was fed per rectum for a week, only a little water being allowed by the mouth. The wound was dressed for the first time on April 29th, five days after the operation. Three days later seven of the stitches were removed and the remainder on May 4th. On May 11th the wound was quite healed. The lochia were normal throughout; no vaginal douches were employed. The patient was not allowed to suckle her child. She was free from pain practically throughout. The bowels acted normally on the sixth day. On June 5th she was allowed out of doors. There was a little trouble subsequently with three sutures coming away; presumably they were those which had been used to approximate the abdominal muscles, judging from the places whence they emerged. I saw the patient recently (Sept. 13th). She was in good health and was menstruating regularly. The child was also doing well.

This case is interesting from the fact of its having occurred under difficult home circumstances. The patient lived in a two-roomed cottage, the capacity of the lower room when destitute of furniture being only 1030 cubic feet, and that of the bedroom being 1616 cubic feet. Her only nurse was her mother. There was considerable difficulty in getting one of the breasts to cease secreting, several belladonna plasters having to be applied before their purpose was fulfilled. Though her hip trouble is on the left side there was undoubtedly more room on the left side of the pelvis where the head was presenting than on the other. This is, I believe, contrary to the usual condition of affairs. There was nothing in her external appearance to lead one to suppose that her true conjugate would be so small.

Rochdale.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF DISTOMA HETEROPHYES IN A LIVING PATIENT.

BY F. M. SANDWITH, M.D. DURH., M.R.C.P. LOND.,
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IN modern text-books such as Eichhorst's *Medicine*, Davidson's *Hygiene and Diseases of Warm Climates*, and some others it is mentioned that Dr. Bilharz found at two post-mortem examinations at Kasr-el-Aini Hospital distoma heterophyes in the fæces of patients. That must have been nearly half a century ago and since then little has been reported about the worm until 1894, when Dr. Looss directed attention to it in Egypt.¹

On March 4th, 1894, a girl was admitted to my wards for cystitis and dysenteric diarrhoea. She lived at the village of Mit Azoun near the town of Mansurah, and she and her mother stated that she had been uncomfortable for six years in consequence of irritation of the bladder and that she was accustomed to pass a few drops of blood after urination. Moreover, for four years she had had rectal tenesmus and had passed both blood and mucus with the motions. The diagnosis of bilharziosis of the bladder and rectum was easily made, but it was not until March 19th that Unsi Effendi, one of the assistants in the Medical School, while counting under the microscope bilharzia eggs in the fæces, discovered the distoma heterophyes. I then examined the fæces daily with the following result. On March 20th there were five worms and many eggs; then no more flukes at any time, but there were two or three distoma heterophyes eggs every day until April 11th, when only one egg could be found. Daily search showed one egg on April 13th, 17th, and 19th, and after that there were no more. The disappearance of the fluke was probably due to a dose of 30 grains of thymol which I gave to try to clear the lower intestine of bilharzia eggs. But this was of little avail, for on June 9th, when the patient was discharged from the hospital and the urine

averaged 1015 in density, 21 ounces in quantity, showing a trace of albumin, and five bilharzia eggs on several slides, there were still bilharzia eggs in the fæces. The age of this patient was guessed at about 15 years, though her face looked older. Her breast and pubes showed no signs of puberty and the catamenia had not yet appeared, but she stated that her contemporaries already had babies of their own. (Peasant girls are often married soon after the catamenia first arrive.) Her weight increased steadily from 67 lb. on March 6th to 78 lb. on May 29th. Her temperature was always 98.4° F. in the mornings and usually rose to 99.3° at sunset. She had no symptoms at any time which could have been attributed to this most minute fluke, and I only record the fact of its discovery because hitherto it has been thought to be of purely post-mortem interest. During the last two years we have mostly failed to find this fluke, but I daresay it would often be found if constantly searched for. Cairo.

RIGHT-SIDED PARALYSIS OF GRADUAL ONSET OCCURRING DURING PREGNANCY.

BY ROBERT CRAIK, M.D. GLASG.

A WOMAN, 36 years of age, who was eight months pregnant with her first child, complained on March 10th of numbness and loss of power in the right hand. On this account she was unable to attend to her housework and had to engage help. On several occasions lately she had let articles fall, so that she did not feel it safe to lift anything with her right hand. She had to take tea with her left hand and was quite unable to lift anything as heavy as a saucepan. There was a constant numbness and a burning feeling in the hand and fingers which gave her much discomfort. Partly on this account she could not sew or knit or button her dress. These symptoms had come on gradually during the last two months and she had been conscious of distinct loss of power in the hand for at least a month. She thought that the numbness came on after the loss of power. Quite lately she had experienced a certain difficulty in speaking, but it was not clear in what way the speech was affected. On examination it was found that the grasp of the right hand was feeble and the forearm was soft and flabby compared with the left. There was no muscular hyperæsthesia evident on pressure. Sensation as tested with a pin seemed to be considerably diminished. With the eyes closed she often hesitated to say which finger was touched with a pencil, but generally answered correctly—always correctly for the thumb and little finger. There were slight headache and habitual constipation. The urine gave no indication of albumin when tested with heat and nitric acid. On March 20th the right hand was in much the same condition as before. The difficulty in speaking was greater. The right side of the face looked flat. She could not pucker the lips to whistle. With a finger in the mouth I could feel that the right cheek was quite flabby. She complained of the dribbling of saliva from the mouth, especially at night. When the tongue was protruded there was slight deviation to the left. She had no trouble during mastication or in the act of swallowing. On inquiry it was found that there was troublesome cramp in the right leg at night, chiefly in the calf. I was of opinion that the knee-jerk was slightly increased on the right side. On April 9th her confinement took place. The labour was tedious owing to the occipito-posterior position of the child's head, and the forceps had to be used. Possibly the position explains the cramps in the leg. The hand was still feeble and numb and the face was flabby on the right side. On May 2nd the right hand was stronger than before, but still remained weaker than the left. The numbness had almost quite gone. The face looked all right. The knee-jerk seemed more marked on the right side. The cramps never returned after the confinement. There was complete recovery within three months after the confinement. There were no symptoms of syphilis. Lead poisoning and alcohol could be excluded. The heart was quite normal and the kidneys were healthy. There was no history of recent illness. The case seemed to belong to the class of palsies directly related to the state of pregnancy. The treatment consisted in rest, milk diet, and purgatives occasionally.

¹ The best anatomical description of the fluke and its eggs will be found in a pamphlet by Dr. Looss, "Ueber den Bau von Distomum Heterophyes." Von Sieb, Kassel, 1894.

On Sept. 11th the mother and child (the latter now aged five months) were both of them quite well.

Conisbro', Yorks.

A MODIFICATION OF THE ARONSON AND PHILLIPS STAINING METHOD AND ITS APPLICATION IN THE CASE OF MALARIAL BLOOD.

BY EDWARD G. HORDER, F.R.C.S. EDIN.

I WAS much interested in Dr. Gerrard's clinical note in THE LANCET of June 3rd, 1899, p. 1490, giving a modification of the Aronson and Phillips Staining Method and its Application in the Case of Malarial Blood. I quite agree with Dr. Gerrard that the triple stain is one of the best we have for malarial blood, but the non-success of this stain in the hands of many men working on the blood has deterred others from using it to demonstrate the malarial parasite. My colleague, Mr. Hill, and I have used no other stain since we learnt how to heat the specimens. I wish to make a few suggestions and try to show how there is still an easier, surer, and quicker method than Dr. Gerrard's modification of the Aronson and Phillips staining method and will take up the points in the following order.

1. *The preparation of the cover.*—Dr. Gerrard and others suggest receiving the blood on a cover-glass and placing this face down on a second, separating them carefully when the blood is fully spread. This is an excellent plan, but requires a lot of time and often it is difficult to obtain an even spread. A quicker way, and I think more satisfactory, is to combine the use of cover-glasses with Manson's smearing. Having ready a glass cover in a pair of Ehrlich's forceps (these are better than Cornet's for holding and picking up covers) and a small piece of gutta-percha (half an inch square), held in a second pair, we proceed to prick the ear, and as the blood exudes the drop is touched by the edge of the gutta-percha, laid flat and drawn across the cover-glass, *commencing from the edge held by, and parallel to, the Ehrlich forceps.* The gutta-percha is held by forceps for the reason that during the greater part of the year in the tropics it is almost impossible to prevent the gutta-percha sticking when held by the fingers and with forceps it is much easier to manipulate. The smearing is commenced at the side held by the forceps for the reason that if begun from any other point the cover-glass is apt to swing round and spoil the specimen. One cover smeared another and another are picked up, and thus 10 or 20 spreads are prepared in a few moments. There is no touching of cover-glass with heated fingers, and the blood being spread by gutta-percha is more even in its results and therefore requiring the same number of exposures to the flame as other specimens spread in the same way.

2. *The heating.*—The quickest, and I believe the most certain, method of heating is by means of a spirit-lamp. After testing a half-dozen specimens prepared as above it is quickly learnt what exposure is required. If a lamp holding five ounces of spirit with a wick half an inch long be used, from 16 to 18 exposures to the flame will be required—that is, it will be necessary to pass the specimen quickly through the flame about 18 times to obtain a satisfactory staining. With the triple stain all depends upon the heating.

3. *The staining.*—After trying various mixtures—for no two books give the same proportions for the preparing of the triple stain—I find nothing better than the Ehrlich-Biondi powder made by Grubler and a solution¹ of this I have in constant use. It is quickly prepared and produces splendid results, and I agree with Dr. Gerrard when he says that for the malarial blood we have nothing better than the triple stain. Two minutes' staining will be found long enough for all specimens taken as above described. The great advantages of the powder are that it is easily packed, that but one bottle is required, a small quantity of the solution is quickly prepared, and is ready for use at once—all strong arguments in its favour for men who are often on the march and wish to stain a preparation immediately.

Pakhoi.

¹ Cabot gives the following formula: Ehrlich-Biondi powder, 15 grains; absolute alcohol, one cubic centimetre; distilled water, six cubic centimetres.

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.

VICTORIA HOSPITAL FOR CHILDREN, CHELSEA.

A CASE OF STRANGULATED INGUINAL HERNIA IN AN INFANT AGED 10½ MONTHS; OPERATION; RECOVERY.

(Under the care of Mr. D'ARCY POWER.)

STRANGULATION of a hernia in a young child is a rare occurrence, for the tissues are soft and are not likely to compress the bowel sufficiently to interfere with the circulation; yet from time to time numerous cases of strangulated hernia in children have been recorded, and it has been met with even during the first few days of life. In many cases partial inversion has led to a return of the bowel, though it has been necessary sometimes to keep the patient in this position for several hours. This treatment was, we believe, first recommended by Pott. It should, of course, only be employed in cases where no very urgent symptoms are present. For the notes of the case we are indebted to Mr. Edward J. Parry, house surgeon.

At 10.30 on the evening of July 26th a well-nourished male child, aged 10½ months, was taken by his mother to the Victoria Hospital with the history of having suddenly strained himself while coughing violently at 3 o'clock on the same afternoon. The child previously had been perfectly healthy except that he had had a right inguinal hernia for about six months for which he had worn a truss. On examination the local signs were as follows: a tumour of about the size of a hen's egg, extremely tense, was found in the scrotum and inguinal region on the right side, possessing the usual signs of a strangulated hernia with the exception that it was almost perfectly translucent. With regard to the general symptoms the child did not appear to be in much pain; he had not vomited at all and had taken his food as usual; the bowels had been open twice since the strangulation occurred. The pulse and temperature were normal. The pelvis and abdomen were elevated and taxis was tried gently for about one minute, but without any favourable result. Mr. D'Arcy Power operated an hour later, eight and a half hours from the commencement of strangulation. Some clear fluid was found in the sac and the gut was congested; the stricture which was fairly tight was situated at the neck of the sac. The bowel was returned and an operation for radical cure was performed. There was a good deal of swelling during the next two or three days, but this disappeared within a week. The infant made a rapid and uninterrupted recovery and was discharged on August 16th.

ROTHERHAM HOSPITAL.

A CASE OF VOLVULUS OF THE SMALL INTESTINE;
LAPAROTOMY; RECOVERY.

(Under the care of Mr. REID.)

IN the following case the slowness with which the symptoms appeared points to the volvulus of the bowel having been by no means acute. It is probable that at first the twisting of the intestine was only slight and that about the time of admission to the hospital the bending of the gut was increased so that complete obstruction resulted. The value of early laparotomy in cases of volvulus is well shown by Braun.¹ For the notes of the case we are indebted to Dr. J. S. Martin, house surgeon.

A married woman, aged 26 years, was admitted into Rotherham Hospital on June 30th, 1899. She had had two children, the youngest of whom was three years old. Ten

¹ Therapeutic Gazette, April 15th, 1892.