clinical experience here was the same as at the Moabit—namely, that severe cases of cholera nostras were clinically identical with mild cases of Asiatic cholera, and that they could only be separated by bacteriological investigation. An important part of the work done in this laboratory was the examination of intestinal discharges and of soiled clothing sent from other places. According to Dr. Kossel's published figures,⁴ forty-two such were examined, and of these nineteen gave the comma bacillus by culture. Fæcal matter and clothing were often received after having been treated with antiseptics, which of course prevented their thorough examination. I have seen there the most perfect cover-glass preparations of comma bacilli taken from the fæcal soiled clothing sent to the laboratory.

With reference to the investigation of the intestinal discharges I may say a word. The presence of comma bacilli may be demonstrated by cover-glass preparations made from the discharges, but this is not accepted as sufficient; plate cultures are made, and on these the characteristic colonies of Koch's comma bacillus are distinguishable under a low power in about twenty-four hours or even less, and, if further proof is required, stab-cultures can be made from the colonies and the changes effected in the nutrient gelatine followed. (These were demonstrated to the Society.) The length of time during which the comma bacillus was present in the discharges was followed in a small number of cases in the Moabit Hospital, with results varying from five to ten days. At Koch's Institute the number of Asiatic cases was too small to base any conclusion upon, but when I was there every motion passed by the Asiatic cases was examined by plate cultures.

With reference to Hamburg, which I also visited, the impression I got was that there had been too many patients to attend to for the staff to spare much time for bacteriological investigation; still, there they told me they had always found the comma bacillus. The experience gained and the observations made in Hamburg will, I trust, be published. One of the assistants at the Eppendorf Hospital had made five hundred necropsies on cholera cases by the time I was there, and such a series of cases could not fail to add to our knowledge even as regards naked-eye appearances.

A word or two may be said with reference to treatment. At the Moabit they tried salol and creolin and tannin injections with no satisfactory result. Calomel was used both in Berlin and in Hamburg, but I am not in a position to speak of the results. What impressed me most at the Moabit, in the old general hospital at Hamburg, and in the new one at Eppendorf was the reliance the staff had on saline injections, and the confidence with which they spoke of them and the absence of risk which attended the operations. At the Moabit Hospital Dr. Guttman believed strongly in the subcutaneous introduction of the saline fluid, in Koch's they believed in its intravenous introduction, and in Hamburg I think they had used both methods. The apparatus used was an exceedingly simple one, but great care was taken to have everything properly sterilised. It is needless for me, to dwell upon the practical significance of the acceptance of Koch's comma bacillus as the cause of Asiatic cholera—it has made the disease a more tangible and comprehensible entity; it has shown how water, food, and clothing are infected and become the vehicles for spreading the disease; and in doing so has shown how it is possible to check and to arrest it, and, best of all, to prevent it. With Europe threatened by such a plague we place a higher value on this portion of Koch's work, and we place it amongst the great discoveries.

Edinburgh.

⁴ Ibid.

PREVENTION OF CHOLERA.—At the Thames Police court this week a captain in the employ of the General Steam Navigation Company was summoned at the instance of Dr. Collingridge, medical officer to the Port of London, for wilfully neglecting to carry out certain of the cholera regulations provided by the Public Health Acts. Dr. Herbert Williams gave evidence in support of the charge. Mr. Gill represented the defendant and said the company were very anxious in every way to carry out the Order in Council, but thought an attempt was being made to saddle their captains with responsibilities they were not bound to undertake, and therefore the time had come to offer resistance. The magistrate said the case was not free from difficulties; yet, having allowed the passengers to land, the captain had taken full responsibility for the consequence, and would be fined £25 and costs.

Clinical Notes : MEDICAL, SURGICAL, OBSTETRICAL AND THERAPEUTICAL.

NOTES ON "NORMAL INTERMITTENT UTERINE CONTRACTIONS OF PREGNANCY."

By J. D. WINDLE, L.R.C.P.I., L.M. DUB., M.R.C.S.

DR. PLAYFAIR, in his work on Midwifery,¹ quoting Dr. Braxton Hicks's paper in the Obstetrical Transactions,² states that "intermittent contractions of the uterus are constant and normal concomitants of pregnancy, continuing during the whole period of utero gestation. The contractions occur every five or ten minutes, sometimes oftener, but rarely at longer intervals. If the hand be kept steadily on the uterus its alternate hardening and relaxation can be appreciated with the greatest ease."

The following case illustrates the fact that these contractions are not, as is usually the case, always painless; indeed, in some instances that have come under my notice the contractions have been such as would lead one to infer that premature labour was about to take place. The first case of this kind I have noticed occurred about three years ago, when I was consulted by a woman in the seventh month of pregnancy for what she described as "cramp in the stomach," and from which she had suffered more or less for some time. Suspecting premature labour was about to occur I visited her at her home, when on palpating the abdomen I found the uterus contracted, and from this I concluded that labour had commenced. The pains continued for about two months, more or less modified by treatment up to the time of actual labour at full term. I may mention that my patient was in good health and that her previous pregnancies had been normal. Remembering the fact of the occurrence of painless intermitting contractions, I concluded that the case was a modified form of the normal state of things—viz., painful instead of painless contractions. Before the termination of pregnancy I had many opportunities of verifying the opinion I had formed. In this and subsequent cases, so far as I could make out, the contractions had no effect on the os or cervix, but the membranes became somewhat, but not markedly, tense. Since then I have noticed many similar cases, but in only one where the painful character of the contractions continued for any considerable period. In this case, also a multipara, they occurred regularly from Jan. 27th, 1892, to Feb. 15th, during which time I visited her every day. Delivery took place on March 2nd. It is a very common experience to meet with cases of threatened abortion and early miscarriages where pains constitute the only symptom, but which subside after a time without anything being expelled from the uterus, and for labour to take place at the full term of utero-gestation. I believe that many of these cases are examples of the painful instead of the normal painless intermitting contractions of pregnancy. If such be the case we have an explanation of the fact that it is rare for abortion or miscarriage to occur when pain is the only symptom.

Southall, Middlesex.

A CASE OF DOUBLE INTUSSUSCEPTION.

By DUNCAN J. CADDY, M.B.

A FEMALE infant aged five months had a very severe fall on Friday, Nov. 21st, 1892. A few hours afterwards she began screaming loudly and appeared to be suffering great pain. The parents administered a powder and afterwards a dose of castor oil, with the result that the infant vomited freely, but nothing was passed per rectum. Next day the child still appeared to be in pain, but took a little milk, and the parents again administered an aperient powder. This caused more vomiting, but still no action of the bowels. On Sunday the child became cold and appeared very ill. On Monday at 8 A.M. the child, after much straining, passed a little bloody mucus per rectum and I was sent for. On arrival I found the child in a state of

collapse, the skin was bathed in a cold sweat and the eyes sunken. The abdomen was tympanitic, the pulse 200, the temperature 103.5° F., and the infant was vomiting stercoraceous matter. Examination per rectum revealed nothing. Upon palpating the abdomen, however, a short, thick, sausage-shaped tumour could be distinguished over the cæcum. It was clearly a case of intussusception, and the child died four hours later. The post-mortem examination revealed an ileo-cæcal intussusception about four inches in length, which had again become invaginated in the bowel further on, thus forming five complete layers. It is only for me to add that the child was well nourished and otherwise healthy, and that, the symptoms setting in almost immediately after the fall, it would appear as though this must have had some direct influence in causing the double intussusception; but I leave this for the consideration of others more experienced than myself.

Earl's Court-gardens, S.W.

HÆMATOMA AURIS.

By E. ROUSE ROUSE, M.R.C.S., L.R.C.P. LOND. &c.,
ASSISTANT MEDICAL OFFICER, COLNEY HATCH ASYLUM.

HAVING collected a few notes on hæmatoma auris or insane ear, I should be glad of their publication in THE LANCET, in the hope that they may be of some interest to medical men, especially those connected with lunacy. I will first take into consideration the class of case in which the insane ear is most common. I think that cases of acute mania and general paralytics in the maniacal stage produce most examples of this class; those of chronic mania with recurrent attacks are also at times sufferers. As to which ear is oftenest affected my own observations differ from most observers, in the fact that the right ear has been most often diseased. If this is really the case, the theory that the flow of blood from the heart to the left side is more direct, and that there are fewer ramifications of the branches of the carotid arteries on the left side, will not hold good, as it is. I believe, generally known that the arteries on the right side anastomose much more freely. The cause of the swelling of the ear or ears is often very difficult to elicit, but I have little doubt that violence of some kind is the usual cause, and this need only be a slight rub or knock to produce the swelling. As an element in prognosis it is very valuable, as no doubt cases in which it occurs generally, but not always, end fatally; this is especially the case in double insane ear. I have also noticed that a fatal termination is much more rapid in these than in other cases. The treatment by blistering is no doubt very valuable in many patients, but I have seen several upon whom it has had little effect either in decreasing the swelling or preventing the after disfigurement. Again, is the disease so uncommon in sane people as is generally believed? My own experience teaches me that it is not, as amongst athletes, especially football players of the Rugby game and boxing men, it is fairly common. I know eight cases in which it occurred; in one the patient had the remains of double insane ear. This also, I think, will assist to prove that violence in some form is the most common cause, as undoubtedly in athletes the swellings can be traced to a blow or rub of some sort. I have not been able in some to discover the degeneration of the arteries which has been stated to so frequently occur, but no doubt this is very often seen, and the rupture of these degenerated vessels is the immediate cause of the swelling. In conclusion I may say that patients of the upper classes are more prone to the disease than the lower classes, at least we generally see many more cases in private asylums than county asylums; but the cause of this is difficult to understand, and perhaps many with more experience than myself will doubt this last assertion.

Colney-hatch, N.

METHOD OF FIXING PATIENTS FOR OPERATIONS UNDER ANÆSTHESIA IN THE SITTING POSTURE.

By DUNDAS GRANT, M.A., M.D., F.R.C.S. ENG.

FOR many of the shorter operations on the mouth, throat, nose and ear it is very desirable to have the patient in the position in relation to light, attitude &c., in which examinations are habitually made. At the same time the sitting posture has many inconveniences for the administra-

tion of anæsthetics, and chloroform is practically inadmissible. Ether, however, as Dr. Silk has said, may be given with comparative security, and nitrous oxide without any anxiety whatever. Several years ago I demonstrated at the Central London Throat and Ear Hospital the possibility of removal of tonsils or adenoids, or even both, during the administration of nitrous oxide, and my colleagues were not slow in adopting a practice which in that institution has now become a matter of daily routine. Hitherto one great difficulty has been the tendency of the patient to slip off the chair at the moment when the anæsthesia becomes complete, and to have recovered consciousness by the time he is "collected" and propped up again. To prevent this accident the following simple method of fixation is recommended. A short jack-towel with the seam unstitched is placed round the back of the patient's neck like a priest's stole, with the ends hanging down in front. Each of these ends has firmly attached to it about two feet of soft, thick cord or thin rope. He is then seated on a chair which has a very narrow, high back, on the posterior surface of which, and at about the height of the patient's head, there is a stout upright hook. The middle of the jack-towel is raised off the patient's neck, lifted over the back of the chair and laid on the hook. The two ends are then brought backwards under the armpits and round the back of the chair. The ropes are then crossed over the hook and tied in a bow. The patient is thus simply, securely and "unalarmedly" fixed so that he cannot slip down. A band may be placed round the forehead to keep the head fixed, but this is most effectively and pleasantly done by the hands of some one standing behind. At the same time the patient can be instantly released by the simple pulling of the ends of the ropes forming the bow.

Upper Wimpole-street, W.

SUDDEN DEATH, WITH NECROPSY, SHOWING RUPTURE IN THE INTERNAL ILIAC ARTERY.

By J. A. EWAN, M.B. EDIN.

THIS case is interesting not only in itself, but also because it well illustrates the importance of holding a post-mortem examination in every case of sudden death before granting a certificate.

A man aged fifty-three was a patient in the Dorset County Asylum for twenty-two days, and previously for two months in the County Hospital. On admission into the asylum his case was at once diagnosed as one of general paralysis, with absolute dementia, tottering gait &c. For some days there was no change in his condition, but on the eighth day he had a series of epileptiform convulsions, which continued until the following morning. After these convulsions ceased he was in a very helpless state, but they did not return until the evening of the twenty-first day, when they again commenced and continued until three o'clock in the morning of the twenty-second day. At a quarter to four his breathing suddenly became stertorous and a quarter of an hour afterwards he was dead. Post mortem were found in the head, as was expected, the usual changes that occur in general paralysis—thickened and adherent membranes, cerebral degeneration &c. and atheromatous arteries. The thoracic and abdominal organs were fairly healthy, but on turning aside the small intestines a large mass of clotted blood was discovered lying in front of the psoas muscle. This clot was carefully removed, and on further examination there was found a rupture of the internal iliac artery close to where it gives off its ilio-lumbar branch. This, then, and not any cerebral lesion, was the immediate cause of death.

Dorset County Asylum.

METROPOLITAN ASYLUMS BOARD.—The number of patients in the various hospitals of the Metropolitan Asylums Board at midnight on Nov. 29th was as follows:—Eastern Hospital, 363 scarlet fever, 61 diphtheria and 39 enteric fever; North-Eastern Hospital, 554 scarlet fever; North-Western Hospital, 314 scarlet fever, 82 diphtheria and 23 enteric fever; Western Hospital, 291 scarlet fever, 31 diphtheria, 1 typhus fever and 16 enteric fever; South-Western Hospital, 285 scarlet fever, 59 diphtheria and 24 enteric fever; South-Eastern Hospital, 366 scarlet fever, 19 diphtheria and 16 enteric fever; Northern Hospital, 856 scarlet fever and 12 diphtheria; Gore Farm Hospital, 786 scarlet fever. On the hospital ship *Atlas* there were 16 cases of small-pox.