

I have pointed out and described the *depression of Reissner's membrane*, resulting from increased extra-labyrinthine tension on the organ of Corti, as first referred to by Steinbrügge and later by myself and other writers, and I cited the case mentioned by Steinbrügge of a boy aged twelve years who died from a cerebral tumour, in which the increase of intra-cranial pressure was shown during life by the presence of optic neuritis, and another case described by Gomperz of a tuberculous subject who died from internal pachymeningitis and cerebral oedema, observing that in both cases the membrane of Reissner was found depressed to such an extent that only a mere slit existed between it and the membrane of Corti.

Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF PROLONGED LABOUR.

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ON April 4th, 1893, I was called to see, in consultation with a native medical man, a case of prolonged labour, which had only come under his notice that morning. The patient was a middle-aged Hindoo woman and a multipara. She had gone to full term. The history obtained from her relatives was that she had been in a state of labour for eight days, and that as the native midwives could not effect delivery they had brought her into the town of Sewan, a distance of thirteen miles. According to the apparently usual custom among the natives, she had been allowed neither food nor drink since labour began. The patient was found to be a well-nourished woman (although, according to her friends, she was much reduced) and rather above the average size. She lay on her back in a semi-conscious state, muttering occasionally to herself. The skin was cold and clammy, respiration hurried and shallow, and the pulse at the wrist scarcely to be felt and not countable. Auscultation over the heart showed that this organ was beating from 150 to 170 per minute. The tongue was dry and glazed. An intensely fetid discharge issued from the vagina. On examination per vaginam a face presentation with the chin towards the right sacro-iliac synchondrosis (first position) was made out low down in the vagina. The child had evidently been dead for some days. There was complete absence of pains, and the uterus appeared to be completely relaxed. On passing a catheter an enormous quantity of rather high-coloured clear urine came away. The native medical man had already attempted to apply a pair of short forceps without success. After some brandy had been given to the patient I adjusted a pair of Simpson's axis-traction forceps, and by easy stages, and without any great force being used, delivered the head, complete rotation forwards of the chin taking place. The patient became very collapsed, so a hypodermic injection of ether was given and the body was delivered without difficulty. The child was a large male and was very much decomposed, the face in particular being almost denuded of soft tissues. A drachm of extractum ergotæ liquidum was given by the mouth. In half an hour, no pains having appeared, I removed the placenta by introducing the hand into the uterine cavity. No hæmorrhage occurred, but a great deal of intensely fetid, reddish fluid came away. The uterus was then very thoroughly washed out with a corrosive sublimate solution (1 in 2000), and the external parts were cleansed with a strong solution of phenyle. Some milk and brandy were given and hot bottles placed around the patient. That evening (six hours later) the temperature was 97° F. and the collapse was still great, but the pulse was a shade stronger. Milk and brandy were given every half hour. Next morning the temperature had become normal and the pulse counted at the wrist was 115 to 120. The patient was much stronger and could talk sensibly. A douche of corrosive sublimate solution (1 in 3000) was used and the urine was drawn off with a catheter. That evening the temperature had risen to 100°, and five grains of quinine

were given. Thence onwards the vagina was washed out twice daily with corrosive sublimate solution (1 in 3000) and the phenyle solution alternately. Fluid nourishment was continued at short intervals. On the second day the uterus was felt for the first time definitely contracted; on the third day the patient micturated and the bowels were moved naturally; and from that time forward she made an uninterrupted recovery and was sent home at her own request a week later. Several weeks afterwards she reported herself as quite recovered.

This case was undoubtedly one of uterine inertia in a previously healthy woman, and this state was brought on by the non-rotation forwards of the chin along with a distended bladder. It seems worthy of note on account of the complete recovery of the patient after such a prolonged labour, such extreme sepsis, and such great prostration. Also it is perhaps an interesting record of a far advanced stage of inertia such as would seldom or never be seen in a country such as England, where proper medical attendance would be sure to be availed of long before this state was reached.

Sewan, Sarun, Bengal.

THREE CASES OF CANCER OF THE GASTRO-INTESTINAL TRACT DEVELOPING DURING PREGNANCY.

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WHEN the stomach becomes infected by cancer during pregnancy the resulting sickness is apt to be attributed to the molecular variations going on in the uterus. If, however, a patient who has borne two or more children and who has never experienced sickness during pregnancy complains of this symptom, and it is evident that the cause is neither uterine nor renal, then we should suspect organic disease of the stomach. In the ordinary course of events sickness, as I have elsewhere¹ remarked, is seldom observed during pregnancy when the tone of the uterus is more or less impaired.

CASE 1. *Cancer of the pylorus; sickness noted from the sixth week of pregnancy.*—The patient was a woman aged forty, who had been married five years and had had three children. The last child was born on March 2nd. At the time when the patient considered herself to have been pregnant for six weeks she began to complain of sickness, a symptom which she had complained of during the early months of her first pregnancy, but which was absent during her second. As the sickness persisted after the third confinement the patient presented herself at the hospital, and on examination I detected a small cake-like, movable, and slightly tender mass close to the umbilicus. Death occurred after the disease had probably been in existence about two years.

CASE 2. *Primary cancer of the stomach and secondary of the pelvic peritoneum; sickness noted from the seventh month of pregnancy.*—This patient, aged thirty, who had been married eight years and had had four children, was seen by me in consultation with Dr. H. P. Miller of Stoke Newington-road. Her last child was born on Aug. 26th. About the seventh month of pregnancy she began to complain of sickness, a symptom which she had never complained of during her former pregnancies. As the sickness persisted after parturition, and pain was experienced in the lower abdomen, Dr. Miller desired me to see the patient. The abdomen was slightly prominent in consequence of the inflation of the bowel, and with difficulty a small, hard, and nodular swelling was detected to the right of and above the umbilicus. Behind the uterus was felt a hard mass with a keel-like ridge, which pushed down the vaginal roof. The pelvic mass was not tender. Death occurred five months after the fourth confinement.

CASE 3. *Cancer of the sigmoid flexure developing during pregnancy.*—The patient was a woman aged twenty, who had been married eighteen months, and had had one child. The child was born two months before the patient came under my observation. Ever since the confinement a small swelling had been observed in the left half of the abdomen. The following were the physical signs. In the left iliac region, about one inch to the inner side of the superior spine of the ilium and extending from its level upwards for three