necropsy to verify my diagnosis, though with the three cardinal symptoms so well marked I have little doubt in my mind that it was a true case of Addison's disease.

I should like to have the opinion of my professional brethren on the questions: Was there any direct connexion between the last and first diseases, or was it simply the case of a body debilitated by a wasting disease becoming a suitable nidus for the invasion of the bacillus tuberculosis, if, as seems generally to be acknowledged, that be the cause of Addison's disease? I examined the patient thoroughly on more than one occasion but was never able to find any tuberculous mischief elsewhere.

Littleport.

NOTE ON A CASE OF FAILURE OF RESPIRATION UNDER ANÆSTHESIA.

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IN a recent issue of THE LANCET¹ there was a report of a meeting of the Society of Anæsthetists at which three cases of Failure of Respiration under Anæsthesia were reported by Mr. Carter Braine. As I have recently had a case somewhat on the same lines I think an account of it may be of interest to anæsthetists generally.

The patient was a well-built lad, aged 18 years, upon whom osteotomy of the neck of the femur for old fracture and subsequent ankylosed hip was being performed. The first stage and second stage passed off normally, except that perhaps the second stage was rather more prolonged and more violent than is usually seen in patients of this class. The operation had been in progress about 10 minutes, nearly an ounce of chloroform having been used in an ordinary open inhaler, when the patient suddenly stopped breathing with his pupils widely dilated and not reacting to light. The heart continued beating, as far as one could judge, quite normally. The tongue was pulled out and the jaw was jerked forwards and upwards several times with no result. The patient's head and the upper part of the trunk were hung over the edge of the operating-couch and artificial respiration was commenced, air entering and leaving the chest quite naturally. No attempt, however, was made by the patient to continue breathing. His colour remained good, though slightly pale. The pulse was very fair, but the pupils still kept widely dilated. Owing to the apparently good condition of the circulatory functions the operation was continued and completed, 10 minutes being thus occupied, during which time the above-mentioned position was maintained and artificial respiration was persisted in. After about 10 minutes the patient's breathing recommenced just as suddenly as it had stopped, the pupils returned to their normal condition, and after another two minutes he began to regain consciousness. The after events were quite normal. At no time was there any sign of approaching vomiting—the patient, indeed, did not vomit at any time after the anæsthesia. The lower jaw, I may mention, was quite flaccid; in fact, it had dropped. The heart sounds were quite normal and there was no albuminuria. Curiously enough, a week later the same patient was again operated upon, and this time a wedge-shaped piece of bone was removed from the neck and great trochanter of the femur. The operation on this last occasion occupied three-quarters of an hour, chloroform being again administered, and at no time did anything unusual occur.

To me this case appears as a true paralysis of the respiratory centre, the circulatory centre being uninterfered with; the chloroform which was used (Duncan and Flockhart's) being above suspicion.

Liverpool.

¹ THE LANCET, May 26th, 1900, p. 1518.

NEW MEDICAL FACULTY IN RUSSIA.—The University of Odessa has hitherto lacked a medical faculty. The necessary buildings have been already partly erected and a commencement will be made next session. There will be at first seven clinics with 195 beds, 14 ordinary and nine extraordinary professors, and nine prosectors and six assistant prosectors. The first dean of the medical faculty will be Professor Podvysotski.

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.

BIRKENHEAD AND WIRRAL CHILDREN'S HOSPITAL.

A CASE OF OMPHALITIS RESULTING IN ULCERATION AT THE UMBILICUS; CLOSURE OF ULCER BY A PLASTIC OPERATION; RECOVERY, WITH A FIRM CICATRIX.

(Under the care of Dr. J. PINKERTON.)

FOR the notes of the case we are indebted to Mr. William Herbert, late house surgeon.

A female infant, aged one month, was on April 15th, 1898, taken by the mother to the Birkenhead and Wirral Children's Hospital for treatment on account of an inflammation of the umbilicus. The mother stated that the inflammation had been present for about a fortnight. The infant, who was born at the eighth month, was small and ill-nourished. On examination there was found to be an extensive inflammation around the umbilicus, the margin of the inflammatory zone being about two inches from the centre. The skin over this area was very red but not boggy. There was no discharge from the umbilicus, nor could a sinus be detected. A dressing of equal parts of saturated boric acid lotion and carbolic lotion (1 in 40) was prescribed, to be applied four times a day. A quarter of a grain of hydrargyrum cum creta was prescribed for internal administration every night. The child was being hand-fed and an ounce of lime water was added to each bottle of diluted milk. When seen a week after this the redness had somewhat subsided. A purulent discharge, however, had made its appearance at the umbilicus; the treatment was continued. On the 30th the discharge of pus continued, but the zone of redness had disappeared and the general health of the infant had improved. Boric acid lotion was prescribed and the grey powder was ordered to be taken every other night. The patient was not again seen till May 17th. The mother then said that on the 15th a "core" had come away from the umbilicus. On inspection a circular ulcer with roughened edges occupied the site of the umbilicus. It was about one-third of an inch in diameter and involved all the soft structures of the abdominal wall. Forming, as it were, the floor to this resulting cavity was a glistening structure which was found to be the peritoneum; but it had escaped, as it showed no inflammatory change. There was no bulging at the opening. The infant looked better. The powders were stopped.

On May 25th (with the consent of Dr. Pinkerton, the honorary medical officer) Mr. William Herbert performed a plastic operation with a view to close the ulcer as the general health of the infant seemed to permit this. No anæsthetic was given. First the edge of the ulcer was pared all round with a hernia bistoury. This instrument was chosen on account of its blunt end which could not injure the peritoneum. A clean, raw margin was obtained, as little healthy tissue as possible being removed. A curved needle, threaded with medium-sized catgut, was pushed through the abdominal wall (inferior right hand corner) about an eighth of an inch from the freshened edge (see figure, *a*). It passed through the whole thickness of the parietes, carrying the suture across the floor of the ulcer, again through the parietes, to emerge at the superior right hand corner (*b*). The suture then curved to the corresponding left upper corner and was inserted there; again carried across the floor it emerged at the left lower angle. The two ends (*c*, *d*) were then tied; good apposition was thus obtained with a certain amount of puckering. A dry dressing (double cyanide gauze) was applied and a flannellette bandage was firmly bound over this. On May 31st the suture was removed and except for a slight superficial portion union was complete. Boric acid in powder was dusted on the wound,

covered with dry lint, and the bandage was re-applied. On June 2nd union by first intention was complete. The child was last seen at the beginning of July. The cicatrix then appeared to be very firm and the flannelette binder was

The freshened edge of the ulcer is represented by the circle.
 x, Floor of the ulcer lined by peritoneum. a, b, c, d indicate the course of the needle carrying the suture.
 e, e', Free ends of suture ready for tying.

discontinued. The infant's general condition was good and there was no trace of any bulging at the cicatrix.

Remarks by Mr. HERBERT.—Little is said in the textbooks both on surgery and on children's diseases about inflammation at the umbilicus and an unfavourable prognosis is given. The inflammation runs much the same course as elsewhere and is doubtless caused by septic organisms. In the above case the condition was no doubt a septic one, the resulting ulceration being dependent upon its severity. It would be interesting to have had more particulars about the "core" which the mother said had come away previously to the ulceration manifesting itself. Three features in the case, however, seem to be noteworthy. 1. The absence of any bulging at the site of the ulcer. This was doubtless due to the fibrous ring of the umbilicus being left more or less intact and capable of offering sufficient resistance to internal pressure. 2. The complete peeling off of the structures superficial to the peritoneum, leaving this membrane to form the floor of the resulting cavity. 3. The absence of toxic symptoms during the free employment of both carbolic and boric solutions, both of which have given rise to unpleasant symptoms in their use in infants and young children. I am indebted to Dr. Pinkerton for permission to publish this case.

LUCEA HOSPITAL, JAMAICA.

A CASE OF PROLAPSE OF THE RECTUM AND A CASE OF FIBROIDS OF THE UTERUS.

(Under the care of Dr. E. R. C. EARLE.)

THE case of prolapse of the rectum and sigmoid flexure described below may be looked upon as really an example of intussusception, for the upper part of the rectum had become invaginated into the lower. Many cases of prolapse commence in this manner, but so long as there is a sulcus between the protruding mass and the anus the case is one of intussusception. A case in many respects resembling the one appearing below was recorded by Dr. C. B. Kelsey,¹ though the intussusception had existed for a longer time. The second of Dr. Earle's cases illustrates well the fact that of all forms of uterine fibroid the most easily removed is the pedunculated subperitoneal variety, and with modern asepsis the risk to life is but slight. In this case the size of the tumours was very great and would have justified even more severe measures.

CASE 1. Prolapse of the rectum with invagination of the sigmoid flexure; recovery.—A feeble old coloured man, 89 years of age, was admitted into Lucea Hospital at 11.30 A.M. on Oct. 22nd, 1899, with a large tumour protruding from the anus. He stated that at 2 P.M. on the previous day, whilst straining at stool, he felt the bowel come down and that it had remained in that condition ever since. On examination

it was seen that a large tumour, eight inches in length and between two and a half and three inches in diameter, protruded from the anus. The tumour consisted of prolapsed rectum and sigmoid flexure. It was conical in shape and slightly smaller at the lower end than at the middle; at the lower end there was an opening similar to a large os uteri, up which the finger could be passed. The surface of the tumour consisted of mucous membrane with concentric sulci; it was dark red in colour and much congested and swollen, with small, dark, submucous hæmorrhages. It was not strangulated at the anus and there was no odour of gangrene. The anus was lax and the finger could with ease be passed up for two or three inches between the sphincter and prolapsed bowel all round the tumour. The patient complained of severe pain in the back but not in the tumour; he was very old, poorly nourished, and very weak.

At 12 noon he was put under chloroform and the tumour, which was thoroughly cleaned and warmed, was replaced gradually and slowly without any great difficulty, owing to the lax condition of the anus. There was a slight laceration in the posterior wall of the anus. Powdered tannic acid and a morphia suppository were put in the rectum and a perineal pad and band were applied. Hot-water bottles were placed at either side and the hips were raised on a pillow.

At 6 P.M. his condition was fairly good. He had slept a little and was in no great pain. Five minims of liquor opii sedativus were given after the operation and one and a half ounces of whisky in water. He passed a good night. On Oct. 23rd, early in the morning, a stool was passed containing serous bloody fluid and small blood-clots. The bowel was washed out with boric acid lotion and a five-grain suppository of tannic acid was inserted. The patient was comfortable and was stronger. At 5 P.M., after an enema of boric acid lotion, no faecal matter came away; the fluid was dark-coloured and was mixed with shreds of mucous membrane. The tannic acid suppository was repeated. The patient rested well during the night. There was no action of the bowels; the pain in the back was relieved, but he had pain in the left shoulder and front of the chest. At 5 P.M. an enema was administered; the stool was very offensive. The suppository was given as before. On the 25th he had slept well; the former pain was relieved, but he now had pain in the left hip. No stool had been passed during the night. The enema and suppository were administered morning and evening as before. On the 26th he had slept well. The bowels had acted once during the night; the stool was offensive. The treatment was continued. On the 27th the patient passed three liquid stools, on the 28th and 29th two, and on the 30th and 31st one each day. There were no signs of prolapse and there was no pain. On the 31st he became very weak and low and had much difficulty in speaking, but he became stronger on Nov. 1st. He was discharged from the hospital on the 5th.

CASE 2. Large fibroids of the uterus; removal; recovery.—A coloured woman, aged 40 years, was admitted into Lucea Hospital on June 1st, 1899, complaining of great distension of the abdomen which had gradually increased during the previous three years. On examination the abdomen was found to be much distended. There was a large moveable tumour felt in the front and right side of the abdomen, passing into the right lumbar region and upwards under the liver, filling the right half of the abdomen; the tumour was firm, elastic, and freely moveable. A second tumour similar in character, freely moveable, but of smaller size, was felt in the left lumbar region. By vaginal examination a large firm elastic tumour was felt, filling the right lateral fornix of the vagina, the cervix being small and displaced towards the left side. The tumour appeared to be situated in the right lateral wall of the uterus. As the patient was in poor health she was kept in the hospital for three weeks prior to operation in order that her physical condition might be improved.

On June 21st, at 8 A.M., chloroform was administered. A dose of castor-oil had been given the night before and a rectal enema and vaginal douche had been administered early in the morning. The abdomen had been thoroughly cleaned and asepticated and the pubes shaved on the previous day and the urine had been drawn off just before the operation. An incision was made in the mid-line from a point two inches below the umbilicus to about one inch above the symphysis and the abdominal cavity was opened; some ascitic fluid escaped. The tumours were seen to be dense, solid fibroids attached to the uterine wall by

¹ The Post-Graduate, New York, August, 1895.