27th.—Every other day a No. 8 catheter is passed; the quantity of urine voided by the urethra is increasing.

June 10th.—A fluctuating swelling, the size of a filbert, just above the perineal wound, was opened.

15th.—Some urine still passes through the wound; tenderness much less. No. 8 catheter passes easily.

20th.—Discharged for Convalescent Home. To pass a catheter every other day.

GUY'S HOSPITAL.

CLINICAL REMARKS ON PRESYSTOLIC MURMUR, AND ON CAPILLARY BRONCHITIS.

(By Dr. WILKS.)

Presystolic murmur.—There is now in Stephen ward a well-marked case of presystolic murmur in a young man, aged twenty. On palpation of the cardiac region a presystolic or diastolic thrill is felt at the left apex, and on auscultation there can be heard, preceding the systole, a long, loud murmur which is followed by a sharp sound. This sharp sound is not the second cardiac sound, as might at first be imagined, but it accompanies the systole, and is the first sound of the heart, modified by an altered condition of the bicuspid valves. Dr. Wilks remarked that the early auscultators, and especially Laennec, distinctly recognised this direct mitral murmur, and knew the pathological condition on which it depended, and even Corvisart had observed the *frémissement* which often accompanies it. Laennec gives a case, which is quoted by Dr. Wilks in the "Note on the History of Valvular Diseases of the Heart," in Guy's Hospital Reports, 1870-71, which exactly resembles that now in the hospital in every particular. Laennec's error was in not appreciating the exact time at which the murmur occurred. The mechanism of the presystolic murmur is still under consideration. Laennec regarded the murmur as being due to prolonged contraction of the auricle, although he knew that in health the contraction of the auricle was sharp and short, and accompanied by no sound. It is still a question whether this murmur is due to the slower contraction of the auricle in consequence of its hypertrophy, and the obstacle it has to overcome, or whether it is owing simply to the blood pouring in from the veins during the diastole of the heart and the pause.

Capillary bronchitis.—In Stephen ward there is a man, aged fifty, who is the subject of severe capillary bronchitis, and in whom both bases of the lungs are impervious to air. There is an intensely cyanotic tint of the skin, and more especially of the nose, lips, ears, hands, and feet, and dyspnoea is extreme; but notwithstanding this, the patient lies on his side in a horizontal position. This latter condition is of grave prognostic import, for the strength of the patient is so reduced that he is unable to sit up, and, moreover, the nervous centres have become so dulled that the urgency of the dyspnoea is not felt. In this case, when the diaphragm descends, the lower part of the chest walls recedes, thus showing that air does not enter the lower part of the lungs, while, on the other hand, the respiratory movement of the upper part of the thorax is exaggerated. As a result of the engorged state of the right heart sequential to the obstructed circulation through the lungs, the jugular veins are dilated and the extremities œdematous. In spite of these depressing circumstances, the patient, as sometimes occurs in such cases, has a remarkable tenacity for life, and is lingering on. In very rare instances recovery may take place, even in the most threatening case, but even then relapse may occur.

ST. THOMAS'S HOSPITAL.

OVARIAN CYST; OVARIOTOMY; RECOVERY.

(Under the care of Mr. SIMON.)

FOR the notes of the following case we are indebted to Mr. William Garton, house-surgeon.

Ellen W—, aged fifty-four, single, was admitted June 6th. She first noticed, about a year ago, that her abdomen was increasing in size, but not one side more than the other. The catamenia ceased seven years ago. On admission, the left side of the abdomen was somewhat more

prominent than the right, and the patient was unable to lie on the left side, on account of a dragging sensation in the abdomen when she attempted to do so. No pain in the tumour; legs not œdematous; no history of local peritonitis or of paracentesis. The tumour appeared to consist of a large single cyst, and the uterus was pronounced by Dr. Barnes to be free from disease.

On July 13th, after chloroform had been administered, Mr. Simon made an incision four inches in length between the umbilicus and the pubes, and through this opening the hand was passed to separate the complete but slight adhesions. A canula was then introduced into the tumour, and about three and a half gallons of dark-coloured fluid allowed to escape. The tumour, having been separated from some omental adhesions, was then withdrawn, and it was found that the extremity of the left Fallopian tube was attached. No hæmorrhage. The clamp was then placed around the narrow pedicle, to the surface of which solid perchloride of iron was applied. The Fallopian tube, after being stripped off the tumour, did not fall back into the abdomen, but remained close to the surface inside the wound. The incision was then brought together by silver sutures.—At 11 A.M. (an hour after the operation) there was slight nausea, but no vomiting.—10 P.M.: Temperature 100.4°; pulse 108. To have a subcutaneous injection of one-third of a grain of morphia.

July 14th.—Had a good night; temperature 99°; urine drawn off by a catheter. To have milk, beef-tea, &c.

15th.—Patient suffered considerably from flatulence, which was relieved by a small dose of brandy.

16th.—Had a good night; catheter passed every five hours; wound healthy; temperature in the evening 102°. To have an opiate.

17th.—Sutures removed, and wide strips of plaster applied to support the wound; temperature in the evening 100°. To have fish.

18th.—Upper part of wound healed; bowels not moved since the operation.

20th.—Temperature 100.4°; catheter not necessary.

22nd.—Bowels relieved by an enema; appetite good; still a little discharge from lower part of wound.

Aug. 1st.—Patient able to sit up. To wear an abdominal belt.

EDINBURGH ROYAL MATERNITY HOSPITAL.

(Cases under the care of Dr. MATTHEWS DUNCAN.)

RETRACTED NIPPLES.

C. L—, aged twenty-six, unmarried, of fair complexion, was delivered on Sept. 1st of her first child at the full time. The labour was natural, but there was a considerable rupture of the perineum. Her nipples were so retracted that they could not be drawn out so as to enable her to suckle her infant. The areola and nipple were both in an imperfectly developed state. The former was only about an inch in diameter, was very slightly tinted with pigmentary deposit, being of a brownish rose colour, with only a few small glandular follicles on it; the nipple did not project at all and was very small, so that if projecting it would not have been larger than a pea. The breast itself was fully developed and turgid with lactiferous engorgement, the milk-ducts full of milk, which could be easily expressed.

In this case the retraction of the nipples was the consequence chiefly of their imperfect development. Such imperfectly developed areolæ and nipples are not very rare, and the condition is not incompatible with successful suckling; but in the present case the retraction was so complete, in addition to the imperfect development, that there was almost no hope of success as a nurse. Fortunately for the woman, she had, before the birth of the child, resolved not to nurse it, and had made arrangements accordingly.

The ordinary causes of retracted nipple in lying-in women are lactiferous engorgement of the mamma and cicatricial bands, the result of the healing of an abscess occurring after a former pregnancy. In cases due to the former of these causes, time is the great cure, the retraction disappearing when the breast becomes "free." Till the freeness comes the nursing may be in abeyance, or its place may be imper-