have performed the perineal operation. I have done so for one very sufficient reason. The operations are done before students and practically their only experience of stone operations is what they see me do. They will be called upon to operate on large stone cases, and for them and for the great majority of practitioners the perineal operation is by far the better. I therefore take frequent opportunities of demonstrating it to them. In the hands of a surgeon constantly operating, however, Bigelow's operation is practically capable of removing any stone however big. Very large stones have been successfully removed by it. Cunningham² records one of eight ounces, but even this has been surpassed by one of my recent cases, which I take the opportunity of recording here. The patient was an Egyptian fellah aged about forty-five years. The stone having been recognised as very big the largest lithotrite, having a gape of 5 inches (made to order for me by Messrs. Down Brothers), was introduced. After some difficulty the stone was grasped, the separation of the blades being to the extent of $4\frac{3}{4}$ inches. My whole force was necessary to crack the stone, and after a very tiring operation lasting 125 minutes the débris, amounting to 340 grammes, or over 12 ounces (dry weight), was entirely removed. The patient's convalescence was rapid and his cure complete. This is by far the largest stone I have ever crushed, and I believe it to be the biggest ever removed by Bigelow's operation. The stone was composed of urates and phosphates and was more than usually dense.

(To be continued.)

THE BRONCHITIS KETTLE, POULTICES, AND OVER-FEEDING IN ACUTE LUNG AFFECTIONS.

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IN these days of almost exclusive devotion to the study of micro-organisms and of abstruse chemical changes taking place in the body there is some fear lest the attention of the ordinary medical student should not be sufficiently concentrated on what, after all, is to be his main object in life—viz., the cure or alleviation of the maladies from which his patients are suffering. Dr. Church, in his recent Harveian Oration,¹ has pointed out in emphatic language that "the very brilliancy of recent discoveries and the vast increase in our knowledge may for a time react prejudicially on the art of medicine." I frequently hear complaints from the older practitioners with whom I come in contact that recently qualified men fresh from the hospital are almost useless as assistants; their theoretical knowledge may be excellent, but they are at a loss when they are confronted with the small details of general practice. May I, therefore, be allowed a little space in the columns of THE LANCET to discuss the prosaic questions of steam kettles, poultices, and diet? As a text for my sermon let me quote the treatment of a case of pneumonia as it is too often carried out—the unfortunate patient is kept in a room with the atmosphere saturated with moisture from a bronchitis kettle, enveloped in huge linseed meal poultices, and is given nourishment every half hour or so.

First of all as regards the practice of charging the air with moisture from what Sir Benjamin Richardson says is not inaptly called a "bronchitis kettle." The folly of this practice has recently been commented on in a monthly medical journal and attention was therein directed to Richardson's able article on "Hydrops Bronchialis" in the *Medical Press and Circular* of Jan. 25th, 1888. I am strongly of opinion that the bronchitis kettle should be practically banished from the sick room; the only instances in which benefit is likely to ensue from its use are cases of dry bronchitis, in which patients have difficulty in bringing up tough pellets of mucus, and even then I would not order it unless there was a dry easterly wind. In cases of pneumonia I have seen nothing but harm resulting from the employment of the

bronchitis kettle, and I always advise that it should be taken away when I find it in use. I do not think that too great stress can be laid on the importance of a free supply of fresh air in cases of pneumonia, and this cannot usually be attained if the bronchitis kettle is at work.

The next point I would raise is as to the routine use of poultices. The longer I practise the fewer poultices I order, and at the present time I have come to the conclusion that except for the relief of pain poultices are of little or no value in the treatment of chest affections, or perhaps I might put it in another way—that the drawbacks inseparable from the use of poultices are not compensated for by the amount of benefit which can reasonably be expected to result from them. To watch a small child with extensive broncho-pneumonia fighting for breath, and then to further hamper its efforts by ordering poultices weighing about a pound seems to me hardly a scientific procedure. I prefer a light jacket of Gamgee tissue or cotton-wool over which some stimulating liniment may be sprinkled. This may be left for hours or even days without disturbing the patient, whereas poultices require to be changed every three or four hours and there is always the risk of the patient being chilled by a cold poultice or scalded by one too hot.

Lastly comes the question of feeding. It seems to me that during acute pulmonary affections more food is forced down the patient's throat than he requires and, moreover, that nourishment is given at too frequent intervals. The drawbacks of over-feeding the patient are very forcibly put in a paper read at the International Medical Congress at Berlin by Dr. Andrew Smith of New York. "The anxiety 'to keep up the strength' and the apprehension excited by the small and feeble radial pulse are apt to suggest the administration of more food than is necessary or beneficial. We forget that the digestive organs are not in a condition to do the work demanded of them in health and also that the pulmonary obstruction interferes with the process of hæmatosis. Giving an excess of food therefore entails a double embarrassment. There is the burden arising from undigested food in the stomach giving rise to flatulent distension and thus rendering respiration more difficult, and there is also the risk of loading the blood with more nutritive material than the imperfect respiration can act upon in the process of sanguinification." In all acute affections, unless vomiting be present, nourishment should not, as a rule, be given oftener than every two hours, and about five ounces of milk, or the equivalent, are usually sufficient. I cannot help thinking that the success which attends one's treatment of pneumonia and enteric fever in hospital practice is largely due to the regular administration of a moderate quantity of nourishment.

In the above remarks I have only briefly touched upon some of the important points in the care of the sick, but from my experience in consulting practice I am convinced that too little attention is bestowed on the necessity of laying down clear and precise directions as to the hygiene of the sick room and the diet of the patient.

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SOME UNUSUAL CASES OF SWELLING OF THE PAROTID GLAND.¹

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I HAVE thought the following group of cases worthy of notice, imperfect as are the records of more than one of them, because they illustrate a minor ailment which appears to have passed almost unnoticed, at any rate in this country. It will be convenient in the first instance to record the brief notes of the cases as they have come under my observation and then to consider their probable nature and refer to cases presumably of the same nature which have been recorded by others.

CASE 1.—A thin, anæmic boy thirteen years of age came to the out-patient department of the Victoria Hospital for Children on Jan. 1st, 1892, on account of a swelling of the right side of his face which had appeared somewhat suddenly

² Brit. Med. Jour., 1891, vol. i., p. 1008.

¹ THE LANCET, Oct. 26th, 1895.

¹ A paper read before the Harveian Society on April 16th, 1896.

during a meal a month previously and since then had become somewhat larger and harder. The boy had never had mumps nor was there any evidence that he had recently been exposed to the infection of that disease. On examination it was at once obvious that the swelling was due to enlargement of the right parotid salivary gland. The swelling was slightly lobulated, tender on pressure, in most parts hard, but, especially below the ear, slightly elastic. On squeezing the gland a string of turbid, ropy mucus could be expressed from the orifice of Stensen's duct into the mouth and this was followed by several drops of saliva. A fine probe could easily be passed along the duct, and no calculus or other obstruction could be detected. On the 6th the boy was admitted to the hospital on account of the increasing size of the swelling. It was still found easy to press a long plug of turbid mucus from the duct, after which a free escape of saliva always followed. Hot fomentations were applied externally and hot water mouth-washes were ordered to be repeated frequently. On the 17th the gland was still larger and the swollen socia parotidis was very obvious. The skin over the gland was reddened and the temperature reached 103.6° F. Movements of the lower jaw were very painful, but no increase in the size of the swelling was observed when food was taken. On the 19th the redness and œdema over the gland were so marked that suppuration was suspected. A short incision was therefore made below the ear and a Lister's sinus forceps cautiously pushed into the gland, without, however, finding pus. From this time the swelling slowly diminished, and on the 28th it was noted that the boy was free from pain. On Feb. 2nd the whole gland was still obviously enlarged and remarkably hard. On the 16th it was suggested that iodide of potassium liniment should be rubbed into the gland once daily. When the boy was last examined, on March 22nd, nearly four months after the onset, the gland was smaller but still very hard.

CASE 2.—A healthy-looking boy aged eleven years came to the Great Northern Central Hospital on April 4th, 1892, on account of a swelling of the left side of his face of about one month's duration. The swelling was said to have diminished slightly in size during the last fortnight. It was painful, especially at meals, but it was not stated that the swelling increased at these times. The boy was not known to have been exposed to the contagion of mumps. There was no history of any inflammatory affection of the mouth or throat. On examination the left parotid gland was found to be considerably swollen and tender. The swelling was slightly lobulated, but the socia parotidis could not be defined. Below the salivary gland a few slightly enlarged lymphatic glands could be felt. On pressing the parotid saliva flowed into the mouth from Stensen's duct. Hot water mouth douches were prescribed and belladonna liniment was rubbed into the parotid region. On the 7th pressure on the gland caused an escape of turbid mucus from the duct; the swelling was smaller and softer. A week later, when the boy was last seen, there was still further diminution in the swelling and mucus could no longer be squeezed from the duct.

CASE 3.—A man twenty-six years of age, whilst on a short railway journey in September, 1889, experienced a feeling of discomfort and slight fulness in the left parotid region. On the following day the swelling was much more marked and was exactly limited to the area occupied by the parotid salivary gland. It was very tender on pressure, and mastication was difficult on account of pain. With the taking of food the swelling appeared to increase. Although there was a history of mumps in childhood affecting, it was believed, both parotids, the diagnosis of mumps was made and isolation for a fortnight was strictly observed. At the end of a week the swelling had practically disappeared. During the next three or four years several milder attacks occurred in which the left parotid gland was obviously swollen and slightly tender for periods of a few days. Frequent abortive attacks were noticed in which the socia parotidis alone was swollen and tender for a day or two, and at the present time, six and a half years after the first attack, this part of the gland can still be felt to be slightly enlarged and indurated.

CASE 4.—A thin, ill-tended child aged fifteen months was brought to the Victoria Hospital for Children on Jan. 7th, 1896, on account of a swelling of the left side of the face and neck, which when it was first noticed, five weeks previously, was thought to be mumps. The swelling had gradually increased, but appeared to cause the child no pain. No history of any trouble with the mouth or throat could be obtained. The child, although very ill-nourished, presented

no other symptom of inherited syphilis. There was congenital ptosis on the left side. The swelling for which advice was sought was due to uniform enlargement of the left parotid salivary gland, which was sufficiently marked at once to attract attention. The swelling was very hard, but did not appear to be tender. Nothing abnormal could be seen in the position of Stensen's duct. A week later the gland was perhaps slightly smaller.

CASE 5.—A man aged thirty-three years came to University College Hospital on Feb. 19th, 1896, on account of a swelling in the left parotid region. This had gradually been increasing for two months; it was said to be most marked in the morning, but had not been noticed to increase during meals. The swelling had the characteristic outline of the parotid gland, but the socia parotidis could not be separately defined. The swelling was uniformly firm to the touch; it was free from pain and tenderness, but caused some discomfort during eating. The skin over the gland was normal. Pressure failed to squeeze anything from Stensen's duct, and I was unable to pass a fine probe along it. There was no evidence of the presence of a calculus. The mucous membrane of the mouth and throat appeared normal. The patient's general health was not good and for several years he had been under treatment for stricture of the urethra.

In reviewing these short records it will be observed that in each instance we have to deal with swelling of one parotid salivary gland. In none of them was there any difficulty in excluding a swelling due to enlarged lymphatic glands, for although this may sometimes closely resemble a swelling of the parotid itself, in these cases the outline of the enlargement was quite characteristic.

Passing to the consideration of the probable nature of the cases, it may be remarked in the first instance that they were not mumps, although in more than one case the condition had been confused with that affection. Amongst the many reasons which might be adduced in connexion with this point I may mention (1) the absence of any known exposure to the contagion of mumps; (2) the prolonged course of the swelling; (3) the limitation of the swelling to one parotid gland; and (4) the absence of infection of other individuals. Continuing the process of exclusion I may say that in each case the presence of a salivary calculus was duly considered and negatived. In the large majority of cases the essential symptom of a salivary calculus is swelling of the gland due to obstruction of the duct, but there is a specimen in the museum of University College illustrating chronic enlargement and induration of the submaxillary gland resulting from the presence of small calculi in its substance. The gland was excised by Mr. Godlee, who, before proceeding to the operation, believed that he had to deal with a tuberculous lymphatic gland. The course pursued by my cases excluded such a condition. Lastly, there were no grounds in any instance for referring the case to the parotid inflammations which are known as "symptomatic parotitis" or "parotid bubo," such as may occur in the course of pyæmic processes, typhoid fever, &c., or to the group, for our knowledge of which we are so much indebted to Mr. Stephen Paget, in which parotitis complicates various abdominal diseases and injuries, at times apparently independently of sepsis.

Passing from the negative to the positive, I may express my belief that the above cases are examples of swelling of the parotid gland resulting from interference with the escape of its secretion due to inflammation of the lining of Stensen's duct. This conclusion was suggested by the fact that in Cases 1 and 2 pressure on the swollen gland caused the escape of a plug of thick, turbid mucus from the duct, followed by a free flow of saliva. In Case 3 also it will be observed that in each attack the swelling affected first the socia parotidis and in the slighter attacks did not extend beyond it. Remembering that the socia parotidis has a small duct of its own which enters Stensen's duct, it is easy to understand that a slight degree of inflammation, insufficient to block the main duct, might completely obstruct the smaller one.

I have been unable to discover that any particular attention has been drawn to such a condition in this country, but in the article on Diseases of the Salivary Glands in Duplay and Reclus's "Traité de Chirurgie" I have found several interesting references to cases probably belonging to this category. Kussmaul records a case of "recurring salivary tumour resulting from fibrino-purulent inflammation of Stensen's

duct." The patient, a woman thirty-two years of age, experienced attacks of swelling of the right parotid gland, recurring every five or six months between the summers of 1875 and 1877. The swelling always appeared somewhat suddenly during meals, and was attended with a feeling of discomfort but no actual pain; it lasted for about half an hour and then rapidly subsided. In the summer of 1878 an attack of more considerable swelling occurred, of longer duration and attended with much pain, especially during meals. The swelling subsided after the escape of some drops of thick pus from Stensen's duct. The attacks now recurred more frequently, sometimes after intervals of not more than two or three weeks, and on one occasion the swelling lasted eight days. No treatment beyond the application of dry warmth to the cheek was adopted. Dr. Krieger, who treated the patient, found that the masses which escaped from the duct consisted of pus and fine filamentous cylinders, the fibrinous nature of which was demonstrated microscopically by Dr. Friedländer. The patient was taught to pass a fine platinum wire sound along the duct and thus obtained relief, for on withdrawing it thick fibrino-purulent matter escaped and after this a free flow of saliva. At the beginning of November, 1878, another attack occurred in which not only the right gland, but to a much slighter degree the left, was affected. After the patient's midday meal Kussmaul found great swelling in front of and below the right ear, the skin was red and hot, and pressure was painful. The sound could be passed only a few millimetres along the duct, but on withdrawing it some yellow, creamy pus escaped, followed by a filamentous thread and clear saliva, after which the sound could be introduced for four centimetres. In an attack in January, 1879, the thread which escaped was three centimetres long and as thick as a knitting needle. This was examined by von Recklinghausen, who found that it consisted of a fine membranous deposit composed of a network of fibrin containing pus and epithelial cells. The patient was seen some time subsequently and had had no further attacks. A chlorate of potash lozenge was taken daily. Another case which is worthy of notice was published by Berthold Stiller of Budapest.³ A man aged thirty-six hurriedly summoned Dr. Stiller on account of a rapidly increasing swelling of the right cheek which appeared during dinner. The swelling corresponded with the right parotid gland and was the seat of a sensation of warmth and discomfort but not of actual pain. Nothing unnatural could be seen in the mouth. Dry heat was applied to the cheek but did no good, for on the following day the swelling was larger and painful. Whilst the patient was handling and squeezing the swelling he spat out a shreddy purulent mass, whereupon the mouth filled with a clear watery fluid. The swelling rapidly diminished and on the following day had disappeared. Subsequently the patient experienced milder attacks every three to six months, and the swelling was invariably relieved by pressure applied to the gland. These two cases afford strong support to the view that I had independently formed as to the nature of at least the first three of those which I have recorded. In both the rapid subsidence of the swelling after relief of the obstruction in the duct shows that it was due simply to retention of secretion and not to inflammation of the gland. In my cases, on the other hand, the persistence of the swelling and induration would point to the occurrence of inflammation of the gland lobules of a kind comparable to that which may occur under similar circumstances in other secreting glands, notably the breast. In Cases 4 and 5 evidence that the primary mischief was in Stensen's duct is wanting, but I strongly suspect that these were also of the same nature.

As perhaps throwing a side light on the subject it may be mentioned that two cases of recurrent swelling of both parotid glands in association with xerostomia or "dry-mouth" have recently been recorded. In Battle's case⁴ both parotids had alternately increased and diminished in size for a period of two years, and whilst the patient was under observation and the glands were at their minimum size the smaller was as large as a walnut, and both were firm and lobulated. In Chappell's case⁵ the parotid glands "would suddenly enlarge at times, become tender, and after two or three days gradually subside." Whilst the patient was first under observation, in May, 1894, "both parotids

were much enlarged, especially the right, and seemingly consisted of three or four nodular masses which were hard and non-sensitive and resembled those of a patient with mumps." In February, 1895, the glands had increased considerably in size. It may be considered probable that in these cases an inflammation of Stensen's duct, associated with the unhealthy condition of the mouth, was the cause of the parotid swellings. A condition similar to that under consideration has been met with in the submaxillary gland by Ipscher.⁶ He was hurriedly summoned to a man aged thirty on account of a swelling which had suddenly formed in the right submaxillary region. Before Dr. Ipscher arrived the patient had relieved himself by pressing on the swelling when "a small white thread" appeared in the mouth followed by "a quantity of sour-tasting water." The right submaxillary gland was still considerably swollen, and the corresponding part of the floor of the mouth was reddened. This was the third attack, and in each of the two previous ones pressure on the swelling had been followed by a similar result. This case was published as the result of Kussmaul's communication, and was regarded by Ipscher as of the same nature. The only instance of swelling of the submaxillary gland, possibly belonging to this class of cases, which I have observed was that of a boy eight years of age who was brought to the Victoria Hospital on Feb. 9th, 1894. The swelling in the neck formed during the night in the winter of 1892 and did not subside for eight months. In November, 1893, it reappeared, and when I saw the boy the swelling evidently involved the right submaxillary salivary gland. There was nothing abnormal in the appearance of Wharton's duct, and a probe could easily be passed along it. Three weeks later the gland was smaller. The nature of this case was obviously doubtful.

I have thought these cases worthy of being recorded, although necessarily incomplete in many respects, because they illustrate a condition of some importance, if only on account of its superficial resemblance to mumps. It is a useful rule of practice always to examine the duct of a swollen salivary gland. If there is any probability that the swelling results from blockage of the duct by inflammatory products the regular passage of a fine probe may be expected to give relief, but induration of the gland is likely to persist for a considerable period.

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SOME CASES OF VENTROFIXATION OF THE UTERUS.

BY HASTINGS GILFORD, F.R.C.S. ENG.

I VENTURE to bring forward these few cases because the discussion on the subject of ventrofixation of the uterus by the British Gynæcological Society gives them some value from a statistical point of view. But apart from this they are, I think, worthy of publication owing to certain special features of interest. Thus, in one case the operation was done because of the perforation of the uterus by a curette. In another intussusception of the bowel set in after the operation, resulting in self-cure. In two of them both ovaries were also removed. In four Keith's operation was performed.

CASE 1.—A woman aged thirty-five years had severe prolapse of the uterus for five years and had suffered much from enlarged and painful ovaries. No pessary could be tolerated and she became thin, haggard, and utterly dispirited from constant pain and uneasiness. Both ovaries were removed in June, 1893, and the uterus was sewn to the edges of the wound with four silk sutures. It was nearly eighteen months before she had fully recovered her health, but now she is in an excellent condition.

CASE 2.—This patient was a woman aged thirty years. Keith's operation was advised owing to persistent pain in the right ovary and retroflexion of the uterus, but the left ovary being found unhealthy at the time of operation was also removed. This was done on April 18th, 1895, and so far as the displacement is concerned the result is satisfactory, but the ovarian disturbance, though better, has not yet disappeared.

CASE 3.—In November, 1894, I was asked to see a woman

³ Wiener Medicinische Wochenschrift, 1881, No. 19.

⁴ Transactions of the Clinical Society, 1895, p. 282.

⁵ New York Medical Journal, Feb. 29th, 1896.

⁶ Berliner Klinische Wochenschrift, 1879, No. 36.