through a large catheter attached to an evacuating bag. So excellent a lithotripsy evacuator as Morgan's has proved quite useless in my hands when the bladder has become distended with clotted blood. Some stronger suction power is needed than the recoil of an indiarubber bag, and all that is wanted is a brass ear syringe, some rubber tubing, and a large evacuating catheter of Bigelow's kind. In this way the bladder is rapidly cleared out; but in order to facilitate the operation I have adopted the ordinary stomach pump syringe, for with it the bladder can be emptied without disconnecting the rubber tubing at the end of each suction, in order to empty the syringe. With the double nozzle of the stomach syringe the apparatus will allow of the bladder being cleared and washed out at the same time without disconnecting the rubber tubing. As it may be convenient to have these instruments ready at hand for emergencies I have had a stomach pump syringe, some rubber tubing and a large-eyed, large-sized evacuating catheter put together in a case by Down Brothers, St. Thomas's-street, Borough, S.E.

Cumberland.

"NOTES FROM A PRACTITIONER'S CASE-BOOK."

BY HUGHES REID DAVIES, M.R.C.S., L.R.C.P. LOND.

UNDER the above heading, in THE LANCET of July 2nd, Dr. Howard Murphy notes an interesting case of dislocated patella, and in concluding his record observes: "I have not been able to find any mention of such a dislocation of the patella (if it deserves such a title) in any of the text-books." A precisely similar case occurred in my own practice in June, 1891, and whilst I administered ether to the patient—a lady of about seventy years of age—Mr. Jonathan Hutchinson, jun., reduced the dislocation, the reduction producing a "loud snap," as in Dr. Murphy's case. Dr. Murphy's experience and mine are peculiarly similar. My patient, like his, had mounted a chair for the purpose of adjusting a window blind, the shifting of which caused the leg to twist in some unexplained manner and the rare dislocation to occur. The after history was equally favourable. I remember there was considerable doubt at the time as to how the lower border of the patella became so firmly fixed, but I do not recollect that any very satisfactory conclusion was arrived at.

The salicylate treatment of chorea.—I have had complete success in the salicylate treatment of the chorea of children, especially when accompanied by a mitral murmur; but of chorea in adults I have had no experience.

My round of general practice has been singularly rich in interesting "cases" during the last two or three years, a few of which I might briefly note perhaps without being deemed tedious.

Infantile intussusception.—Two of these cases I have been able to successfully reduce—under an anæsthetic—by perflation per rectum with an ordinary Higginson's syringe. To the first I was called in consultation by Dr. J. C. H. Dickinson, whilst the other occurred in my own practice, and both cases came under my notice within the space of a year.

Floating kidneys.—Of these I have had many, sometimes single and once double. One case became an in-patient at the London Hospital, under the care of Mr. Treves, with a view to fixation of the kidney. The interest in this case was further advanced by the fact that whilst under operation a fair sized renal calculus was discovered and removed. But of this case I am hardly justified in speaking, as doubtless Mr. Treves has it on record.

Foreign bodies removed.—1. A needle-case from a vaginal vagina. 2. A large plug of coarse tobacco, encased in wax, from each ear of a commercial traveller—a Devonshire man. He was much troubled by tinnitus aurium and almost complete deafness, both of which symptoms were immediately relieved by removal of the foreign bodies. This patient informed me that he distinctly remembered some thirty years back being treated for earache by the west country method of plugging the ear with tobacco. Therefore, upon his own showing, the length of time during which the foreign bodies had remained in his meatus was thirty years. 3. Two saloon-pistol bullets, one from the thecal eminence, the other from the flexor surface of the first phalanx of the third finger. 4. A needle, after a year's residence, from the hand of an old lady of eighty-five. 5. The complete metallic portion of an etching-pen, at least two inches in length, which was situated for three weeks in a vertical position about

one-sixteenth of an inch from the deep palmar arch. 6. Complete occlusion of right nasal passage by a foreign body for thirteen years,¹ &c.

In conclusion I may say that one can hardly call "general practice" *monotonous* with such a list.

Bow-road, E.

FRACTURE OF THE UPPER JAW WITH MALAR DEPRESSION.

BY GEORGE WHERRY, M.C. CANTAB., F.R.C.S. ENG., &c.,
UNIVERSITY LECTURER IN SURGERY, CAMBRIDGE.

FRACTURE of the upper jaw with malar depression occurs so frequently at football, and is so easily overlooked, that I call attention again to the subject, and mention a case as an illustration. A fortnight ago an athletic undergraduate called upon me and stated that he could do no reading on account of headaches, which he considered to be the sequel of a football accident five weeks before. He stated that during a match he was knocked senseless by the charge of a player, whose head struck him full upon the prominence of the cheek. Vomiting followed after a short period of unconsciousness and then apparent recovery. On examination there was a yellow stain about the left lower ocular conjunctiva where it had been blood-shot; no other sign of ecchymosis was present. The left malar prominence was slightly depressed as compared with the other side, and an irregular chink could be felt along the orbital margin. There was a very evident line of fracture to be felt on placing the finger inside the cheek on the malar process of the superior maxilla. The patient had not been able to bite on that side since the accident, and there was a remarkable gap which prevented the first molar from touching the lower teeth on that side, a condition which was probably a mere coincidence. There was a patch of numbness in the cheek, but not that definite area of anæsthesia which is found after injury to the infra-orbital nerve. Neuralgia had lately kept him awake at night.

In cases which I have briefly recorded among others to illustrate the effects of blows upon the malar bone,² though there was fracture of the jaw with malar depression, yet not more shock and not more ecchymosis could be discovered than is usual in an ordinary black eye, but a slight deformity was permanent. Other cases were followed by serious results, as orbital abscess, paralysis of the infra-orbital nerve, or serious head symptoms suggestive of fractured base. An interesting case is recorded by Mr. Holmes of a gentleman who, after a fall, received a fatal brain injury. An orbital ecchymosis during life exactly resembled that which attends fracture of the base of the skull was found after death to be due to a fracture of the malar bone near its junction with the frontal. In every case which comes under observation after a blow upon the malar prominence an examination should be made of the orbital ridge, of the malar process of the upper jaw and the zygomatic arch on the injured side. The finger in the mouth passed up beneath the cheek will readily detect any fracture of the malar process. The injury above described should be considered of interest and importance like a head injury, and, however trifling it may appear, should not be looked upon lightly.

Cambridge.

EMPHYSEMATOUS VAGINITIS.

BY H. E. WRIGHT, L.R.C.P. EDIN., M.R.C.S., J.P., &c.

DR. HERMAN, in THE LANCET of June 6th, 1891, describes a case of what he calls emphysematous vaginitis, and he remarks upon the rarity of this disease in England within the past few weeks. I have had a case in my practice here which seems to be closely allied to Dr. Herman's, especially to those cases which he quotes from German literature. Although I did not verify the presence of gas in the vesicles, it is quite possible it may have existed in some of them, as I did not pay particular attention to the point. The following are notes of the case:—

Mrs. —, aged twenty-seven, had been under my care for endocervicitis and erosion of the os uteri for nearly three months. On Sept. 2nd she came to me to have the last applica-

¹ THE LANCET, Nov. 15th, 1890.

² Practitioner, Sept. 1891; Camb. Med. Soc. Proc., 1889.

tion of nitrate of silver made to the cervix, and on passing Ferguson's speculum I noticed the vagina was studded with white spots, some of the size of a hempseed, others that of a small pea. The spots were milky white and about a third of an inch apart. A close examination showed them to be vesicles, and in adjusting the speculum some of the vesicles were ruptured and a watery, opaque fluid exuded. The ruptured vesicles left small pits in the mucous membrane. The cervix was quite free from the vesicles, which were most abundant in the upper two-thirds of the vagina, the lower third and the vulva being unaffected. I had never seen such a condition of the vagina before and I have a large practice in diseases of women. The milky-white spots suggested the *oidium albicans*, but closer examination clearly showed the spots to be true vesicles. The patient and her husband were surprised when I informed them of the condition of the vagina, which apparently had given rise to no special symptoms. I applied the nitrate of silver as usual to the cervix and left the vagina alone. Three days after this the husband came to me and said that his wife complained of an irritating watery discharge from the vagina and some burning of the passage and itching of the vulva. I prescribed, without again seeing the patient, some borax and glycerine, to be used in warm water as an injection two or three times a day. I heard nothing more of my patient for about ten days, when her husband came to consult me about himself. He said, "I have got the same complaint which my wife has just had. It came on a few days after I had connexion with her, which was the day before she came to you." I had advised him not to have intercourse with his wife until the vagina should have regained its healthy condition. On examining the husband, I found the whole surface of the glans penis excoriated in small spots or patches; there were no vesicles, but the condition of the glans was very suggestive. I must mention that the irritation and soreness of the penis had existed for one week prior to this visit. There was slight redness of the orifice of the urethra and occasionally some slight burning in passing urine. There was no discharge, either water or pus. I prescribed a lead lotion and in a few days he was quite well. I regret that I did not examine some of the vesicles for the *oidium albicans*, as their milky whiteness and rapid disappearance after using a lotion of borax and glycerine convince me that I might have been successful in my search.

Greytown, Natal.

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. THOMAS'S HOSPITAL.

CASES ILLUSTRATING THE TREATMENT OF RECURRENT PELVIC PERITONITIS BY ABDOMINAL SECTION; REMARKS.

(Under the care of Dr. CULLINGWORTH.)

WE continue and conclude this week the series of instructive cases of recurrent pelvic peritonitis commenced at page 20 of our last issue. We have already published four of the cases and as this week we give the remarks of the operator, advise our readers to refer to those cases before reading the remarks. As Dr. Cullingworth points out, it is impossible to prevent the occasional formation of a faecal fistula after the separation of adhesions which are so firm as those found in the patients under his care and others of a similar character.

CASE 5.—J. L.—, aged thirty-one, a primipara, by occupation a nurse, was admitted into Adelaide ward on March 3rd, 1892, suffering from pain in the abdomen and sickness. Previous history: In November, 1890, the patient strained herself in her efforts to put out a fire and for a week afterwards she complained of dragging pains in the lower part of the abdomen. At the end of this time, whilst out walking, she was suddenly seized with acute pain in the abdomen, went home in a cab, being unable to walk on account of the pain, and at once went to bed. Two days

later, the period being then a fortnight overdue, she began to lose dark-coloured blood from the vagina copiously and suffered from vomiting, constipation and retention of urine. On Dec. 18th, 1890, she was admitted into the ward complaining of hæmorrhage and pain and with a distinct abdominal swelling. A diagnosis of intra-peritoneal hæmatocele and right hæmato-salpinx was made and an operation advised but declined. She left the hospital on Jan. 14th, 1891, still losing blood. The loss continued till April, when it ceased. A month later she menstruated normally and has remained regular since. In October she noticed a yellow vaginal discharge, and experienced pain in the back and left iliac region, which continued to trouble her for some months; her general health, however, did not suffer, and she remained at her duties as an infirmity nurse till February of the present year. In the first week of February last (her period being due) she experienced a sudden sharp attack of abdominal pain and tenderness, accompanied by vomiting. Her period came on the same day, the flow being much more profuse than usual. She remained in bed for eight days and then got up and resumed her duties; her period had ceased, but the pain in the abdomen continued and was aggravated by any unusual exertion. Three weeks after the commencement of the above attack there was a sudden exacerbation of pain, with vomiting and hæmorrhage. She remained in bed for a week and says her temperature reached 104° F. on one occasion. At the end of the week she was readmitted. On examination the abdomen was rigid and there was considerable tenderness over the lower part and especially in the left iliac region. Per vaginam, the right fornix was normal in height; the left was depressed by a firm, irregular, tender mass, the size of a duck's egg, occupying the left posterior quarter of the pelvis and displacing the uterus slightly forwards and to the right. The uterus was movable and slightly enlarged, its canal measuring three inches. Similar but smaller masses were felt behind and on the right. No evidence of any separation could be detected between them. The urine was normal and the temperature 101·4°. Three weeks later—viz., on March 24th—the patient had not improved and the physical signs remained unaltered. The abdomen was opened and the pelvic viscera were found obscured from view by adherent omentum and intestine. After these had been separated the left Fallopian tube and ovary were found to be enlarged, inflamed and densely adherent. During the process of separation, which was tedious and difficult, the diseased ovary was ruptured and its purulent contents (about two fluid ounces) escaped. There was a small non-suppurating cyst of the right ovary. The right tube was adherent, but not diseased. After removal the collapsed ovary measured two inches by an inch and three-quarters and its wall was acutely inflamed. The abdomen was thoroughly douched and drained for forty-eight hours. Convalescence was complete and unmarred by complications. The patient was discharged on April 18th, feeling quite well, the abdominal wound having been completely healed for over a fortnight. She reported herself a month later, and was then in good health.

CASE 6.—A. C.—, aged thirty-nine, married, was admitted into Adelaide ward on March 29th, 1892, complaining of abdominal pain and uterine hæmorrhage of three weeks' duration. Previous history: She began to menstruate at the age of eleven and has always been regular, the flow being somewhat profuse and lasting from five to six days. She married in 1881, when twenty-seven years of age, and has had one child, born the following year. She married a second time at Easter, 1887, having been a widow a little over twelve months, and has not been pregnant since. She enjoyed good health till Easter, 1891, when she was confined to bed for a fortnight with pain in the lower part of the abdomen. She quickly recovered from this attack and remained well till three weeks ago, when she again suffered from pain in the lower part of the abdomen and left iliac region. The last menstrual period had ceased fourteen days previously. On the following day she had a flooding with aggravation of the pain and the bleeding continued, gradually diminishing till March 24th, when it ceased. The pain, however, continued to be severe and compelled her to keep her bed. During the last three weeks she has also complained of loss of appetite, diarrhoea and vomiting. On admission she was a well-nourished woman, complaining of constant pain in the lower part of the abdomen and of flooding, which had recently stopped. The abdomen presented nothing abnormal on examination, except some slight tenderness and resistance in the left iliac region. Per vaginam both lateral fornices were found depressed, the right more than the left. Uterus