pressure, and the bronchial veins were probably more exposed to pressure and to possible reflux than any other veins, owing to the fact that their parent veins (the left innominate and the vena azygos) arise near the heart, and are at their origin unguarded by valves. Severe congestion must have been occasioned in this manner within the sensitive respiratory membrane, and this alone may have sufficed to excite a sustained expiratory reflex such as I have described.

Clinically the case is of importance (1) because it shows that the mere removal of sixteen ounces of blood does not suffice to ward off the fatal consequences of the rupture; (2) because it suggests that death is probably due to the pressure of the blood within the cranium rather than to the quality of the blood; and (3) because it also shows that, in spite of the existence of some collateral circulation (which was, in my case, evidenced by the much slighter degree of the cyanosis in the upper limbs than in the head), the progressive increase of the intracranial pressure is likely to be too rapid for the establishment of a sufficient collateral relief.

Diagnosis in obscure cases, such as the present one, where the aneurysm is latent, is aided by the suddenness and intensity of the cyanosis, coupled with the relative freedom from dyspnoea. It would be greatly aided by the existence of a well-marked venous pulsation; but, judging from my experience in this case, I doubt whether pulsation will be found present in every case at the time when venous tension is at its height. If venesection should be resorted to, an arterial character of the blood flowing from the vein would be likewise almost conclusive. I am not prepared to state definitely from memory that, in this case, the colour of the blood spirting from the vein was brighter than appeared consistent with the degree of the cyanosis; such is, however, my strong impression of what occurred.

As regards *prognosis*, by far the most important quantity—namely, the size of the rupture—is incapable of being ascertained during life. The same must be said also of the next important factor—viz., the size and capabilities of the collateral channels, and especially of the communications between the vena azygos, on the one hand, and the inferior vena cava and its lumbar and renal branches on the other. In estimating the possible duration of survival these important anastomoses should not be overlooked. In cases of gradual erosion, preceded by pressure sufficient to obliterate the channel of the superior vena cava,² they would probably enable the circulation to be carried on. For in itself the partial reversal of the route followed by the blood does not give rise to so serious a form of contamination as that suffered by the blood in congenital cyanosis. But where the rupture is sudden and extensive, the chances of the mechanical distribution of the blood being spontaneously, or by the help of any method of treatment whatsoever, restored to and maintained in a condition of equilibrium, even approximate, must be admitted to be extremely small.

Curzon-street, W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

CASE OF TETANUS OCCURRING TEN DAYS AFTER DELIVERY.

BY HENRY PEACOCK, M.R.C.P., F.R.C.S.

M. B—, aged twenty-five, residing about three miles from Gloucester, was attended by a midwife on March 1st, 1888, the case being a primipara. The midwife sent for me after (as she said) the woman had been in labour for forty-eight hours. On arriving I found that the pains had ceased, and that the head was resting on the perineum, which was very rigid and enormously distended. I at once applied the forceps, and had little difficulty in delivering her of a large and vigorous female child. There was a slight laceration of the perineum at the fourchette, but not involving the sphincter, or of sufficient consequence to cause any particular notice. I saw her the following day,

and so well did she appear that I did not consider it necessary to call again, and I left her in charge of her mother and a neighbour. On the tenth day after her confinement I was called in, and found her in the following condition: lochia and lactation natural, pulse 90, temperature 100°. I was told that she had been doing remarkably well up to the eighth day, when she complained of a little difficulty in swallowing and of stiffness about the neck. I at once diagnosed an attack of tetanus; in fact, trismus had set in, the jaws being so firmly closed that it was impossible to open the mouth without using the handle of a spoon as a lever. The muscles of the neck were thrown into agonising spasm on the slightest motion or on any attempt made to touch her; the head was thrown back (opisthotonos), and her expression exhibited the "risus sardonicus" in a remarkable degree. A turpentine enema was at first administered, and a strong chloroform and opium liniment rubbed on the neck and back. On my next visit, a few hours later, I threw up by the rectum thirty grains of the hydrate of chloral, and gave the same drug by the mouth in fifteen-grain doses every four hours. On my visit next day, I found the paroxysms somewhat less, and there was a little less difficulty in opening the mouth. My friend Mr. Cuthbert, surgeon, of Gloucester, who took a kindly interest in the case, accompanied me in my next visit, and agreed with me that the same treatment should be persevered in, although he expressed little hope of the patient's recovery. On the next day (the third from the attack), the tetanic spasms were more violent, but she was still able to take nourishment in the shape of beef-tea and milk. I injected hypodermically a quarter of a grain of morphia, and still continued the chloral every four hours. Sound sleep followed the morphia injection, and the violence of the spasms was somewhat abated and occurred less frequently. On my next visit with Mr. Cuthbert, we found her much worse, the pulse 120 and temperature 100°. On the fourth day from the attack the paroxysms were less violent, but the diaphragm and abdominal muscles were affected, and death took place the same night, evidently from exhaustion.

Now on referring to old and modern works on obstetric medicine, I cannot find any record of tetanus following delivery, and I am at a loss to account for the cause. The laceration of the perineum would naturally suggest that it was a decided case of traumatic tetanus, but as slight and even severe lacerations are so frequent in primiparæ one would look to some other cause, and as puerperal disease had been prevalent in the neighbourhood for some months previously, might not a peculiar state of the nervous system brought on by the epidemic influence predispose to the attack? or was it caused by the perineum having been so long in a distended state with such direct pressure and stretching of the cutaneous branches of the pudic nerve? Such cases are certainly very rare, for in a practice of nearly fifty years I have never witnessed one like it.

Gloucester.

ILL EFFECTS OF ANTIPYRIN.

BY THOMAS WINGRAVE, M.R.C.S. ENG.

OWING to the indiscriminate way in which antipyrin is now being administered for an endless variety of diseases, I think that all cases should be recorded in which unpleasant symptoms arise from its administration. The following are brief particulars of a case now under my care.

A young lady aged twenty-one, has been under my care suffering from chronic ovaritis, associated with intense dysmenorrhœa. In addition to treatment by bromide of ammonium and tincture of gelsemium (which, by the way, were fairly successful in reducing the pain), I had given her some powders consisting of ten grains of antipyrin, one of which was to be taken when the paroxysms became severe. On July 25th last she took one of these (the first); about five minutes afterwards she experienced a very curious sense of heavy weight in the thorax, with a feeling of suffocation, her breathing became hurried and difficult, and there followed almost immediately a loss of power in the left side (the right side was slightly affected); in a few minutes a peculiar, very bright erythema appeared over the whole surface of the body, the patient appearing, as her mother said, "just like a boiled lobster." This rash was accompanied by a sensation of "pins-and-needles" down

² Dr. Charlewood Turner's case probably belonged to this class. See Path. Soc. Trans., vol. xxxvi., p. 148.

the left arm and leg; the circulation seemed to be arrested for a little while, as the rash faded to a dull purple. In a few minutes a feeling of collapse set in, accompanied by a profuse cold perspiration, and simultaneously severe vomiting began. In about ten minutes, under the influence of stimulants, all these unpleasant symptoms passed off, and she seemed to have recovered entirely. That the drug was good was shown by the fact that two or three other patients had had some quite recently from the same box, and I can only attribute the symptoms above described to an idiosyncrasy on the part of the patient. If such untoward attacks are to be reported frequently, it seems to me that the action of the drug should be more fully investigated experimentally than seems at present to be the case.

West-street, Finsbury-circus, E.C.

A PERFORATION OF THE SEPTUM NASI OCCURRING IN CEMENT WORKERS.

BY ALEXANDER G. R. FOULERTON,

RESIDENT ASSISTANT SURGEON TO ST. BARTHOLOMEW'S HOSPITAL, CHATHAM.

THIS perforation of the cartilaginous septum of the nose is not uncommon amongst workers in cement factories and probably in other trades in which conditions similar to those which I shall describe are prevalent. It occurs as a round opening situated a little above the columna and close to the floor of the nostril. Its size will vary, and beyond a little discharge from the ulcerating edges of the perforation no inconvenience results. Its causation is as follows. The dry cement dust is drawn into the nostrils and accumulates on the hairs in the neighbourhood. This necessitates the frequent use of the little finger in order to clear the passage out. An abrasion of the epithelium at a spot on the septum, against which the nail scrapes as the finger is rotated, becomes, on the course of events which gave rise to it being repeated, an ulcer. The ulceration is after a time followed by perforation. This lesion, which, so far as I am aware, has not been described before, is of some little practical importance, inasmuch as one would be rather apt to attribute to syphilis a perforation of this sort if no obvious cause were to be found.

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.

CHARING-CROSS HOSPITAL.

EXTRA-UTERINE GESTATION; ABDOMINAL SECTION;
PERITONITIS; DEATH; NECROPSY.

(Under the care of Mr. BELLAMY.)

DR. MATTHEWS DUNCAN,¹ in a clinical lecture on extra-uterine gestation, has passed this subject under review, and alluded to several cases under his care. He says, "In extra-uterine gestation much has yet to be done before the utility of laparotomy can be well defined. We need more knowledge of the natural progress of the disease, more knowledge of the anatomy, more experience in laparotomy?" That the literature on this subject is now very extensive is proved by reference to the medical journals of the last few months, cases being recorded in large numbers, but accounts are still valuable. As regards the frequency of extra-uterine gestation, Bandl mentions five cases out of 60,000 gynaecological and obstetrical cases under observation during a period of five years in Vienna, whilst Goodell² says, "Extra-uterine foetation is by no means so rare a complication as is supposed by the majority of the profession, and is

perhaps the most common cause of sudden death in women. H. F. Formad, the well-known pathologist, is one of the two coroner's physicians in Philadelphia, and he holds now in his possession nineteen specimens of extra-uterine foetation which he has collected within four years at inquests made by him in his official capacity." We have recently published notes of two cases of extra-uterine foetation successfully treated by abdominal section.³ The first case was one of tubal gestation; rupture at the end of the second month; several slight hæmorrhages into the peritoneal cavity in the first half of the third month; the left Fallopian tube, which had been expanded and ruptured, was removed. The second case was one of subperitoneo-pelvic gestation. At the operation, performed at the beginning of the fifth month, a foetus, about six inches long, was taken from a sac in the left broad ligament, the sides of the opening in the sac stitched to the abdominal wound, and the placenta left *in situ* for several days. An attempt to remove it twelve days later caused severe hæmorrhage, and the whole of it was not removed for more than three weeks. Hæmorrhage is a cause of considerable anxiety to the operator in these cases, and it will be observed that Mr. Bellamy found it necessary to plug the cavity in his patient in order to arrest it. This has led to the suggestion that, as the death of the child will in time sever the vascular connexions of the placenta and allow it to be more easily detached, the operation should be postponed until evidence of the death of the foetus is obtained. But, although a foetus may be carried for months or even years, the risk is too serious, from rupture of the sac, to allow the suggestion to have much weight in practice. The following is from notes by Dr. F. O. Stedman, surgical registrar.

Mrs. H—, tailorress, aged twenty-five, was admitted on April 22nd, 1889. The following was her condition on April 24th. In the centre of the abdomen, situated entirely below the umbilicus, was a swelling, which had been gradually getting larger during the last three months. On percussion, dulness began about three fingers' breadth below the umbilicus; extremities of flank resonant. In the right flank the dulness commenced at a distance of three fingers' breadth from the anterior superior spine, and commenced at about the same distance on the left side. There was no bulging in the flank. The measurements were: at the umbilicus, 25 in.; and at a point 2 in. below the umbilicus, 27.5 in. From the xiphoid cartilage to the umbilicus, 6 in.; and from the umbilicus to the symphysis pubis, 6 in. From the right anterior superior spine to the umbilicus, 6 in., and the same measurement on the left side. There was most pain on the right side of the swelling; sometimes the pain extended across the abdomen. She had not menstruated for three months, and had one child four years and a half ago. Vaginal examination showed the cervix severed and partly softened. Urine clear and straw-coloured; sp. gr. 1014, no albumen. On either side of the cervix a firm mass could be felt above. Milk could be squeezed from the breast. Dr. Watt Black in consultation examined the patient, and found a tense elastic tumour in the right side of the lower part of the abdomen, reaching to within three fingers' breadth of the umbilicus, and the uterus pushed over to the left side.

On April 25th, at 10 A.M., Mr. Bellamy operated by making a median incision, about three inches in length, below the umbilicus. On opening the peritoneum a large quantity of clot appeared, which was not quite recent, but had not become organised. On removing some of this clot a foetus (three to four months old) appeared, and was readily removed, the umbilical cord tearing through. A mass was then removed consisting of blood-clot and apparently of placenta; there was some oozing from the pelvic region, which was temporarily stopped by putting in a large sponge. The lower part of the great omentum was infiltrated and matted together with blood-clot; it was therefore ligatured in two places, cut off, and removed. It was impossible to ascertain what was the exact situation of the ectopic gestation, but it seems to have been either in the right Fallopian tube or between the tube and the ovary. A large cavity, continuing to ooze, was plugged with three sponges, having ligatures attached to them, which were brought out of the abdominal wound. The wound was then closed at its upper part with Chinese twist, and a large sponge placed over the abdomen, which was dressed antiseptically. The pulse was regular and easily compressible (120). At

¹ THE LANCET, vol. ii, 1889, p. 53.

² Sajous, vol. ii., F. 39, 1889.

³ THE LANCET, vol. ii, 1889, p. 69 (Mirror of Hospital Practice).