while other facts, which to my mind tell powerfully against the flexion theory, he makes no attempt to explain; and at to a third class of observations, his experience is so different from mine, and from that of others who have studied the subject, that I cannot reconcile them, but must leave it to those interested in the subject to observe for themselves and decide which is right. Dr. Hewitt puts forward as clinical evidence of the morbid effects of flexion the escape of menstrual and leucorrhœal discharge in gushes, the passage of clots at the menstrual period, and enlargement of the body of the uterus at the menstrual period. To give these clinical phenomena any value as evidence bearing on the question, it ought to be shown that they occur only or with much greater frequency in those women in whom flexion of the uterus is present. Dr. Hewitt does not seem to have instituted any inquiry into the frequency with which clots are passed and fluid said to escape in gushes in women with bent and straight uteri respectively. I have not made any such inquiry myself, not thinking it worth the trouble; but if such evidence is thought worth consideration, it appears to me that this is the first point to be settled. Were such an inquiry made, I believe it would be found that the clots and gushes would be described pretty nearly as often, in proportion to their number, by women with straight uteri as by those with flexion. I do not think it of moment, because in the great majority of cases in which clots are passed, it is impossible to say whether the blood coagulated in the uterus or in the vagina. It is my rule, when patients say that they pass clots, to ask them to bring them for me to see; and I generally find them small and recent, and telling nothing by their shape of the place in which they were formed. As to the gushes, the correctness of the fact rests entirely upon the patient's statement, and patients—females especially—can so seldom describe with scientific accuracy, that to build a theory on such descriptions seems to me to be building on sand. Of course we must take the patients' statements when it is only through them that we can get the information we want, and I quite agree with Dr. Hewitt that their complaints ought not to be treated as fanciful; but subjective symptoms stated by patients ought not to be seriously put side by side with things seen by trained observers. Granted that discharge does escape in gushes, what evidence is there that the accumulation was in the uterus, and not in the vagina? It is common enough for secretions, and occasionally air, to be retained in the vagina in much greater quantity than the unimpregnated uterus will hold. In short, these phenomena do not influence my opinion, for the reasons—(1) That the fact of the occurrence of the gushes rests only on the sensations of patients; (2) if gushes and clots do escape there is no evidence that the expelled products were retained in utero; (3) no evidence has been adduced to show that they are at all peculiar to women whose uteri are bent.

There is an observation of Schultze's bearing on the supposed accumulation of fluid in the uterus behind a bend in it, which I quoted in one of my papers, and which I must allude to here because Dr. Hewitt, doubtless through my fault, misrepresents its meaning. I did not cite the mere fact that Schultze had passed the sound into an anteverted uterus during the height of the menstrual pain as evidence that the canal was not obstructed. The point of the observation, which Dr. Hewitt does not mention, is this: that when the instrument was so passed, at the height of the pain, no escape of blood followed its withdrawal—showing clearly that in the case or cases examined there was no accumulation of blood in the uterine cavity. Schultze's statement as to the patency of the canal during the pain has been recently confirmed by observations made by Dr. J. E. Burton of Liverpool.²

There are other clinical phenomena of which Dr. Hewitt offers no explanation. Some of the most striking instances of benefit from treatment by pessaries are furnished by cases in which the uterus is quite straight, being simply retroverted, not retroflexed. No theory as to obstruction of the canal, or strangulation of the vessels by flexion, helps us here. The removal of symptoms must have resulted from the removal of some condition quite other than flexion. The promptness of the relief following mechanical treatment shows that it is a condition associated with the displacement, and the number of cases of retroversion which do not cause trouble shows that it is a condition not present in every case. I believe the elucidation is to be

found in the disposition of the utero-sacral ligaments. Dr. Hewitt, although he condemns this as "mere trifling," yet has no explanation of these cases to put in its place. Again, there is, to use Dr. Hewitt's words, the "liability to greater congestion in retroflexion than in anteversion cases." This needs explanation, but Dr. Hewitt offers none. Anteversion is frequently met with so acute that the lower part of the cervix is parallel with the body of the uterus, while retroflexion so extreme as this is uncommon. If congestion depended on the flexion, it ought to be in proportion to the acuteness of the bend, which it is not, as Dr. Hewitt, in the sentence quoted, practically admits.

(To be concluded.)

CASE OF DOUBLE WOUND IN THE SAME LIMB FROM A SINGLE GUNSHOT.

By BRIGADE-SURGEON G. L. HINDE, A.M.D.

THE following case of conservative surgery presents many points of interest:—

Private R. S—, 7th Dragoon Guards, aged twenty, when at rifle practice, seeing his carbine, which he had lent to a comrade, lying on the ground, the hammer at full cock, and not knowing it was loaded, proceeded to ease the spring. To do this he leaned his left hand on the muzzle and pulled the

trigger with his right thumb. On the discharge of the weapon he was severely wounded both in the hand and in the upper arm. The arm and hand were temporarily tied up with handkerchiefs, and the man was brought to the Station Hospital, Shorncliffe, where it was found that the bullet had perforated the hand in its centre through a small circular wound. The whole integrity of the hand seemed to be loosened, and there was a large irregular opening at the back, extending from the metacarpo-phalangeal joint of the ring finger obliquely across to the centre of the metacarpal bone of the index finger, and then back to the os magnum. The

second metacarpal bone was gone with the exception of its head; the first and third metacarpal bones were exposed for almost their entire length; and the os magnum was chipped at its metacarpal articulating surface. The extensor tendons of the second finger were also destroyed, the others much displaced. All ragged tissues and those hardened from powder and fire were removed, and the wound cleansed from all clots and debris by syringing with tepid carbolic water, and then packed with lint steeped in carbolic oil, and the whole supported by a light bandage. Further examination showed that the bullet had also perforated the upper arm on the

² British Medical Journal, Sept. 27th, 1884, p. 607.

inside, somewhat anterior to the artery, and fractured the humerus at the junction of the middle and lower third, and then passed out at the back of the arm, the entrance wound being small, the exit irregularly circular, about two inches in diameter, with everted edges, and having a mass of muscle protruding. Inside the integuments a large cavity was found lined with broken up tissues mixed with fragments of bone. One large piece of bone, which appeared to be of almost the entire circumference of the shaft, and one inch and a half long, having plenty of attachments, was brought into position between the fractured ends of the shaft, so as to give a base for the deposit of callus, it being hoped that it would have sufficient vitality not to become a foreign body. Having removed all spiculæ, ragged fascia, and muscle, the cavity was cleansed from clots by syringing, and filled from both sides with lint saturated with carbolic oil; the limb was then placed on a jointed arm-splint in a semiflexed position. All the wounds were covered with carbolised gauze, and kept moistened with carbolic lotion. There was very little swelling, and little constitutional disturbance for the following five days. On the sixth day the patient complained of burning pain in all the wounds, suppuration being fully established. I proceeded to dress the wounds of the hand. On removing the plugs profuse hæmorrhage occurred, apparently from both palmar arches; so, after consultation, it was decided to tie the brachial artery. The operation was carried out immediately. A ligature was placed upon the artery where most superficial in its upper third, and all wounds were dressed with carbolic oil. Catgut ligatures were tried, but, being found unsound, silk was used. The night following the temperature went up to 102.4°. After a purgative enema the temperature began to decrease. The next morning it was only 101.2°. With the aid of cotton-wool the hand and arm retained natural warmth. All the wounds were dressed daily antiseptically. The ligature came away on the tenth day, and steady progress continued. Some slight changes in treatment were required—such as strapping a gaping wound, and a short febrile attack combated—otherwise it might be said that the treatment was uniformly antiseptic and simple. On this (the 108th) day the state of the limb was as follows:—The elbow had a good motion, but its action was limited owing to cicatrices being adherent to the biceps and the triceps muscles. All motion was complete in the wrist-joint. Motion in joints of fingers good. Apposition with thumb returned under passive motion and daily practice. The second finger had lost all power, but retains its shape; all joints perfect under passive motion; it may require operative interference hereafter. The upper arm is shortened about three-quarters of an inch. The above drawings show the relative position of wounds.

NOTES OF A

CASE OF POST-HEMIPLEGIC HEMICHOREA ASSOCIATED WITH INSANITY.

By C. THEODORE EWART, M.B., M.CH.

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ALTHOUGH the following notes are meagre, they may be of some slight clinical interest.

E. M.—, cab-driver, aged forty-two, was admitted into the Fisherton House Asylum on March 29th, 1884. The patient is a fairly well nourished man suffering from aphasia, and has extreme difficulty in speaking. Hesitation, delay, irregularity, and jerkiness are noticed in his articulation, "from the incoördinate action of the cerebral centres, whose function it is to translate thought into the corresponding motor acts of speech." I understand that on two occasions he has lost consciousness, the symptoms being of an apoplectic nature. There is no history of hereditary predisposition to insanity. His mind is depressed, and he is irritable, obstinate, and taciturn. His perception is defective, indicative of failure of brain power, and he does not seem capable of conceiving an exact idea of his situation. He has never had rheumatic fever, and there is no cardiac mischief. There are violent choreic movements of the right arm, and, though to a much less degree, the right leg. The left arm is not affected by spasm, but is partially paralysed. The

movements on the right side are so severe that his face is bruised from the self-inflicted wounds, and his hand hurt from striking against his bed. The force is such that an attendant's face coming in the line of motion his eye received a severe contusion. The upper right forearm is an inch larger than the left, and this increased muscular development must be due to the constant movement, which only ceases during sleep. The muscles of the face are very much contorted. By the influence of the orbicularis and neighbouring muscles the mouth is drawn into odd positions. The forehead is wrinkled, and the whole face presents the most contradictory expressions; in fact, there is a "delirium of the sensori-motor ganglia." A certain amount of anæsthesia is present, but there is no great loss of tactile sensibility in the affected hand, which grasps with greater firmness than the other. The sense of hearing is blunted, but sight, taste, and smell are not. Mastication and deglutition are imperfectly performed. When attempting a definite movement the spasmodic action is much exaggerated. The hand is alternately supinated and pronated, extended and flexed, and so combined as almost to defy description. Control over the bladder and rectum is retained. No albumen in the urine. Knee-jerk and ankle clonus exaggerated.

Treatment.—Cod-liver oil was ordered three times a day. Twenty minims of the tincture of Indian hemp combined with twenty grains of bromide of potassium were prescribed every four hours, and a draught containing thirty grains of chloral hydrate and ten grains of bromide of potassium was given at bedtime to procure sleep. As soon as the spasmodic action ceased he was put on fifteen-drop doses of the tincture of perchloride of iron. The bowels were kept open. The diet consisted of beef-tea, milk, eggs, and brandy. The right arm was bandaged to his side; at first when this was done the lower extremity of the same side was violently affected, and had also to be bound. In a fortnight he was able to button and unbutton his coat, and could dress himself; in another week he could converse in an intelligible manner. He carried his hand in the pocket of his coat, so as to prevent its disordered movements. He is now able to execute any intended movement, but in a slightly tremulous manner, and there is no difference in the size of the two forearms. There is still a fidgety manner, which shows itself in grimaces, needless haste, and a want of precision.

Remarks.—I consider from the symptoms that the hæmorrhage must have occurred in the corpus striatum, optic thalamus, and medulla oblongata. Raymond says that in six cases where a post-mortem examination was made the lesion was situated in every instance in the posterior part of the optic thalamus, and involved the fibres of the internal capsule. The lesions which have been found to give rise most frequently to hemichorea are yellow cicatrices, the remains of old hæmorrhages, or softening from occlusion of the posterior external optic artery, although choreiform movements have occasionally been observed during the growth of tumours in this region. The symptoms do not appear to depend upon lesion of the optic thalamus itself, inasmuch as they are never present unless some of the fibres of the sensory peduncular and pyramidal tracts are injured; nor does it even appear to be caused by injury of the sensory fibres, since hemianæsthesia with bilateral hemianopsia may be present without being associated with choreiform movements. It would seem, therefore, that injury to some of the fibres which lie in front of the sensory peduncular tract is the cause of hemichorea (Ross).

SCHOLARSHIPS.—At the Westminster Hospital Medical School the Fence entrance scholarship of £40 per annum, tenable for two years, has been awarded to Mr. James Dickinson; and the entrance scholarship of £20 per annum, tenable for two years, to Mr. George Thomas James.—At King's College the entrance scholarships have been awarded as follows:—Warneford scholarship of £75 each to Messrs. A. S. Sandifer and T. B. Beach; Sambrooke Exhibition of £50 to Mr. H. S. Ballance; and Clothworkers' Science Exhibitions of £50 and £25 to Messrs. T. G. Brodie and C. W. Atkinson.

THE portrait of the late Duke of Albany, by Mr. Walter Goodman, recently exhibited in the Guildhall Galleries, has been purchased by the Secretary of the National Hospital for the Paralysed and Epileptic, Queen-square, Bloomsbury, on behalf of the Board of Management of that Institution.