of two weeks, at which time she was lost sight of.

CASE III.—*Febris Intermittens Tertian.*—Feb. 15, 1866. M. A. B., aged 11. Has resided in Webster Place for the last three years. Born in Boston, where she has always lived. Never slept out of town. Generally well, although at present somewhat anæmic. Has felt rather indisposed for last fortnight. Six days ago, had a pretty severe chill about 2, P.M., which has returned about half an hour earlier every second day since. Chill continues about two hours, and is followed by a febrile condition, hot skin, flushed face, pain in head and back, and general discomfort, which lasts for three or four hours and terminates in copious perspiration. Appetite good, and functions of system pretty well performed between attacks. Quiniae sulph. gr. ij. at 6, 7 and 8, A.M., every day for a week, and then gradually decreased. Disease arrested. Lost sight of at end of two weeks.

CASE IV.—*Febris Intermittens Quotidian.*—Sept. 13, 1866. J. K., aged 6; residing in Congress Street. Always lived in Boston. Never out of town more than two or three miles. Always healthy. Well-marked chill at 4, P.M., every day for three days, lasting about an hour, and followed by feverishness for five or six hours, which terminates in perspiration. Rigor quite severe, with some nausea and vomiting towards its termination. Considerable headache and pain in eyes during hot stage; skin and conjunctivæ somewhat jaundiced. Increased dullness, with tenderness on pressure, and dull, aching pain in splenic and hepatic regions. Liver and spleen apparently enlarged, as felt through the abdominal walls. A puffy swelling, the size of half a small orange, situated over the lower third of the sternum, appears with the commencement and disappears with the termination of each attack. Feels pretty well, and has moderately good appetite during forenoon and early part of afternoon. Intermission perfect. Had a similar attack, but less severe, some months since. To have quiniae sulph. gr. ij. at 7, 8 and 9, A.M. This delayed, but did not prevent, the usual daily attack, and he was ordered gr. iv. at 10 and 11, A.M., which mitigated, but did not entirely arrest it. I then gave him gr. iij. at 5, and gr. ij. at 6, 7 and 8, A.M., which produced slight frontal headache and ringing in the ears, and accomplished the desired result. The quinine was continued for several days, and until the patient was lost sight of there was no further return of the disease.

The father of this child formerly lived in the West Indies quite a number of years, and had intermittent fever frequently while there.

CASE V.—*Febris Intermittens Quotidian.*—Jan. 7, 1868. P. S. McG., aged 13; residing in Salutation Street. Always lived in Boston. Never slept out of town. Always healthy. Decided chill between 4 and 5, P.M., every day for five days, lasting about one hour, and followed by febrile disturbance, hot skin, headache, thirst and general distress. Hot stage continues six or seven hours, and then gives way to perspiration and sleep, after which he feels quite well until the next attack. Intermission perfect. Spleen and liver apparently somewhat enlarged. Quiniae sulph. gr. ij. at 6, 7, 8, 9 and 10, A.M. This was continued for two days. On the third day, in order to obtain additional evidence of the nature of the disease, it was withheld, when the paroxysm returned with all its original vigor, anticipating the time of its previous daily occurrence by about an hour. On the fourth day, the quinine was resumed and continued for several days. Slight frontal headache was the only physiological symptom of its action obtained. Up to the present time—Feb. 19th—there has been no return of the disease.

The mother of this boy formerly lived in the north of Ireland, and subsequently in the vicinity of Montreal, from whence she removed to Boston eighteen years ago. Upon several occasions she has had what seems to have been attacks of intermittent fever, the chill being so severe as to oblige her to go to bed and remain there during its continuance.

RUPTURE OF THE UTERUS.

By G. J. TOWNSEND, M.D., Natick, Mass.

Mrs. N., aged 35, German, strong, muscular and florid, sent for me on the morning of June 13th, 1867, at 9 o'clock. She was in labor with her sixth child. Her pains were brisk, and her husband told me I should not be detained more than half an hour.

Her previous labors had all been severe, though favorable, owing to a projection forwards, of the promontory of the sacrum, diminishing the conjugate diameter of the brim of the pelvis more than one-fifth.

She had worked hard from early youth, and the increased deposit of bone in the sacrum was, without doubt, from an effort of nature to strengthen the spine, and enable it to sustain the too great burden imposed upon it.

Throughout this pregnancy, Mrs. N. had worked harder, even, than usual, owing to the protracted illness of her husband; and her work had been cultivating a vegetable garden and driving pegs into heavy brogans. Indeed, after her pains had begun she scrubbed up her floor, that all might be tidy at my advent.

On my first examination, the os was fully dilated, membranes unruptured, the vertex was just entering the brim in the first position, face to the left. The pains continued hard and frequent, with apparent slow progress, and no impaction, until 1½, P.M., after which time the head neither advanced nor retreated. At 2½, P.M., being very tired, the patient begged to turn upon her hands and knees, for rest, a position, by the bye, very common amongst both Germans and Irish, when left to themselves, and not a bad one, either. Previously she had been lying in our usual position, viz., on left side.

In less than five minutes after her change, she began to complain, though not very urgently, of pain in her bowels, saying she had just such pain in her former labor, and that peppermint relieved it. The labor pains ceased entirely. Suspecting at once the nature of the case, I gave her some peppermint, and sent at once for my friend and neighbor, Dr. Partridge. He was soon at hand, with ether and instruments. I made an attempt to apply the forceps, with but slight hopes of success, and failed, the head receding before the second blade, though it seemed pretty firmly impacted. I then introduced my hand, encountering a coil of intestine very soon after it entered the cavity of the uterus, brought down the feet, turned and delivered. The head passed with some little difficulty, and the child was still-born.

After the removal of the placenta, the rent could be distinctly traced, and the intestines felt through it. It was anterior, some six inches in length, extending diagonally across the body of the uterus, below the Fallopian tubes apparently. This diagnosis was confirmed by the autopsy.

A fatal prognosis was given to the friends, and a full opiate was administered. On my second and last visit to the patient the same evening, the usual symptoms of collapse were present, though not strongly marked, and the abdomen was enormously distended.

On the strength of my unfavorable opinion, the case passed out of my hands, and a neighboring empiric took charge of it. He of course pronounced the opinion of Dr. Partridge and myself all nonsense, and said he would have the patient out before long.

As to his treatment I know nothing, save that it consisted largely of *veratrum viride*, and forty-eight hours before death took place he boasted, in the village inn, that he had reduced her pulse to its natural number, but that she did not seem to gain much strength. He called in consultation a notorious practitioner from a manufacturing town, who also pronounced our diagnosis absurd.

The patient lived until the evening of July 4th, just three weeks* after the accident, sat up several times in a chair to have her bed made, and even walked a few steps to her chair and back again to the bed.

At the autopsy, which was performed by my friend, Dr. Lincoln, the abdomen was quite flat, very slightly if at all tympanitic. On dissection, it was found that the anterior portion of the neck of the uterus had entirely sloughed away. The rent extended diagonally across the body of the organ, from the front of the left broad ligament, to the right, involving the right broad ligament, but lying in front of the left. The cavity of the uterus was lined with a grumous fluid. The vagina was somewhat sphacelated, at its upper part. The intestines were everywhere bathed in pus, and covered more or less with adhesions. The uterus measured three and a half inches from one Fallopian tube to the opposite, four and a half inches from the fundus to the upper edge of the rupture, and the parietes were ten lines in thickness.

The points of interest in the case are—
1st. The situation of the rupture, which being anterior and low down toward the neck, allowed the free escape of the lochia, and afterwards of the slough, thus remedying the distention of the abdomen which occurs in these cases, and which was enormous the last time I saw the patient.

2d. The comparatively mild character of the pain, and of the collapse, which followed the accident.

3d. The remarkable tenacity of life the patient evinced. Suffering from the fearful consequences of her accident, and under the influence of a most depressing remedy, she yet lived three weeks, and at one time walked several steps from her bed to a chair.

I have by me the record of but one case, where the patient lived so long, and that one died on the twenty-fourth day.

I will only add, that during the progress of the labor no manual interference was used, and no oxytocic administered.

* Patient died at 6, P.M., July 4th, having lived four hours into the twenty-second day. So reported when I made the autopsy.—G. C. LINCOLN.