pregnancy. Such a distinction is, to my mind, of no importance as far as treatment is concerned.

I contend that it is safer and that the danger of abortion is less, to treat all retroverted pregnant uteri as soon as diagnosed, with packing and pessaries until such time as the organ has become so large that it cannot fall backward into the pelvis. This will be between the third and fourth month.

I think that there is a belief in the profession that pregnant uteri should not be treated by vaginal packing, and that packing the vagina causes abortion. This I believe to be erroneous. Certainly such treatment did not cause abortion in the cases I have reported. When the uterus is replaceable and has been replaced, it should be held in the normal position by a suitably-fitted pessary. It is well to leave out packing during the times that would be the menstrual periods.

As regards Class 2, the incarcerated uteri, the treatment is to dislodge the fundus and put it in its proper position as soon as possible. To this end ether may be necessary, although in a majority of cases the replacement is readily performed by placing the patient on her back with knees drawn up, seizing the cervix with a tenaculum and pulling downward on this, and at the same time pushing the fundus up with one or two fingers in the rectum.

When the fundus is emerging from the pelvis, I let go with the tenaculum and pushing the cervix backward with a finger in the vagina, massage the fundus forward, with my other hand on the abdomen. When this method proves unsuccessful, I put the patient in the knee-chest position and repeat the procedure.

In Case VIII, which exhibited a most unusual combination of pathological conditions, the uterus was so large, being four and a half months pregnant, that very forcible manipulation succeeded in only partially dislodging the fundus. Several days later, however, it was found in its proper position.

The small size of the child in this case is of interest. It seems probable that the surgical interference and the cutting off of the ovarian artery on one side was accountable in a measure for this. It is safe to say that had the case been allowed to take its course without surgical aid, she would either have aborted or had a difficult labor.

In Case VII, it occurs to one as strange that the introduction of two bougies four inches in the uterine cavity and subsequent dilatation of the cervix did not produce abortion. The explanation is found in the fact that the products of conception were located in the uterine horn and were not reached by the bougies.

Cases VII and VIII are striking instances of the great tolerance of the pregnant uterus; and their happy outcome, as well as the results of my investigation of the literature of the subject, confirm me in my belief that all retrodeviations of the pregnant uterus should be treated by replacement as soon as diagnosed.

Symptoms of exaggerated backache, dysuria, intractable nausea and vomiting, or pelvic pains occurring during early pregnancy, should lead at once to a bimanual examination, and the physician should satisfy himself that the uterus is in proper position.

SULPHUR FROM IRELAND. — Sulphur was once a lucrative product of Ireland, and mines were worked at Ballymontagh in the County Wicklow. It is now believed that the mines can still be worked on profitable terms, and it is likely that they will be re-opened.

Clinical Department.

A CASE OF EMBOLISM OF THE RIGHT FEMORAL ARTERY APPARENTLY FROM CARDIAC WEAKNESS.¹

BY SAMUEL L. ABBOT, M.D.

THE patient was a middle-aged married woman, in comfortable circumstances, who up to the time of the attack was in fair health. There was no history of previous rheumatism or influenza. Her health had not been robust at any time, but she was not an invalid. She was in the habit of drinking beer moderately every day.

The first intimation of the attack was a moderate pain in the right foot, coming on in the afternoon. Towards night the foot became very white and extremely cold. The next morning while walking across the room the patient's leg gave way under her and she turned her right ankle painfully. There was some purple discoloration above the ankle, and the leg below the knee had become quite cold. She was still able to walk with some difficulty. The following morning, on coming down stairs, she was seized with a very acute pain in the outer cords of the popliteal space, which led her to suppose that she had ruptured something at this spot. From this time she was unable to walk. On this day I saw her for the first time, and found the outside of the leg from the knee down of a deep purple color, exactly like that of a venous clot, and there were several spots of purplish ecchymosis on the inside up to the knee. The whole leg from the knee down was extremely tender to the touch and considerably enlarged from edema; the circumference at the calf of fourteen and five-eighths inches, being two inches greater than that of the left calf. The outer hamstring tendons and the popliteal space were exquisitely tender to the touch, but no evidence of special local injury could be detected. Pain was felt on movement from the knee to the toes. Except for the local trouble the patient considered herself to be in her usual health. Her appetite was natural and her skin was cool. Her temperature, on the only occasion on which it was taken was 100°.

No pulse could be felt in the femoral artery at the groin, nor in that of the left groin. The left leg was apparently in its normal condition.

On examination of the heart its action was found to be extremely weak, pulsation 160 beats to the minute. There was a distinct want of emphasis to the second sound, and it was nearly as long as the first, the rhythm being very like that of the fetal heart. There was no abnormal cardiac murmur, no local tenderness or enlargement of the organ. At the wrist the pulse was extremely weak.

The leg was kept flexed at the knee as extension was extremely painful. Warm foot-baths were prescribed, the limb in the intervals being wrapped in several thicknesses of cotton wadding. A pill of one-thirtieth of a grain of sulphate of strychnia was prescribed, to be taken every two hours, with one minim of a one-per-cent. solution of glonoin. Five-grain tablets of Dover's powder were prescribed, to be taken, *pro re nata* for sleeplessness.

On the next day the limb was perfectly cold from two or three inches above the knee down, and the swelling was increasing upwards. The leg was not

¹ Read before the Boston Society for Medical Improvement, January 7, 1896.

painful when at rest, and was considerably less tender to the touch and somewhat less cold. The pulse had fallen to 120, but was somewhat intermittent, although stronger. The patient ate her usual amount of food with relish. The dose of strychnia was increased to one-twentieth of a grain and the solution of glonoin to two minims.

On the fifth day of the attack there was considerable edema of the *left* leg, extending half way up to the knee, without pain or discoloration, or apparent reduction of temperature. The ecchymosis of the right leg was increasing and passing around to the calf on the inside. Pulse 111, stronger and more regular. The heart-sounds were also stronger, and the rhythm was much better. There had been no uncomfortable feeling in the head from the glonoin, and the dose was increased to three minims of the solution, with five minims of the tincture of digitalis; the strychnia was continued.

On the next day the pulse had risen to 132; temperature 100°. Ecchymosis extended above the knee, with swelling and tenderness. Below the knee the leg was somewhat smaller, apparently from a constant exudation of bloody serum from behind, the cuticle being somewhat detached, perhaps owing to hot applications to the part at the outset of the trouble. The patient had had a good night under the influence of thirty grains of Dover's powder in divided doses. Her appetite was good and she had eaten a chop for breakfast.

On the seventh day there was a little twitching of the tendons of the wrist, and the strychnia was directed to be given at intervals of four hours. Pulse 102, a little irregular. Sole of foot warm. The next morning the patient was moribund, there being no pulse at the wrist.

I am led to report this case, as it must be one of great rarity. It is only the second that I have seen in a long professional experience. The first was under my care in the Massachusetts General Hospital and occurred in a patient affected with malignant endocarditis. In that case there was evidence of obstruction at the mitral valves, probably from a thrombus. In the course of the case embolism of the right femoral artery occurred, with disappearance of the cardiac souffle and the pulse in the right femoral artery at the groin. Under the use of glonoin the pulse returned to the groin, the embolus evidently being forced down the artery from the increased freedom of the circulation below, and the spots of venous ecchymosis turned to a raspberry color from the increased force of the circulation. In this case also the patient died.

In the present case there was no autopsy, and the only probable cause of the symptoms seems to have been the heart weakness. There was no gangrene in either case.

CANCER OF RIGHT KIDNEY; NEPHRECTOMY; NO RECURRENCE AFTER EIGHTEEN MONTHS.

BY WILLIAM N. SWIFT, M.D., NEW BEDFORD, MASS.

A. G. T., forty-seven years old, butcher. No history of malignant disease in the family. Three sisters died of phthisis pulmonalis. Well until two years before, then began to run down. No definite symptoms until spring of 1893. Began to have night-sweats, and noticed a bunch in right side of abdomen.

I saw him in June, 1893. The patient was anemic, but showed no other symptoms except a tumor in right side of abdomen, about the size of a small cocoanut. It was just below the ribs, and extended back to the loin. Was slightly movable and somewhat tender on pressure. The patient complained of distress in the region of the tumor, but no sharp pain. Also distress in the right side of back, most marked when stooping over. Could not lie on left side at night, as it increased distress. Micturition frequent and little at a time. Marked sagging feeling in both testicles, and at times some pain in right testicle. The patient complained of weakness and profuse sweating. Urine normal in quantity, but contained small amount of urea. No albumin or abnormal deposit.

A diagnosis of probable tumor of the kidney was made, and operation advised. The patient decided to wait.

During the summer his weakness and sweating became more marked, and also the distress in his side.

Operation, September 13, 1893, at St. Luke's Hospital. An incision, five and a half inches long, was made over the middle of the tumor three and a quarter inches from the median line. The tumor at once presented. It seemed to contain fluid, but a needle showed it to be a solid growth. It was enucleated without difficulty, and was found to come from the lower part of the right kidney. The kidney and tumor were removed. The ureter was tied, and its free end touched with strong carbolic acid. The vessels were tied with silk by transfixing the pedicle. The abdominal wound was sewed up in layers with catgut. Every precaution was taken to make the operation aseptic. No antiseptic solutions were used except for washing the patient's skin and operator's hands.

The tumor was as large as a good-sized cocoanut. It originated from the lower and outer part of the kidney, and was completely encapsulated. Microscopic examination showed it to be a carcinoma.

The patient did perfectly well, and left the hospital on the twenty-third day.

The amounts of urine passed on the days following