should thoroughly wash his hands with liquid chlorine or chlorinated lime-water; and in a work he published at a later date, entitled "Die Aetiologie &c.," he insisted on "removal of maternity wards from insanitary surroundings, scrupulous attention to general cleanliness and frequent use of antiseptics in every form." Semmelweis died in 1865 at the age of forty-seven, and certainly until recently his name has been forgotten—if ever known—by most of us. It is now, however, proposed to erect an international monument¹ to his memory in his native town of Budapest, in recognition of his discoveries in connexion with the etiology and prevention of puerperal fever; and, for the purpose of obtaining contributions from the United Kingdom, India and the British Colonies, an executive committee has been formed, of which Sir Spencer Wells is chairman and Dr. Cullingworth honorary treasurer. The maximum subscription has been fixed at one guinea in order that the project may meet with general support. I venture to hope that this communication may stimulate some of my professional brethren to contribute.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL AND THERAPEUTICAL.

EXCISION OF THE RECTUM AND PART OF THE SIGMOID FLEXURE (TWELVE INCHES) FOR MALIGNANT DISEASE.

BY F. A. PURCELL, M.CH., M.D. R.U.I.,
SURGEON TO THE CANCER HOSPITAL, BROMPTON.

A WOMAN aged forty-six was admitted into Marsden Ward of the Cancer Hospital on Feb. 23rd, 1893. She is the mother of seven children, the youngest being five years old. She is a thin spare woman of nervous temperament and highly excitable. She menstruates regularly; the bowels are troublesome, being generally relaxed, never constipated. She suffers from pain in the body after straining. For some months she has been passing blood with her motions. About five weeks before she presented herself here she consulted Dr. Robinson of Yaxley. He made an examination and found a growth per rectum, and recommended her to seek further advice at the Cancer Hospital. On examination the sphincter was found to be dilatable, easily admitting two fingers; the folds of the intestine fell down. On insinuating the finger further up to its utmost, and on in-pressing the perineum, a hard mass was reached, the bowel and mass were freely movable and by gently drawing the parts downwards the finger passed through the diseased tube and was able to be got beyond the growth. The entire circumference was implicated and disease was more pronounced anteriorly and to the left, where ulceration had occurred. The lumen of the tube was patent, no obstruction proceeding to occlusion existing. Nothing could be made out on examining per vaginam.

On Feb. 28th she was placed on the table, having been previously prepared by having copious enemata administered and the bladder emptied. She was anaesthetised with ether by Dr. English and placed in the lithotomy position, the legs being supported by Clover's crutch. On examining the rectum a quantity of solid and liquid faeces escaped, and the bowel had to be washed out to cleanse it; I was assisted by my colleagues, Messrs. Jessett, Cotterell and Barber. My colleagues made an examination and concurred in the attempt to remove the disease by total extirpation, although it was situated beyond the usual limit very considerably. The sphincter ani was stretched but left intact, the mucous membrane, one inch inside, was incised all round, as also were the muscular and serous coats, thus freeing the bowel about one inch from the margin of the anus. The rectum was now detached from its surroundings, the posterior wall of the vagina was dissected off and stripped by means of the finger-nail and scissors; any bleeding vessel was seized with clamp forceps. At about four

and a half to five inches up, the peritoneum anteriorly was opened, which gave exit to a flow of coloured fluid. Some further attachments of the recto-sigmoid mesocolon were divided, as also other bands—a procedure which released the bowel; the part with the growth had to be gradually brought down and was delivered between the fingers. The white longitudinal bands indicating the sigmoid flexure were observed descending over the growth and spreading out upon and being lost over the upper part of the rectum. Two inches above the growth was the spot selected, where the bowel seemed well clear of the disease, and there the gut was cut across with scissors, the end was clamped with five pairs of torsion forceps, the parts were well douched and cleansed, and all the vessels ligatured; the upper end was then drawn carefully down without any tension and sutured with interrupted silkworm gut sutures to the mucous membrane at the anus. Some of the free mucous membrane, as being superfluous, was cut away, a rubber drainage-tube was lodged behind the bowel, a pad of absorbent wool was secured by a T-bandage, and a morphia suppository administered. She passed that night fairly well. The next day her temperature rose, but fell the second day after, when she passed a large motion, and up to the present she is doing well.

The measurements of the piece of bowel were taken when it was removed; the gut was afterwards placed in spirit and water and has shrunk considerably, and requires stretching to obtain the same measurement as when it was fresh. The piece removed measured twelve inches, and as one inch of mucous membrane was left above and inside the anus the gut was cut thirteen inches from its margin. From the anal extremity of the specimen to the lower limit of the disease was a distance of seven inches; the disease occupies three inches, and two inches of sound bowel shows above. The white longitudinal bands descending from the sigmoid flexure are seen running over the growth and passing down for two inches below the lower border of the disease. The bowel posteriorly, being the middle and lower portion of the rectum, is devoid of peritoneum, and is shredded where it had been peeled away from the sacrum; also anteriorly, where it had been detached from the posterior wall of the vagina. The line of the reflexion of the peritoneum is seen lower down in front than in its posterior aspect; the three inches occupied by the disease has much thickened the gut all round, being more pronounced in the front and to the left side, where it has broken down, the finger having burst through the ulceration during manipulation at the time of operation. On laying open the bowel the lumen of the tube is patent. The mucous coat is infiltrated and ulcerated, the ulceration being more extensive where the disease was most pronounced; the muscular coat is also infiltrated. The disease is cylindriciform epithelioma.

Ulceration ending in perforation would have evidently preceded occlusion, as the lumen of the tube is patent. This would have ended either by perforating into the abdominal cavity, or adhesive inflammation might have prevented this for a time by agglutinating the diseased and ulcerated portion of the bowel to some neighbouring part, possibly to some coil of the small intestine or to the uterus and vagina.

Manchester-square, W.

A CASE OF ACUTE ALCOHOLIC POISONING.

BY WM. BERRY, F.R.C.S. IREL.,
HON. MEDICAL OFFICER, ROYAL ALBERT EDWARD INFIRMARY, WIGAN.

CASES of acute alcoholic poisoning are of sufficient rarity to cause the following case to be worthy of record in THE LANCET.

A man aged thirty-three, at the time of the occurrence following the occupation of a labourer in a railway goods yard, on Feb. 11th, at 2 P.M., partook with his comrades of some whisky drawn out of some casks supposed to have been empty. He is said to have drunk between ten and fifteen ounces of the spirit. At 2.20 P.M. he was seen by a carter to go and sit on a form in the machine office in a state of drunkenness. Within a few minutes he fell to the ground in a deep sleep. This carter left him at 3 P.M., thinking that he was merely drunk and would sleep off the effects of the liquor and then go home. At 6 P.M. the carter found him in the same condition, and on the man's wife arriving to seek her husband the latter was lifted on to a form. Mr. Berry was sent for and saw

¹ A special meeting of the medical profession in aid of the movement to erect an international monument to Semmelweis was held in the library of the Royal College of Physicians on Oct. 24th, 1892, a report of which appeared in THE LANCET of Oct. 29th.—ED. L.

him about 7 P.M. He found him lying on the form with his face somewhat flushed, the pupils contracted almost to pin points, the conjunctivæ insensitive and suffused, respiration slow but regular and somewhat laboured, and the radial pulse slow and scarcely perceptible. As nothing could be done on the spot a hypodermic injection of twenty minims of ether was given, and the man was removed in an ambulance to his own house, which was not very far off. On arriving there he was placed on a couch and was found in the same state of profound coma, it being impossible to rouse him. A faint spirituous odour could be detected in the breath, and so without loss of time the stomach-pump was used and the stomach washed out with warm water. The water returned almost clear, only containing a little mucus, and had no odour of spirits. (It may be mentioned here that he had not taken any dinner that day and had eaten nothing since breakfast.) The patient was then undressed and put to bed, and another hypodermic injection of ether was given. The extremities were now extremely cold; the conjunctivæ still insensible; the pupils minutely contracted; respiration was laboured, but not stertorous; the pulse was weak and the heart sounds were very indistinct. Attempts to rouse the patient were of no avail. Hot bottles were applied to the extremities and the sides, and mustard plasters over the præcordial region, the nape of the neck and the calves of the legs. The hands and arms were vigorously rubbed, and the patient was covered with warm blankets. Another hypodermic injection of ether was given before the patient was left. On a second visit at twelve, midnight, reaction was found to have commenced: the body and extremities were warm and vesication had taken place at the left hip where one of the hot bottles had been applied. But the pupils were still contracted, the conjunctivæ insensitive, coma was quite as deep, the pulse slightly improved, and the heart sounds were still very indistinct. A hypodermic injection of atropine ($\frac{1}{30}$ gr.) was given and some hot coffee ordered for the patient as soon as he showed signs of being able to swallow. Cloths dipped in vinegar and water were also ordered to be applied over the forehead and temples. He never recovered consciousness and died at 9 A.M.

Necropsy (thirty hours after death), by Mr. FOREMAN, L.R.C.P., L.R.C.S. Edin.—The body was well nourished. There were some marks of psoriasis guttata on the left thigh and forearm. There were no marks of violence, but there was slight emphysema over the right first and second ribs at the seat of the hypodermic injection. Rigor mortis was complete. There was hypostatic congestion on the dorsum. On removing the calvaria the skull was found to be somewhat thin; the dura mater was slightly adherent and very much congested, the vessels being filled with dark fluid blood. There was no effusion of serum on the surface of the brain. On removing the brain there was no effusion at the base and the vessels were normal. On cutting into the substance of the brain it appeared healthy. There was no effusion in any of the ventricles. On opening the thorax the lungs were found to be healthy; there were slight adhesions of the left pleura, and there was very little dark fluid in the pleural cavities. The pericardium contained very little fluid. The heart was in a state of diastole; the right ventricle was empty and the valves were healthy. The left ventricle contained a small quantity of dark fluid blood; but the valves were healthy, though the lining membrane and muscular wall were of a dark chocolate colour. The stomach, distended with gas, contained a little greenish mucus. The mucous membrane had very dark patches scattered over it, but there was no corrugation. No smell of alcohol could be detected. The liver was congested. The gall-bladder was half filled with bile. The spleen was normal. The intestines were healthy. The kidneys were slightly congested; the capsule was not adherent. The bladder was healthy and contained about six ounces of urine.

Remarks by Mr. BERRY.—This case is interesting from the suddenness of the onset, the perfect insensibility, the persistent minute contraction of both pupils (as it is usually stated that in cases of alcoholic poisoning the pupils are dilated), the slowness of the pulse and the snoring respiration in contradistinction to the stertorous breathing of coma from compression, the absence of the clammy skin seen in opium poisoning, and the reaction which took place without any restoration to consciousness, together with the failure of treatment to avert a fatal issue. I have to thank Mr. Das for the notes of the case.

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.

ST. SAVIOUR'S UNION INFIRMARY, EAST DULWICH GROVE.

ULCERATIVE ENDOCARDITIS OF MALARIAL TYPE IN A
MAN WHO HAD FORMERLY HAD AGUE.

(Under the care of Dr. C. GROSS, late Medical Superintendent;
reported by THEODORE FISHER, M.D. Lond.)

THE malarial type of ulcerative endocarditis does not appear to be a common variety of the disease. Amongst the fifty-three cases recorded by Dr. F. Taylor in the Guy's Hospital Reports for 1891 there is no example, and Dr. Osler at the time of his Gulstonian Lectures had not seen a case. The latter, however, refers to cases recorded by other observers—e.g., Drs. Wilks, Bristowe, Coupland, Lancereaux, Leyden and Ormerod—and mentions that some have noted the previous occurrence of ague. Dr. Lancereaux briefly refers to a case in a young man aged twenty-five, who had contracted intermittent fever during residence in Africa, and was treated in 1860 in the Hôpital de la Pitié for a cardiac affection accompanied by a paroxysmal fever, against which sulphate of quinine remained powerless. The patient died, and his heart showed lesions of ulcerative endocarditis.¹ The same writer quotes another case in a man aged twenty-five, who seven years before had suffered from fever in Africa. About 1 P.M. in the day he had rigors followed by heat and abundant sweating. The paroxysms, although not occurring with great regularity, continued for the last three weeks of life.² Dr. Ormerod, in the Gulstonian Lectures for 1851, quoted a case that was under the care of Dr. Bond of Cambridge, in which, although no history is mentioned, the district from which the report comes is worthy of note. A gentleman aged sixty-one, suffering from heart disease, which was found afterwards to be of the ulcerative form, "had two paroxysms (rigors) recurring pretty regularly every day—viz., at 4 A.M. and 4 P.M."³ Another interesting case is recorded by Dr. Bristowe. About four months previously to admission the patient thought she caught ague whilst staying at a village in Hampshire. She was attacked by rigors with a cold, hot and sweating stage soon after her return to London. When first seen by Dr. Bristowe, seventeen days before death, rigors occurred with remarkable regularity at intervals of about twelve hours, the temperature intermitting between 95° 8' to 97° and 104° 8' to 105°. After the first four days the temperature was sometimes irregular, sometimes of the malarial type. It is possible that in this case rigors ushering in the fatal disease were mistaken for ague.⁴ Quite recently, Dr. Osler has recorded two cases of chronic intermittent fever associated with malignant endocarditis,⁵ one of which was under his own care. In this case, occurring in a man aged forty-three, there was "an undefined history" twenty years before of what the patient called "chronic malaria." The malarial type of ulcerative endocarditis doubtless does occur without a previous history of ague, as is shown by the interesting temperature chart of one of Dr. Coupland's cases,⁶ yet it is not unreasonable to suppose that when this disease has followed malaria the previous attacks of fever have had some effect upon the character of the temperature. The attacks may be supposed to have left their stamp upon the heat centres, so that when those centres were upset there was a tendency to act upon certain lines. The altered blood of the majority of febrile diseases finds it difficult to overcome the daily habit of the nervous system, but those habits having been outgrown and new paths, at least for a time, laid down when fresh but somewhat similar disturbance occurs, it is not difficult for the nervous organisation to act upon those same paths and to run to similar extremes. The following case is interesting from that point of view. Periods

¹ Archives Générales, 1873.

² Gazette Médicale, 1882.

³ London Medical Gazette, 1851.

⁴ Brit. Med. Jour., 1880.

⁵ Practitioner, March, 1893.

⁶ Medical Times and Gazette, 1882.