inject the drug very slowly is doubtless advisable, as in the case of the violent prickling coming on, as it does instantly should the accident occur, the needle can be withdrawn without having given the full dose, and the effects would consequently be less severe. As a preventive, I do not see that much else can be done, as, if atropine be added to the injection, the question arises, what is the immediate action of the atropine when thrown directly into the circulation?

Redbourne, Lincolnshire.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

TREATMENT OF CHRONIC DYSENTERY.

By J. G. M. G. STACK, L.R.C.P. Ed.

KNOWING the extreme difficulty often experienced in making any curative attempts over this disease, and not being aware that the same treatment has ever been pursued, I venture to forward particulars of a case of two years' duration, treated with most beneficial results by enemata of iodoform.

G. S.—, a sailor in the China trade, contracted, about two years before I first saw him, an attack of acute dysentery; on his return home he was admitted into Greenwich Hospital, and on his discharge from that institution he resided in Liverpool for about eighteen months under medical treatment for chronic dysentery. As there was no improvement in his symptoms, he was advised to take a trip to South America, which he did, coming under my care. He daily passed between four and six stools, calls to which had to be immediately attended to; the first part of the evacuation consisted of a light-coloured slimy substance having the peculiarly unpleasant dysenteric odour, the ordinary motion following which, however, was of very light consistence and small size. He had naturally lost much of his former energy, and was greatly fatigued by the slightest exertion. After a fruitless trial of a variety of remedies—amongst others, mercury internally and by inunction over the left inguinal region, opium and powdered ipecacuanha in large doses, iodide of potassium, iron, &c.,—I at last determined upon trying iodoform by enema. Two grains of iodoform suspended in mucilage of starch were thrown up the rectum by means of a long tube after each motion. At the end of three days the dose had been gradually increased to six grains. In a fortnight's time he was passing but one motion daily, which was in every way normal, with the exception of its small bulk. On our arrival in Liverpool he passed from under my observation, and I regret being unable to give the subsequent history; but for the last three weeks while under my care, and with the enemata discontinued, he had had no relapse, the looseness being completely checked, and the motions presenting no dysenteric characteristics.

Should "Enquirer," whose letter appears in THE LANCET of Oct. 20th, be disposed to give the iodoform treatment a trial, I shall be glad to hear the result.

Gosberton, Lincolnshire.

A CASE OF POST-PUERPERAL PERITONITIS WITH SUBPERITONEAL ABSCESS; OPERATION; RECOVERY.

By JOHN W. TAYLOR, F.R.C.S. Eng.,

SURGEON TO THE BIRMINGHAM AND MIDLAND HOSPITAL FOR WOMEN.

IN March, 1888, I was asked to see a patient who was supposed to be dying from puerperal peritonitis. This is relevant to the patient's condition, as the case was considered hopeless, and the consultation was stated at the outset to be solely for the satisfaction of the friends of the patient and her medical attendant. The notes of the case at this date are as follows:—

"A. B.—, aged thirty-three, was confined eight weeks ago. Had poor food and very hard work during the whole

of her pregnancy, working until the day of her confinement. So far as can be ascertained, the confinement presented no unusual features, but was followed by great prostration and weakness. It was not until the fifth week that the patient managed to get up and go outside of her house to a church which is only a few doors from her dwelling. She returned very ill, and has been in bed ever since, suffering with great abdominal pain (mainly on the left side), almost constant sickness, and irregular diarrhoea. At our visit she is noticed to be very emaciated, her face anxious and haggard (looks about forty-seven). She is crying with pain, and frequently vomiting a little bilious fluid. On examination a large tumour is found on the left side of the pelvis, pushing the uterus altogether to the right, and fixing it in this situation. The upper limit of the tumour can be felt above the left groin. The whole of the abdomen is greatly distended and very tender, and the tumour, which may be an extensive parametric exudation, is evidently accompanied by acute and serious peritonitis."

The patient was removed the same day to a private operating ward, and on March 9th I opened the abdomen in the middle line. The intestine was very adherent immediately beneath the incision, and there was considerable difficulty in finding the peritoneal cavity on account of this. By extending the incision upwards an opening was found, and the intestine separated from its adhesions, disclosing the upper surface of a large subperitoneal abscess on the left side, which was on the point of bursting, or perhaps had already done so to a very limited extent. As I pressed my finger over its surface in the direction of the left groin the sac or peritoneal wall suddenly gave way, and a considerable quantity of curdy pus was evacuated. The interior of the cavity felt ragged and uneven to the touch of the examining finger, and, so far as the relations could be made out, the abscess and surrounding infiltration was mainly in the cellular tissue below the peritoneum, and neither ovary nor tube was specially involved. A second incision in the abdominal wall was made above the left groin, and immediately over the opening into the abscess. A large-sized rubber drainage tube was passed into its cavity, the abdomen well washed out, and the median incision closed. For three or four days the result was doubtful. The pulse remained exceedingly weak and rapid, varying from 130 to 150 beats per minute, and the prostration was very great. Nutrient enemata were given every six hours, and from the first a little beef-juice was allowed by the mouth. This was retained by the stomach, and was, I consider, of decided benefit in tiding the patient over a time of serious danger. By the close of the first week the pulse had fallen to 110 and there were evident signs of recovery, which hereafter was uninterrupted.

All cases of peritonitis connected in any way with the puerperal period are of special interest, and the question of operative treatment in most of them is a very difficult one to decide. This, except for the emaciated and exhausted state of the patient, was less difficult than many. The physical signs of a local cause were evident, and there can be but little doubt that the thorough surgical treatment of the local condition saved the patient's life.

Birmingham.

A COIN RETAINED IN THE OESOPHAGUS FOUR MONTHS.

By H. MARTIN DOYLE, M.R.C.S.

THE following case came under my observation while in charge of the receiving room at the London Hospital.

The patient, a strong, healthy boy, four years of age, had, while playing with some money, swallowed a halfpenny. He was immediately taken to Charing-cross Hospital, where an emetic was administered, but without any good effect. I saw him four days afterwards. He had been very sick since taking the emetic, had cried a great deal, and complained of pain, which he located about the middle of the sternum. He looked ill, had lost his appetite, and was very restless both day and night. There had been several motions of the bowels, and, although the faeces were carefully scrutinised, the missing coin was not found. As the friends had some objection to the probang or coin-catcher being used, I advised a pultaceous diet and patience. I saw the child some days afterwards, and was informed that he had not yet passed the coin. He, however, appeared to be