again, the labour was in every way perfectly normal. The first stage was of average duration; the second somewhat rapid. After the end of the second stage a large dose of ergot was administered and the placenta expressed by Credé's method fifteen minutes after the birth of the child. While my hand was on the abdomen grasping the uterus I felt it become softer, enlarge, and then harden again. The organ was irregular in shape, and hæmorrhage at once declared itself. The routine course of treatment was pursued. Hot and iced water was used internally. Ergotinine was injected hypodermically. The interior of the uterus was irrigated with ferric chloride and water. The uterus was grasped between the hands, one within its cavity and the other upon the abdomen, but the hæmorrhage continued. The patient was pulseless, with sighing respiration, complained of noises in her ears, blindness, and rapidly became unconscious. As her consciousness left her I felt the walls of the uterus soften, and this softening was followed by equable and firm contraction which drove my hand down into the vagina. The contraction persisted, but the hæmorrhage ceased. The patient recovered, but for weeks she was extremely feeble and suffered much from fever.

This, shortly, is an account of the only two cases I have met with which appear to me to accurately fit the condition described by Dr. Gibbons—viz., "persistent tonic spasm of the walls of the body of the uterus causing post-partum hæmorrhage." Such cases appear, as a rule, to present the following points in common: (1) the patients are usually neurotics; (2) successive labours in the same patient are always attended by post-partum hæmorrhage; (3) the cases are of rare occurrence; and (4) the hæmorrhage resists ordinary attempts to control it, and its cessation is brought about by syncope with consequent relaxation of the spasm affecting the uterine wall and subsequent contraction. Perhaps, after all, in these cases the etiology is not of such importance as the treatment, and it does not matter very much whether we include them under the heading of "contraction without completeness of retraction" or ascribe them to apolarity or tetany of the body of the uterus. Still, if the view set forth by Dr. Gibbons is correct, if these cases are due to a real spasm affecting the body of the uterus, then, I think, we must admit the value of his view as indicating a line of treatment to be adopted in such cases. In his brochure Dr. Gibbons logically follows out his view of the etiology of these cases by recommending the administration of an anæsthetic as the best form of treatment,

and if a third case occurs to me in my own practice I shall certainly use chloroform. The clinical and striking point about these cases of post-partum hæmorrhage is that the body of the uterus can be felt above the pubes perfectly hard, but not regularly contracted, and at the same time the existence of an actual cavity within the body of the uterus from which the bleeding occurs is plainly evident. This short note has no pretensions to originality, and my only justification for having written it is that it may be of some use to my professional brethren in calling attention to a rare form of post-partum hæmorrhage, and indicating a possibly successful method of treating it.

Calcutta.

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.

WESTMINSTER HOSPITAL.

A CASE OF UNILATERAL TUMOUR OF THE PONS; DEATH; NECROPSY.

(Under the care of Dr. DE HAVILLAND HALL.)

THIS interesting contribution to the literature of the lesions of this region is a very complete one, and is, therefore, of much value. Dr. Starr has written on this subject, describing a case which was under his care, and giving an abstract of twenty-six others which he had collected from various sources. He considers it possible to arrive at a very exact diagnosis of lesions in this region and summarises his conclusions as follows:—"1. If in any case anæsthesia of one side of the face occurs (not due to neuritis of the trigeminus or the cortical lesion) the lesion lies in the medulla or pons, in the outer third of the formatio reticularis. Its position in this part is to be determined by the other symptoms present; for if it is situated high up (cephalad) in the pons it will be on the side opposite to the anæsthesia, and if it is situated lower down (caudad), in the pons or in the medulla, it will be on the same side as the anæsthesia. 2. If in any case anæsthesia of the limbs occurs (not due to cerebral lesion) the lesion lies in the medulla or pons, in the inner two-thirds of the formatio reticularis, and upon the side opposite to the anæsthesia, or in the spinal cord. 3. If one side of the face and the limbs of the opposite side are anæsthetic, the lesion affects the entire lateral extent of the formatio reticularis and lies in the medulla or in the pons, below the point of union of the ascending and descending roots of the fifth nerve. 4. If the face and limbs of the same side are anæsthetic, the lesion lies in the brain at a point higher than the junction of the ascending and descending roots of the fifth nerve in the pons. Its position is then to be determined by other symptoms. It may involve the entire formatio reticularis in the upper pons, or crus cerebri; it may be situated in the posterior part of the internal capsule; it may lie in the centrum ovale, destroying the radiation of sensory fibres from the internal capsule; or it may be in the sensory area of the cortex in which all of these tracts terminate."¹ For the account of this case we are indebted to the medical registrar, Dr. J. Porter Parkinson.

A labourer aged forty-five was admitted to the Westminster Hospital on April 9th, 1895, complaining of headache and paralysis of his face. He was a single man, coming of a long-lived and healthy family. He had small-pox in 1875 and contracted syphilis in 1877, having a chancre on the penis followed by sore-throat and secondary rash, neither of which were very severe, and both disappeared rapidly under treatment, since which time he had been well. There was some history of excess of beer, but not of spirits. His illness commenced in November, 1893, with some pain over the left malar bone, which lasted three months, and nothing fresh

¹ Sajous' *Annual of the Universal Medical Sciences*, 1894, vol. ii., A 40, *Medical Record*, New York, 1893.

was noticed till April, 1894, when he had violent attacks of headache on the vertex and left side of the head, coming on almost daily and obliging him to cease work; this lasted till the end of May, when he resumed work, but noticed that his mouth was drawn to the right. In August, 1894, he was again seized with a burning pain in the left side of the face, but managed to work till Sept. 1st, 1894, when his left eye became inflamed; he was then treated for a month at the Ophthalmic Hospital, Moorfields, and finally had the eye removed. Early in January, 1895, he had attacks of vomiting coming on about half an hour after food, which recurred for three months and were accompanied by severe headaches, while about this time he noticed soreness of the left side of the mouth, cheek, and tongue. For the last year his speech had been rather defective. At this time the patient was a man of muddy complexion, with grey hair, and arcus senilis; he was rather anæmic and wasted; there were a few pigmented scars on the legs, but none elsewhere. His arteries were tortuous and fibroid; the pulse was normal and regular. He had severe burning headache above the left zygoma, then there was great tenderness to pressure. His mind was clear, though torpid, and he had no giddiness. His speech was thick and blurred, though distinguishable. The left eye had been removed, but the right had no paralysis, and its pupil reacted to light and accommodation; the fundus was normal. There was slight nystagmus on looking to the right. There was paralysis of all the muscles supplied by the left facial nerve, except for slight movements of the eyelids and forehead when the opposite side moved. The whole region supplied by the left trigeminal nerve was completely anæsthetic, and there was also paralysis and wasting of the left temporal and masseter muscles and apparently also of the external pterygoid, for when the mouth opened the chin deviated to the left. The skin of the face was rather glossy on the left side, but there was no loss of hair or other trophic change. There was no loss of hearing, smell, or taste on either side. The left vocal cord lay in the cadaveric position, and did not move on articulation; the uvula was drawn to the right, and the arch of the soft palate relaxed on the left, with diminished palatal reflex. There was no paralysis or wasting of the tongue, which was protruded straight forward, but he complained of great soreness on its left side and toothache on the same side. The movements were good in the head and neck. The grasp was slightly less on the right side, and there were increased tendon reflexes in both arms, but no sensory or motor changes. The gait was rather weak and stiff; there was no weakness of the legs, but the knee-jerks were abnormally active, and ankle-clonus could be obtained. There was no affection of the bladder or rectum. There was nothing abnormal in the chest or abdomen, except that the liver was slightly enlarged. The urine was of sp. gr. 1008 and neutral. It contained no albumen or sugar. There was a slight deficit of urates. The patient was given a mixture containing mercury and iodide of potassium, but his headache and malaise continued till April 25th, when he began to have difficulty in swallowing; this improved in a few days, but returned, till finally an attempt to swallow produced choking fits and rejection of the liquid food, so that a catheter had to be used for feeding. On May 7th there was some loss of sensibility to heat and cold in the right arm and leg, and a week later he began to lose power in this side. The choking fits returned independently of food, and he occasionally coughed up a mucoid expectoration. There were detected signs of bronchitis and broncho-pneumonia at the base of the right lung, and the temperature, which previously had been normal, rose to 101.6° F., to drop next day to normal. These fits of choking increased in frequency and exhausted the patient, who was already very weak from the slight amount of nourishment he was able to swallow, till he died on May 17th, about six weeks after his admission. At the necropsy, made by Dr. Hebb, the dura mater was found to be non-adherent to the brain, except over the left lobe of the cerebellum, and for about an inch in the middle of the third left temporo-sphenoidal convolution, where it was firmly attached, and the subjacent cortex was atrophied. The inner wall of the straight sinus was thickened and felt like a solid cord, though the lumen was still patent. In the left cerebellar peduncle, stretching as far as the middle line of the pons, was an elongated gumma measuring 1½ in. by ½ in., firm, gray, and glistening, with central fibro-caseation. The pons was larger than natural and felt boggy. The arteries at the base were normal. The left Gasserian ganglion was atrophied, so that it was about half as large as the right,

but there was no thickening around it; the root and divisions of the trigeminal were all thin and atrophied. The left half of the medulla was much atrophied and about three-quarters the size of the right, and there was some wasting of the facial and vagus nerves. There were no changes to be seen in the fresh cord. There was very marked wasting of the intrinsic muscles of the larynx on the left side; also there was well-marked syphilitic aortitis. The lower lobes of both lungs were pneumonic and friable, except the lower part of the right lung, where there was a mass of pigmented fibrous tissue, the superjacent pleura being thickened, white, and opaque—evidently the remains of a syphilitic lesion. The rest of the organs were apparently normal.

Remarks by Dr. J. PORTER PARKINSON.—The diagnosis of this case did not present much difficulty; the paralysis—complete of the trigeminal nerve and partial of the facial nerve—indicated a lesion in the position or neighbourhood of the nucleus of the trigeminal nerve, and when the rightsided hemiplegia became marked this was certain. The evidence of previous syphilis pointed to the lesion being due to a syphilitic lesion, while the absence of involvement of other cranial nerves, such as the auditory nerve, made one suspect the lesion to be in the brain substance. The gradual onset of bulbar symptoms was evidently due to extension of the lesion downwards. The case from the first symptom lasted thirteen months, and it is interesting to note that it began by pain referred to the extremity of the malar twig of the trigeminal nerve. The gumma appeared to press equally on the reticular formation and the pyramidal bundle of the pons, and the loss of sensibility to heat and cold on the right side may have been due to pressure on the former. It would be useless to try to make any deductions from an isolated case but unilateral tumours in this situation are sufficiently infrequent to make it worth while placing each one on record.

WEST HERTS INFIRMARY.

CASE OF PERFORATING GASTRIC ULCER; LAPAROTOMY;
DEATH; NECROPSY.

(Under the care of Dr. RUSSELL STEELE.)

THIS case is one of the kind to which special attention has been frequently drawn in the columns of THE LANCET by reason of the great importance of such cases as an addition to our somewhat imperfect knowledge of the subject. The complication which apparently proved fatal, that of the escape of stomach contents through a second ulcer in the posterior wall, is one which need not be in any way regarded as weighing against operation; it is very rare to meet with more than one ulcer. Then, again, it has been calculated that of ulcers on the posterior wall only 2 per cent. perforate, as opposed to 85 per cent. of those situated on the anterior wall. The type of patient appears to have been typical of that recognised as characteristic of the sufferer from gastric ulcer. The promptitude of diagnosis and management of the case were all that could be desired, and we can only regret that the unusual, almost unknown, complication prevented the attainment of the hoped-for success. For the notes of this case we are indebted to Dr. William Martin, house surgeon.

A female patient, unmarried, aged twenty-one years, was admitted to the West Herts Infirmary, Hemel Hempstead, at 9 P.M. on Nov. 17th, 1894, suffering from great shock. She was too ill to go very closely into the history, but the following points were elicited. For about six months she had been troubled with dyspepsia, which had been much worse for about two months. She had severe pain in the "stomach and back" on taking food. The pain, which came on soon after taking anything, was relieved by vomiting. For some time she had vomited after every meal when any attempt was made to take solid food. The pain, although aggravated by ingestion of food, was often felt very severely, quite independent of this, especially in the back. She had never to her knowledge vomited blood or passed any by the bowel. Menstruation began at nineteen years of age, was regular for a short time, but had been absent for six months. On Nov. 17th she was about her ordinary work as a nurse-maid during the day. She had dinner at 2 P.M., consisting of salt beef and potatoes, but took very little. She had nothing else by the mouth after this. At 5.30 P.M. she was in her room doing her hair, when, as she was stretching her