corresponding portion of the mesentery were congested but were not thrombosed. Having regard to the patient's great age the establishment of an artificial anus was suggested, but the anæsthetist (Mr. Bellamy Gardner) agreeing that the operation could proceed a portion of the gut $4\frac{1}{2}$ in. in length was removed, the stricture having been eased by a vertical cut directly upwards through Poupart's ligament. A Murphy's button with a diameter of $\frac{1}{16}$ in. was inserted in the usual way and all bleeding points in the mesentery were secured. The parts were cleansed with a 1 in 2000 perchloride solution and the bowel together with the mesentery was returned into the abdominal cavity through the enlarged crural opening. The sac was ligatured and cut off, the deep parts were united with a fishing gut stitch, a drainage tube was inserted between the skin and the muscular planes and the superficial wound was sewn with interrupted fishing gut sutures. The pulse was 104, regular, and stronger after the operation than it had been before it. In the after treatment nothing was given by the mouth except sips of warm water for four days; small nutrient enemata were administered every two hours and all were retained. The patient passed a large stool from the lower bowel during the night after the operation. Two days after the operation flatulence became troublesome and great relief was obtained from turpentine enemata. The drainage-tube was retained for two days. The superficial wound suppurated for a while owing to contamination by the fluid in the hernial sac at the time of the operation. Hypostatic congestion set in at the bases of the lungs ten days after the operation. The patient suffered from colicky pains and some localised tenderness in the right iliac fossa which was worse at some times than others and these were complained of until the button was passed on the thirtieth day after operation. She left the hospital five weeks after the operation. I visited the patient at her home on Jan. 19th, 1898, and found that the wound was sound, that there was no sign of hernia on coughing, that the bowels were acting quite regularly and without pain, and that beyond the fact that she was seventy-eight years of age she had nothing to complain of.

I believe that the pain and tenderness in the right iliac fossa noted in the above case were caused by the button's passage being obstructed by the ileo-cæcal valve. That the button might be in the rectum was put out of court by examination for it in that situation. With regard to the division of Poupart's ligament, as Ball has pointed out, this does not weaken the abdominal wall any more than an incision in any other part of the abdomen. In the above case the soundness of the wound at the present time bears out this statement. Resection through the original wound presents less risk of infection than the plan practised by some surgeons of opening the abdomen and drawing the gangrenous bowel from the crural canal across the peritoneal cavity and resecting through a second wound. The great age of the patient is the most remarkable feature in the case. I am indebted to Mr. Bloxam for permission to publish the case and also to Mr. Morgan for permission to mention a recent case of his by way of illustrating a point in this paper.

Charing-cross Hospital.

LLANELLY HOSPITAL.—Owing to the resignations of the nursing staff at the Llanelly Hospital the committee of that institution has decided to temporarily close the hospital except in cases of serious accidents.

THE NEUROLOGICAL SOCIETY OF LONDON.—This society held its first meeting out of London on April 23rd, when, at the invitation of Dr. Alexander Hill, vice-Chancellor of the University, a meeting was held in the Physiological Laboratory at Cambridge. The following communications were made:—Dr. Alexander Hill: Some Specimens of Granules (demonstration).—Professor MacAlister: The Race-characters of Australian Brains (demonstration).—Dr. J. N. Langley: Some Points relating to the Sympathetic System (demonstration).—Dr. Gaskell (for Miss Alcock): The Distribution of the Facial Nerve in *Ammocetes*.—Dr. F. E. Batten: (1) Nerve Terminations in Muscle Spindles (demonstration); and (2) (for Dr. Sihler of Ohio), Motor Nerve Termination within the Muscle Spindle (demonstration).—Dr. Mott: Degeneration of the Neuron (demonstration). At the conclusion of the meeting members and visitors were entertained at dinner by the Vice-Chancellor in Downing Hall.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTES ON FOUR CASES OF PUERPERAL ECLAMPSIA.

BY G. FOWLER, L.R.C.P. EDIN.

CASE 1.—The patient was a married woman, aged eighteen years, eight months pregnant with her first child. There was no neurotic family history. The patient enjoyed perfect health till the day before I was sent for. She then complained of giddiness and flashes before her eyes and voided a very small quantity of urine which coagulated into a semi-solid muddy-looking mass. When I arrived at the house in the morning she had passed a restless night and complained very much of "slight twitches" (spasmodic contractions) of her hands and feet. I gave her full doses of chloral and applied mustard sinapisms to her calves. Two hours after I was hastily summoned as she had had a general convulsion and was quite unconscious. I found her in a violent general epileptiform seizure, having bitten her tongue rather severely. I tried to prevent her from further damaging her tongue by means of a gag and at once administered chloroform and kept her under its influence for nearly half an hour. As long as she was under the anæsthetic no convulsion existed, but as soon as its effects had passed away the fits came on again at regular intervals. As a last resource, considering the gravity of the case, with the consent of those most interested in her, I induced premature labour, dilating the os by means of Hegar's dilators and Barnes's bags, and when the os had fully dilated ruptured the membranes and delivered her with Simpson's long forceps. The whole operation lasted some time but was to my entire satisfaction. The child was stillborn. After delivery the mother had one severe convulsive seizure and from this time all proceeded well, the patient gradually recovering consciousness but having no recollection of what had occurred for some hours previous to or during labour. Since then I have delivered this patient of her second child, a healthy male, which presented in an occipito-posterior position.

CASE 2.—The patient was a married woman, aged twenty-one years, seven months pregnant with her first child. I was hurriedly summoned to see her as she had had a number of fits and was quite unconscious. When I arrived I found that both the upper and the lower extremities were very much swollen and oedematous. Urine had not been voided for twenty-four hours. Digital examination revealed an almost fully dilated os, a roomy pelvis, a cranial presentation, and the membranes intact. Fearing the onset of further convulsions I at once ruptured the membranes and awaited the result. This increased the uterine contractions, but unhappily while the head was rapidly descending a severe convulsive attack came on resembling an epileptic fit and this seemed to stop the further progress of the labour. This convulsion was soon followed by another, the fits occurring at regular intervals. As the head appeared to me to be acting as an irritant by its pressure, and being also well within reach, I resolved upon instrumental delivery and delivered the patient without any difficulty of a living male child. The placenta followed rapidly. The patient had no more fits, passed urine eight hours after the birth of the child, and progressed favourably, the urine remaining albuminous for about three days. Both child and mother are now doing well.

CASE 3.—This patient resembled Case 1 in every respect. I treated her in the same manner and was successful in delivering her of a living child. Both mother and child progressed favourably.

CASE 4.—The patient, a rather anæmic young woman with a good previous history, was taken in a fit four days after the birth of her first child, which was born without the aid of a medical man. The temperature was normal and the lochia were healthy. The urine was albuminous. There was no rupture of the perineum. The fits occurred at regular intervals and the patient remained in a semi-comatose state between them. I gave her full doses of chloral by the

rectum and administered chloroform and injected pilocarpine hypodermically. This treatment benefited the patient, especially the administration of chloroform, which kept the seizures well under control. She had no convulsive seizures for about a couple of hours after the administration of chloroform had been stopped. I then left her to see another urgent case and returned just in time to see the patient in a violent general convulsion in which she died (probably asphyxiated).

Certain points are worthy of note in these cases: (1) the disregard the majority of patients pay to the premonitory symptoms, sending for medical aid only when the eclamptic seizures come on; (2) the value of instrumental delivery and the induction of premature labour in certain cases of puerperal eclampsia; (3) the value of chloroform in controlling the fits; (4) the appearance of albumin in the urine of all four patients and its complete disappearance three or four days after delivery in the first three cases; and (5) the fact that all four patients were primiparae.

A CASE OF SPASMODIC DYSPNOEA.

By J. E. S. BARNETT, F.R.C.S. ENG.

THE patient in the present instance was a male child who soon after birth began to suffer from attacks described by his mother as "grunting and blue all over." When he was three and a half months old I saw him and learned that the fits were becoming more frequent and enduring. His breathing was laboured, with suprasternal and subcostal recession during respiration, locomotion of the larynx, and action of the nares. During an attack these symptoms were intensified and in addition cyanosis became marked in the lips, face, and finger-nails. In the intervals there was free but noisy entrance of air into both lungs. The temperature was 97.8° F. in the groin, the heart sounds were normal, and the apex was in the natural position. The child was unusually fat and big for his age and he took his mother's breast well. The fits became more severe, threatening dissolution, and the mother was anxious that something should be done. Treatment by hot fomentations and by a steam-kettle under a tent proved useless. Papilloma and spasmodic catarrhal laryngitis were thought of as possible conditions. Tracheotomy was performed on March 17th, 1898, the infant being then four months old. No difficulty was experienced except in the introduction of the tube; the smallest vulcanite was used. There was no marked immediate relief, but next day the breathing was less laboured, and although the fits persisted the cyanosis was lessened and for the next day or two was absent. No oedema, emphysema, or suppuration occurred about the wound and the child's condition improved; his temperature remained normal throughout except for a rise to 100° on one evening. When the vulcanite tube was removed it was replaced first by a Parker's and afterwards by a Marrant Baker's rubber tube. Three weeks after the tracheotomy the child suffered from a prolonged attack of dyspnoea, became gradually more and more cyanosed, and eventually died. At the post-mortem examination it was found that the thymus gland was enlarged and that outlying lobules of gland tissue extended well into the root of the neck. Perhaps the recurrent laryngeal nerves were irritated and set up spasm of the larynx which the tracheotomy relieved, but the gland still growing caused direct and fatal pressure on the trachea. From the appearance of the parts when the deep fascia was divided this pressure must have been considerable. There was neither ulceration of the trachea nor papilloma of the larynx.

Paddington.

A CASE OF SHINGLES OCCURRING PRINCIPALLY ON THE SCAR OF A BURN.

By HERBERT FREDERICK, L.R.C.P. LOND., M.R.C.S. ENG.,
LATE ASSISTANT HOUSE SURGEON TO THE HOSPITAL FOR SICK
CHILDREN, GREAT ORMOND-STREET.

THE patient in this case was a boy, nine years of age, who came under my care on Dec. 6th, 1897, for well-developed shingles on the left side of the trunk. On Nov. 22nd, 1893, he had an extensive burn on the left thoracic and abdominal regions, owing to his nightshirt catching fire. He was treated as an in-patient at St. Mary's Hospital for eight

weeks. When I first saw the patient I was informed that twelve hours previously—i.e., about 9 P.M. on the previous evening—he had suffered from great pain in his left side which was so severe as to make him scream and to keep him awake during the early part of the night. On examination I found that he was a well-nourished boy with an extensive scar on his left chest, side, and abdomen. The skin was puckered and reddish in colour, with bands of thick fibrous tissue running in all directions. He was suffering from typical shingles on the left side. The rash started from the tips of the eleventh and twelfth dorsal and the first lumbar vertebrae and was continued round the left side in a band varying in breadth from 1½ in. to 3½ in. The greater part of the rash was on the site of the scar, though several groups of vesicles were present on the otherwise healthy skin. Two or three spots were on the right side of the middle line both in front and on the back. The rash presented nothing atypical; it was confluent in places and pain of a neuralgic character was present with considerable intensity. The child seemed to be poorly and his appetite was bad. His mother told me that he had been "out of sorts" for the last few days. During the nights of Dec. 6th, 7th, and 8th he could only sleep lying on the left side—the side of the lesion. The treatment consisted in protecting the side with absorbent wool and in giving tincture of perchloride of iron internally; 3 grains of calomel were given on the nights of the 6th and 7th, followed for a week afterwards by 3-grain powders of mercury with chalk at bedtime. The disease ran the usual course and recovery took place without any unusual symptoms. The neuralgic pain disappeared completely on the 10th.

The interest of the case seems to lie in the following points. It is not often that one comes across a case of shingles occurring on the site of such an extensive burn. Personally I have never seen one before, nor have any of my medical friends to whom I have detailed the case. From the nature of the scar it is evident that the skin over the burnt area must have been pretty thoroughly destroyed down to the deeper layers of the dermis and consequently the nerve terminations must have been destroyed too. The few spots occurring on the right side of the median line both on the back and front demonstrate very prettily the overlapping of the nerve-supply in those regions. This point is noted by Fagge,¹ but the case negatives his assertion that "pain of a neuralgic character is entirely absent in young patients." The mother put the child to bed herself and is certain that no spots were present—in fact, until the morning she thought the pain was due to pleurisy.

Queen's Park, W.

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.

SEAMEN'S HOSPITAL, GREENWICH.

A CASE OF TRAUMATIC TETANUS TREATED BY ANTITOXIN ON THE SEVENTH DAY AFTER INJURY; DEATH.

(Under the care of Dr. CURNOW.)

ON several recent occasions we have published in "The Mirror of Hospital Practice" reports of cases of tetanus in which the antitoxin has been employed and we gladly print the following cases as it is advisable that as many of these cases as possible should be put on record, for the value of tetanus antitoxin is still debateable. We would not suggest that the antitoxin has no controlling power over the disease for its efficacy in this respect has been abundantly established, but it cannot be said that at present we are in any degree certain of the frequency with which the antitoxin should be given or even of the most suitable dose for any given case. Cases of tetanus vary

¹ Fagge and Pye-Smith: Text-book of the Principles and Practice of Medicine, third edition, vol. ii., p. 939.