comfort or the success of an operation I advised her to go into the union infirmary, but she put it off from day to day until Sept. 6th when she was admitted. In the meantime her condition had gone from bad to worse; her strength began to fail, the râles in her lung to get louder and coarser, and she expectorated yellow phlegm. The temperature was 100°, the respirations were 40, and the pulse was 90. On the 9th I was about to make an incision in her side in hopes of giving her at least temporary relief, but her breathing became so embarrassed that I was obliged to desist. Her temperature on this day reached its highest point (101°) and remained at that point until her death on the 11th.

Twenty-four hours after the patient's death I made a restricted post-mortem examination, as I could not get permission to do more. I opened the chest through an incision along the ribs and through the attached diaphragm. I examined the seat of entrance of the trocar and found no trace of it on the inside; but about a pint and a half of a yellow gelatinous fluid, consisting partly of cysts varying in size from a threepenny piece to that of a five-shilling piece and looking like nothing so much as slightly yellow-tinged jellyfish, with a little pus towards the end, flowed out.

I think there are several points of interest in this case, apart from its rarity, as regards diagnosis: 1. The very low temperature, which was never above 100°, up to within a couple of days before death. 2. The character of the expectoration with the well-defined streak of blood. 3. The intermittent and severe dyspnoea. 4. The diarrhoea. 5. The fact of the patient having years before suffered from drinking foul water. Dr. Clifford Allbutt in his "System of Medicine" refers to all these points as being characteristic, and I think they go a very long way towards differentiating it from pleurisy with effusion or empyema, and its being confined to one side would, I think, be sufficient to exclude hydrothorax.

Minster, Sheerness.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF PUERPERAL FEVER SUCCESSFULLY TREATED WITH ANTISTREPTOCOCCIC SERUM.

BY HERBERT E. WALLER, M.R.C.S. ENG., L.R.C.P. LOND.,

AND

FRANCIS R. GIBBS, M.R.C.S. ENG., L.R.C.P. LOND.

THE patient, who was a primipara, 23 years of age, was confined on Nov. 25th, at 9 P.M. It was a difficult high forceps case, the presentation being occipito-posterior and the head not well flexed. The cervix uteri was torn in two places, but not to any considerable extent, and the perineum was ruptured. Two stitches were inserted and full antiseptic precautions were observed throughout. The patient suffered a good deal from shock, having been in labour fully 36 hours. A vaginal douche of solution of corrosive sublimate (1 in 2000) was given next morning. On the morning of Nov. 28th (the third day after delivery) the patient had a pulse of 120 per minute and a temperature of 102.8° F. She had had several rigors during the previous night; the uterus was tender, and the tongue was tremulous. An enema was given and was followed by a good action of the bowels. By night the temperature rose to 104° and the pulse was 180 and irregular, sometimes beating at the rate of 200 and only to be counted with certainty by using a stethoscope. The uterus was accordingly well irrigated with the same solution as before by means of a long channelled glass tube. The lochia were scanty and offensive. Tincture of digitalis in doses of five minims every four hours and brandy at the rate of six ounces in 24 hours were given. On the 29th the temperature was still 103.6° and the pulse was 150. She was taking her food well and appeared remarkably well throughout, a feature in itself by no means cheering. Another intra-uterine douche was given and the serum treatment was commenced, six or seven cubic centimetres of anti-streptococcic serum being given in the morning as a first

dose. 20 grains of sulphate of quinine were given in two doses during the day, some dizziness and slight deafness resulting. The bowels were loose during the day, being opened four times. In the evening the temperature was 103° and the pulse was 159. The skin was cool and moist. The uterus was again washed out and the perineal wound, which was sloughy, was painted with silver nitrate solution; 10 cubic centimetres of serum were injected and 15 minims of tincture of digitalis were given every four hours together with chalk mixture for the diarrhoea. Brandy was continued at the same rate as before. On the 30th the temperature was normal, but the pulse was still 120. 10 cubic centimetres of serum were injected, the uterus was washed out morning and evening, and the other treatment was continued as before, but with the omission of the quinine. In the evening the temperature was 99.4° and the pulse was 116. On Dec. 1st the morning temperature was normal and the pulse was 104, the evening temperature being 99.8° and the pulse 120. 10 cubic centimetres of serum were injected in the morning and a uterine douche was given morning and evening. The patient was drowsy throughout the day and it was decided to wait a day before giving a further injection of serum. There was no subsequent rise of temperature and recovery was uninterrupted. The injection of the antistreptococcic serum produced no local symptoms other than a slightly raised irritating erythema which occurred a few days afterwards and lasted only a few hours.

Previously we had tried the antistreptococcic serum on only two cases, both of which terminated fatally. One of these patients was a young woman suffering from puerperal fever who came under our care several days after delivery. She had been having uterine douches twice daily, but the antistreptococcic serum was not used till the third or fourth day after delivery, and did not seem to exert any influence. The patient preserved that characteristic absence of subjective symptoms which has been marked in every case that has come under our notice. A few days before her death, when her temperature was 106° F., she sat up in bed playing with the baby and professed herself "All right to-day, thank you." The other case was that of a man, aged 81 years, who had his superior maxilla, including the contents of the orbit, removed for sarcoma of the antrum. Hæmorrhage was very free and the actual cautery had to be used. The patient was a very hearty old man and stood the operation well, but, unfortunately, erysipelas set in in a few days afterwards. We tried the serum on the next day, injecting 20 cubic centimetres at first and 10 cubic centimetres daily afterwards, but no good seemed to result, and the injections gave rise to considerable pain locally, so the treatment was abandoned. The old man only survived a few days more.

The success in the treatment of the third patient (the case described above) was due, we believe, to the early injection of the serum, which was ordered by telegram from, and sent immediately by, Messrs. Burroughs and Wellcome. It will be observed that the first douche produced probably no effect, as the fall in temperature from 104° on the evening of Nov. 28th to 103.6° on the morning of the 29th was, perhaps, only natural. The first dose of serum, accompanied by a douche, produced a slight effect—namely, a fall in temperature from 103.6° in the morning to 103° at night. The second dose (and douche) produced a fall in temperature from 103° at night to normal in the morning, and under continuance of the treatment the temperature did not again reach 100°. No bacteriological examination of the blood was made, but the symptoms of the onset of the malady were as well marked as in any case which we have been unfortunate enough to witness.

Bourne End, Bucks.

INFECTIVE PAROTITIS AFTER ABDOMINAL SECTION AFFECTING TWO OTHER MEMBERS OF A FAMILY.

BY BERTRAM ADDENBROOKE, M.D. DURH., M.R.C.S. ENG.

THE history of the following cases is, I venture to think, of the greatest interest.

On Nov. 5th, 1900, I performed the operation of abdominal section on a boy, aged 13 years, who suffered from suppurative peritonitis (non-tuberculous). Three days after the operation he complained of pain and stiffness in the

region of the left parotid gland. This soon spread to the right side, and within 24 hours he was suffering from a severe attack of double parotitis, a somewhat rare though recognised complication after abdominal section; the parotitis gradually resolved and no outward traces of the attack remained after Nov. 13th. On Nov. 21st an aunt of the patient visited him and stayed with him for about an hour and a half, kissing him both on entering and leaving the room; she had walked about seven miles to see the boy and she walked the same distance home again. On reaching home she complained of feeling very tired. Previously to this visit she had not seen the boy since an hour before the operation. On Nov. 24th (three days after her visit) she complained of stiffness in the region of the parotid glands and developed double parotitis, which gradually resolved. On Nov. 27th the sister of the last patient, with whom she was living, also complained of stiffness in the region of the parotid gland and she developed likewise, in a few hours, a mild attack of parotitis which also in a few days subsided; this third patient had never been in contact with the original patient at any period of his illness. I inquired most carefully for any cases of parotitis epidemica (mumps) in the neighbourhood where these patients lived, but failed to elicit any history of such. I would suggest that the two attacks of parotitis, in the aunt and her sister respectively, were due to direct infection, and hence the rapidity of the onset of illness after being inoculated, the infection travelling down Stenson's duct to the mouth of the boy, thence to the aunt, and then by the same route from the aunt to her sister.

Metastasis is, I venture to think, not a very satisfactory explanation either of the parotitis that occurs after abdominal section or of the well-known orchitis that follows after mumps, although it is the best one we have. If, however, the operation was, by metastasis, the determining cause of the parotitis in the boy, there was a very striking point in connexion with these cases—namely, (1) three days after the operation (the determining cause) the boy developed parotitis; (2) three days after visiting the boy the aunt developed parotitis (having rendered herself by over-exertion and fatigue less resistant to infection); and (3) three days later the sister developed the same affection, evidently having caught it from the previous patient (the boy's aunt). In all of these there is the definite incubation period of three days. Had these cases of parotitis suppurred, cultures might have been made and some evidence as to the connecting links between the cases obtained, but fortunately for the patients themselves, suppuration did not occur. I have been unable to find any record of similar cases, and I hope that some of your readers may be able to throw some light on an interesting pathological condition.

Kidderminster.

MEASLES AT SWANSEA.—At the meeting of the Swansea Sanitary Committee held on Dec. 17th the medical officer of health, Mr. E. Davies, reported that 29 deaths from measles had occurred during the past nine weeks and that five of the elementary schools in the town had been closed owing to the epidemic. Mr. J. A. Rawlings remarked that measles ought to be included in the list of notifiable diseases, and it was eventually decided that notice to that effect should be given.

BRISTOL MEDICAL MISSION.—At the meeting of the Bristol Medical Missionary Society held on Dec. 18th it was stated that during the past 12 months 8310 patients had been treated against 7535 in 1899, and that of this number more than 2000 had been attended at their own homes. The expenditure for the year amounted to £726 and the income to £643. The adverse balance of the mission now amounts to about £300 and a special effort is to be made to raise that amount.

INFANTILE MORTALITY AND HEREDITARY SYPHILIS.—At the meeting of the Stonehouse (Plymouth) District Council held on Dec. 11th the medical officer of health (Mr. T. Leah) reported upon the infantile mortality, which is higher than the average throughout the county of Devon. Stonehouse is the most densely populated town in the area of the Devon County Council and Mr. Leah stated that the density of the population was one of the causes of this mortality, while he added that hereditary syphilis was decidedly on the increase since the Contagious Diseases Act was repealed.

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. Prooemium.

ANCOATS HOSPITAL, MANCHESTER.

A CASE OF MELANOTIC SARCOMA OF THE LIVER; WITH
REMARKS ON THE DIAGNOSIS OF MELANOTIC TUMOURS
OF THE INTERNAL ORGANS.

(Under the care of Dr. R. T. WILLIAMSON.)

MELANOTIC sarcoma of the liver is nearly always secondary, though some very definite cases have been recorded in which it appeared to be primary.¹ The association of the affection of the liver with the same form of growth in the eye is frequent and only a short time intervenes between the primary eye affection and the appearance of the disease in the liver, as in the case recorded below, but in one case the interval between the removal of the eye and death from the growth in the liver was 10 years.² As in Dr. Williamson's case, it is not rare for secondary sarcomatous growths of the liver to give rise to a uniform enlargement in which no individual tumour masses can be felt.

A girl, aged 16 years, was admitted into the Ancoats Hospital on Sept. 13th, 1900, on account of enlargement of the abdomen. Three months before admission her sight had commenced to fail in the right eye and in a short time vision was lost in this eye. The eye was removed, on account of intra-ocular tumour, by Mr. E. Roberts, surgeon to the Manchester Royal Eye Hospital, five weeks before the patient's admission to the Ancoats Hospital. Four weeks after the operation she first noticed the swelling of the abdomen.

On admission the patient was fairly well nourished. There was no jaundice and no pigment spots or tumours were present in the skin. The temperature was normal. There was no cedema of the legs. Nothing abnormal could be detected in the heart and lungs. The liver was very much enlarged; its upper limit reached as high as the fourth rib; its lower edge extended down to the iliac crest on the right side and could be felt below the umbilicus in the middle line. The lower edge of the liver was sharp and even. The surface of the liver was quite smooth and firm. The hepatic enlargement was uniform. There was no hepatic pain or tenderness, and there was no ascites. The spleen was not enlarged. The patient vomited occasionally and suffered from diarrhoea. There was no hæmatemesis.

The urine was slightly darker than normal urine when freshly passed, but it had only a slight brownish tinge. When allowed to stand exposed to the air for several days, however, it became black in colour, but when kept in a corked bottle it had not changed its colour at the end of seven weeks. The specific gravity was 1015 and the reaction was acid; albumin and sugar were absent. The addition of nitric acid to the urine produced a deep black coloration with a slight brownish tinge. A solution of perchloride of iron produced a deep black coloration. Sulphuric acid and bichromate of potash also produced a deep black coloration. These are the reactions for melanin. There was no reaction of the urine for blood pigment with tincture of guaiacum and ozonic ether and no hæmin crystals could be obtained. A deep Prussian blue coloration was obtained on the addition of nitro-prusside of sodium, liquor potassæ, and acetic acid.

During the four weeks that the patient was in hospital she gradually lost flesh. At times she suffered from severe pain in the abdomen chiefly in the region of the epigastrium. At other times the pain was absent and on these occasions, even at the end of the illness, the liver was painless on palpation. Towards the end of the patient's illness the feet were slightly cedematous, but there was never any ascites. There was no

¹ Delépine: THE LANCET, Jan. 24th, 1891, p. 196.

² Loc. cit.