particularly well and artificial respiration had to be employed for about 20 minutes after she had been put back into bed; she also had a good deal of after-sickness.

As regards the progress of the case so far as the operation was concerned everything went on well and the wound healed by first intention and no pain was complained of, but on the 11th, nine days after the operation, the patient began to spit blood, not in very large quantities but frothy and bright red in colour. The expectoration was very viscid and tenacious but not rusty. There was no rise of temperature and she did not complain of feeling ill though she was naturally a good deal alarmed at seeing the blood. On the 13th she complained of vague pains in the right shoulder and side. On auscultation nothing abnormal could be detected and as the pains were not constantly in one place but shifted about, being alternately worse in one situation and then in another and not always being limited to the right side, I put them down to either muscular rheumatism or else intercostal neuralgia. This condition of things continued till the 27th, the hæmoptysis being constant, though the blood varied at times in colour from a bright red to a very dark purple—almost black. On the 28th I discovered well-marked signs of pleurisy on the right side and there were pain on breathing and coarse crepitations showing that the pleurisy was of the moist variety. The pain was relieved by a linseed-and-mustard poultice. Leeches were suggested, but the patient absolutely refused to allow the nurse to put them on. Night sweats now supervened and continued till March 7th, on which date they were so severe that the nurse had to change the patient's clothing three times during the night. The pulse was very rapid (about 120) and remained at this rate for about 10 days; the temperature rose to 102° F. on the night of the 7th. On the 8th there was effusion of fluid into the right pleural cavity, the fluid reaching almost to the level of the spine of the scapula and the physical signs were well marked. This was the only day on which the patient was distressed to an alarming extent and 18 ounces of perfectly clear fluid were withdrawn by aspiration, after which she was much relieved. Directly after the removal of the fluid there was marked tubular breathing to be heard at the inferior angle of the scapula. The temperature dropped to nearly normal and only once again rose above 100°, in fact it was after this date nearly always subnormal. Sir R. Douglas Powell and Dr. Whipham very kindly saw the patient on two or three occasions both before and after the tapping and came to the conclusion that it was a case of pulmonary embolism. On the 13th there were vague pains behind the left scapula similar to those experienced on the right side, but fortunately they disappeared and nothing developed. About the 20th a fresh feature manifested itself—severe pain in the region of the bladder after micturition. The urine was examined and was found to be very faintly acid with a distinct trace of albumin and a little mucus. The pain was relieved by hot fomentations. A small fissure at the anus was also discovered at this time. The hæmoptysis gradually subsided and the right lung slowly returned to its normal condition. Breath sounds were audible at the extreme base, though there was still dulness present. On April 15th the patient went to Bournemouth and the last I heard of her was that she was practically well and able to take walking exercise, which she had not been able to indulge in with any degree of comfort for some time previous to the operation.

There are a few points of interest connected with this case to which I may perhaps be allowed to refer. In the first place as to the diagnosis: the hæmoptysis, night sweats, rapid pulse, and the family history, led me, I must own, to regard the case at first as one of tuberculosis, though it must be acknowledged that there was no rise of temperature before the pleurisy manifested itself, neither could any signs be detected in the lungs, nor any tubercle bacilli in the sputum, which was carefully examined on three separate occasions. Another view was to make the ether the scapegoat, for it was thought that this might possibly have set up congestion at the bases of the lungs, but taking into account that there was no hæmoptysis till nine days after its administration, and the fact that when there was hæmoptysis the blood was bright-red in colour and not dark as might have been expected if it had been poured out at the time or soon after the operation, this view was put out of court. The only cause left was pulmonary embolism due to a clot being washed up from the seat of the operation as there was no evidence of morbus cordis present. A curious circumstance

was that at no time were there any very urgent symptoms such as one usually meets with in cases of this nature. There was no sudden onset and the only time that the breathing was at all embarrassed was when there was a collection of fluid in the pleural cavity, and it was at once relieved by the removal of the fluid. Another point not in any way connected with the lung trouble was the severe bladder pain, and I must own that no very satisfactory explanation of this seems to be apparent. The urine was very faintly acid, so it could not have been due to the presence of an excess of uric acid.

As regards the treatment adopted there is nothing special to note, it being that usually employed in these cases and the symptoms were treated as they arose. There was a good deal of pain complained of when the lung began to expand and this was relieved by the application of blisters. Hyoscyamus with Vichy and Contrexéville waters were used for the bladder trouble. I should be very glad of any suggestions as to the cause of this bladder pain, as it may arise again, and unless a cause can be found which either could be removed or could give some indications as to the line of treatment the ultimate result may be unsatisfactory not only to the patient but also to the medical attendant.

Seymour-street, W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF SUDDEN EXTRUSION OF UTERINE FIBROID SIMULATING INVERSION OF UTERUS.

BY EDWARD MALINS, M.D. EDIN.,

PROFESSOR OF MIDWIFERY, MASON UNIVERSITY COLLEGE; OBSTETRIC OFFICER TO THE GENERAL HOSPITAL, BIRMINGHAM.

ON June 21st, 1899, at 1.30 A.M., a woman was admitted into the General Hospital, Birmingham, with a note from a medical man stating the case to be one of inversion of the uterus. The patient was in a collapsed condition; she was very pale, her face was pinched, her lips were exsanguine, and the body surface was cold. There was vomiting. The pulse was very rapid and small with severe pain in the lower abdomen. On examination a large mass was seen between the thighs protruding from the vagina. She stated that in straining to pass urine this had suddenly appeared with intense pain, loss of blood, and fainting. A medical man was sent for who advised her removal to the hospital at once. The mass was large, oblong shaped, from some seven to eight inches long, about four inches in diameter at the widest part, narrower at the distal end, and about two inches in diameter at its attachment just within the vagina. It was congested-looking in appearance, dark red, with bluish patches; it was smooth and moist to the touch; the consistence was firm and unyielding. The finger of one hand pushed well up the rectum and the fingers of the opposite hand over the pubes could be approximated. The point of a sound introduced into the bladder could also be felt through the rectum. Posteriorly to the attachment within the vagina low down a small aperture was found after some search; into this a sound was directed to the extent of two and a half inches, sliding behind and above the attachment of the pedicle. The conclusion drawn was that the mass was a large fibroid derived from, and obliterating, the anterior lip of the cervix and dragging the uterus tightly down into the lower part of the vagina. Immediate removal was decided upon. The patient was placed under ether and a transverse incision was made across the base below the bladder and a similar one posteriorly; bleeding which was free was arrested by pressure forceps and tying vessels on progress; the base was dissected away and the mass was removed; the edges of the respective incisions were brought together by silk sutures; the vagina was washed out with a 1 in 2000 perchloride of mercury solution and packed with iodoform gauze. The growth weighed 2 lb. 6 oz. It had the characters of an œdematous fibro-myoma, with some extravasations of blood in places and here and there in the interior some small cysts filled with colloid-looking material.

The patient made good progress and was sent to a convalescent institution on July 8th.

Subsequently to the operation the following history was elicited. The patient was 47 years of age and single. Some two years ago she had retention of urine following a strain. She stated that she did not pass urine for three days, when 86 ounces were taken away by catheter. On another occasion 66 ounces were removed. Since that time she had used a catheter herself for attacks of retention. The menstrual periods had lately become more frequent and more profuse, with irregular discharges of blood, but none of any other kind. In July, 1898, she first noticed a "swelling" inside which seemed to come down on straining to pass urine or in having the bowels moved. She then attended a hospital in London and was advised to wait before anything could be done. She had had little pain except when the attacks of retention occurred. Her general health had been feeble but she continued at work as a servant.

The case is interesting as showing how so large a growth may exist without active treatment and with comparatively little distress and the sudden onset of symptoms necessitating immediate removal. The differential diagnosis in these cases appears to rest not so much upon the question of inversion as upon inversion complicated with attached fibroid—a much more difficult connexion in some cases to decide clearly. It is not common for growths of this kind to develop from the cervical lip; generally they are extruded from the interior of the uterus. Certain localised growths of the uterine walls I believe sometimes alter their position. It would be interesting to ascertain if, originally arising in the uterine wall, the direction and development could be made towards and through the substance of the cervix.

Birmingham.

A CASE OF HERNIOTOMY IN A SEPTUAGENARIAN FOLLOWING IMMEDIATELY ON AN ATTACK OF HYPOSTATIC PNEUMONIA.

BY T. WILSON PARRY, M.A., M.B., B.C. CANTAB.

ABOUT Nov. 22nd, 1898, I was sent for to see a widow, 74 years of age, who, her friends told me, had been ailing for some days and had been obliged to take to her bed. I found her breathing heavily and looking very ill. I examined her carefully and discovered on putting my ear to her back râles over both chests and on percussion there was definite dulness over both bases. I write these facts from memory, as I took no notes of the case, considering them at that time to be unimportant and uninteresting from a recording view-point. Her temperature, as far as I can remember, never mounted above 103° F. I need hardly state that I at once propped her up in bed and I prescribed for her a mixture containing ipecacuanha wine, carbonate of ammonia, and tincture of cinchona. One feature of interest was attached to this part of the case—viz., she refused food. I had recourse, therefore, to what I have found to be of great advantage in country practice among villagers who become stubborn on this point. I have frequently noticed that when an old person falls sick the sympathising friends and relations consider it an unkind thing to trouble the patient to take food if it is not wished for; consequently, in some instances, a patient's friends do their best, quite unconsciously, to starve their unfortunate relation to death. Happily, however, for the patient in question I was called in in time. I insisted that if she did not take her food by the mouth she should have it by the rectum. Upon this the patient made the required effort and took that amount of food and stimulant which I considered necessary for her in the orthodox manner, and eventually, after some weeks of patient watching and nursing, she slowly got better. On Jan. 8th, 1899, I called upon her and found her so far improved as to be able to say that I thought it unnecessary for me to see her again but that she was to let me know at once if she were not so well. On the very next day, at about 9 P.M., I was sent for urgently as the patient was in great pain. I went at once and to my astonishment found that she had got a strangulated femoral hernia on the right side. She had been sick several times and she had great pain in the right groin. I tried careful taxis but failed to reduce the hernia. There was no ice to be had in the place, so I had to content myself by filling an ice-bag with cold water, raising the foot of the bed

and applying the ice-bag to the groin, relieving her of its weight as far as possible by slinging it from a fixed point above. As I was single-handed I despatched a messenger for medical assistance and Dr. Knox of Bakewell kindly came over and gave chloroform for me. After repeating taxis under the anæsthetic and again failing I cut down, incised Hey's and Gimbernat's ligaments, and reduced the rupture without opening the sac. In the after treatment I was, of course, obliged to keep the patient propped up in bed during the whole time to avoid a relapse of the hypostatic congestion, and I am glad to say that she made a very satisfactory though somewhat tardy recovery. The point of interest in this case is that a woman who had passed the proverbial "three score years and ten" should successfully survive two such serious illnesses, either of which was easily sufficient to cost her her life, and the fact of the one following so immediately in the wake of the other with such excellent results makes it, to my mind, doubly interesting and satisfactory.

Youlgreave.

A FOREIGN BODY IN THE RECTUM.

BY JAMES S. MARTIN, M.B. EDIN., M.R.C.S. ENG.,
HOUSE SURGEON, ROTHERHAM HOSPITAL.

THE presence of large foreign bodies in the rectum, though not very uncommon, is sufficiently so to warrant a brief notice of such a case when it occurs.

A patient who was admitted into the Rotherham Hospital on July 9th, 1899, stated that he had a glass bottle in the rectum which had got fixed there when he had sat upon it. On examination the base of the bottle could be felt by the finger in the middle part of the rectum. It lay with the base in the hollow of the sacrum and was freely moveable. The top could be felt to impinge upon the sacral promontory. It did not convey to the finger any impression of its true size and one or two ineffectual attempts were made to remove it without an anæsthetic. Afterwards chloroform was given and the bottle was extracted with midwifery forceps as it was too large to allow of its being brought through by the hand. It was a thick glass bottle three inches in height, with a circumference of six inches and a diameter of two inches. The neck of the bottle was conical. The patient went home on the next day feeling quite well.

The true history of the case would appear to be that the patient had been intoxicated in the presence of five or six friends who had inserted the bottle as a practical joke.

I am indebted to Mr. Lyth, under whose care the patient was, for permission to publish the case.

Rotherham.

BRITISH DENTAL ASSOCIATION.—The annual meeting of the Western Counties Branch of the British Dental Association was held at Weymouth on July 21st and 22nd. The President, Mr. W. A. Hunt, L.R.C.P. Lond., M.R.C.S. Eng., delivered an interesting address and papers were read by Mr. Thompson, Mr. Taylor Genge, and the President. The report showed that the members now numbered 83 and that there was a favourable balance of £24. The annual dinner took place at the Royal Hotel in the evening. On July 22nd there was an excursion to Sherborne Castle. It was decided that next year's meeting should be held at Bristol and Mr. H. Helyar of Yeovil was nominated as President.

MEDICAL FEES UNDER THE POOR-LAW.—At a recent meeting of the St. Germans Board of Guardians (Cornwall) it was stated that Mr. Gill, the medical officer of the St. Germans district, claimed £5 for attendance upon a parish patient. It appeared that the patient was a member of a friendly society of which Mr. Gill was the surgeon and that he suffered from a compound fracture of the leg. During the illness the man became a parish patient, receiving parish relief, and as he resided in Mr. Gill's district the extra fee was claimed. A considerable discussion arose as to whether the club or the guardians were liable for the medical attendance, as the surgeon had received no order from the relieving officer to attend the man. The guardians eventually decided by 13 votes to 11 to pay the fee.