some degree of softening and additional enlargement, and when the congestion a little subsides the part affected is left hard and resistant.

There may be found considerable hardness, with slight enlargement of the uterus, without change of shape to any great amount, for it is by no means a *necessary* effect of defective involution of the uterus that it should undergo a change of shape. Whether that happens or not will depend on circumstances. The defective involution leaves the uterine framework, so to speak, large; it hardens in that enlarged state, this condition persisting perhaps for months, and even for years.

The degree of hardness observed varies. Sometimes the uterus possesses a quite stony hardness, the cervical portion presenting rounded projections of considerable size, very firm to the touch. In process of time these hard portions may become still harder. The hardness is most intense when there is an associated chronic flexion present. These hard nodular enlargements of the cervical portion alter the natural shape of the os uteri to a notable degree. Dr. Henry Bennet some years since differentiated them from a condition with which they were formerly liable to be confounded—viz., the early stage of uterine cancer.

(C) *Increase in bulk.* This, as already remarked, is frequently associated with undue hardness, particularly when the malady has existed for some time. But increase in bulk is often attended also with greater softness than ordinary. The defectively involuted uterus is large and soft at first. It is subsequently large and *hard*. In regard to mere size, all degrees of it may be encountered when flexion is associated with it; the enlargement is most marked at the two extremities of the uterus, and it is unnecessary here to explain the mechanism of its production, this being the same whether the patient has been pregnant or not. The difference is, however, great in degree, for the organ is rarely found anything like so large in the nulliparous subject as when pregnancy has formerly occurred. Cases are exceedingly common in which the patient is found to have an enlarged, distorted uterus, which sometimes presents considerable softness, but at other times is found to be hard and resistant. The organ contains much blood, its vessels are increased in size; it is the seat of repeated congestions, which alternately appear and disappear. The organ grows by the continual additions that are made to its bulk as the result of these repeated congestions, until it attains a very considerable magnitude. The body of the uterus is not unfrequently found so heavy that it is altogether at the mercy of external forces. The uterine stem, narrowed at its middle, offers a quite inadequate resistance to further flexion. The disorder is thus perpetuated, each successive attack of congestion leaving the organ more and more helpless.

Thus it happens that in women who have had children the uterus is frequently so much enlarged that its bulk renders treatment difficult in a greater degree than is the case with nulliparous subjects.

The obstacle which a coexisting flexion offers to the return of the uterus to its normal size after parturition is very great. I have had opportunities on several occasions of appreciating this difficulty in cases where the uterus has suddenly become flexed within a short time after the occurrence of labour. The involution is very greatly retarded by the occurrence of the flexion, and in like manner in the chronic cases of conjoined flexion and enlargement I have found the great obstacle to the reduction of the enlargement is the flexion. When the uterus has become much hardened, as well as flexed and enlarged, the difficulty is proportionately increased. But nevertheless it is a fact, which I have over and over again observed, that the diminution in the bulk of the enlarged uterus which occurs when the organ is straightened is very frequently quite remarkable. The explanation, of course, is that the processes of nutrition, circulation, and absorption go on much more readily when the uterus possesses its natural shape. There is nothing very wonderful in this, but the very simplicity of the explanation seems to be a barrier to its acceptance with many.

The very great importance of enlargement of the *body* of the uterus as a factor in the majority of actual cases comes out more and more as clinical observation is extended, more especially in the case of women who have had pregnancies. Unquestionably this condition was formerly frequently over-

looked, but there is no doubt that it will come to be regarded with more and more attention in the future. The appreciation of the existence of this enlargement is sometimes not easy. The increase in the size of the cervical portion of the uterus is recognised readily enough, but unless the enlargement of the body of the uterus be looked for, circumstances are such that it will be frequently undetected. Not rarely the cervical portion is only slightly enlarged, while the body of the uterus is very much increased in size, and unwieldy to a degree.

Here another practical remark may be made. It is my experience that enlargement of the body of the uterus is far more commonly overlooked when the organ is anteфлекed than when it is retroфлекed. One reason is that the body of the uterus is more readily felt by the touch in cases of retroflexion than in cases of anteфлекion. But another is that careful exploration through the roof of the vagina by digital examination is too often omitted. Perhaps the most common case which presents itself in ordinary practice is that of a patient who has had pregnancies and who has since become affected with enlargement of the uterus, anteфлекion, anteversion, and descent of the whole organ below its natural position in the pelvis. The facts lie before us, and it does not require a highly skilled observer to appreciate them. It is only necessary to insist on the investigation covering the whole ground; these abnormal conditions will not then so frequently be altogether unnoted and unrecognised.

According to my experience, cases are not very common in which the body of the uterus is much enlarged *unaccompanied* with change of shape (of course fibroid enlargements are here excluded from consideration), and this is an important argument for the truth of what has been above said regarding the connexion between the distortion and the enlargement.

(D) *Diminution in bulk.* On this subject little remains to be added to what has already been stated respecting the nulliparous uterus. The cases of super-involution of the uterus described by Simpson come under this category, but they are very rare. The local atrophy, limited to the seat of the bend in cases of flexion, is, however, very important. See previous remarks on the nulliparous uterus.

CASE OF RETRO-PHARYNGEAL ABSCESS COMPLICATED WITH, AND OBSCURED BY, SUBACUTE LARYNGITIS:

TRACHEOTOMY PERFORMED FOR RELIEF OF LATTER
BEFORE FORMER WAS DISCOVERED.

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THE above case came under my observation when I was in medical charge of the 18th Bengal Infantry, now stationed at Baxa, Bhootan. It may be worthy of publication, as it presents the following peculiarities:—

- (a) Origin of the abscess low down in the pharynx.
- (b) Complication with laryngitis.
- (c) The history of the case pointing to laryngitis.

The patient, a sepoy of the regiment above-mentioned, rushed into hospital about 9 p.m. one day in a state of great excitement, coughing violently. I was summoned immediately. As I found him capable of giving answers to my questions, and heard his statement that a fragment of the husk of paddy went down the wrong way, I dismissed the immediate gravity of the case from my mind, and told him that in a few hours the coughing would expel the husk. He, however, thought differently, and, placing his finger on the middle of the right side of the thyroid cartilage, wished me to insert some instrument to extract it. He said that if this were not done, he should die before morning. I dismissed him to his charpoy, and placed an attendant to watch over him.

On visiting the hospital the next morning, I found him quite composed, but he still pointed to the same spot, and expressed his belief that the fragment was still there. He returned to his duty.

About twelve days after he made his appearance in the hospital complaining of difficulty of deglutition and respiration. The signs and symptoms were briefly these. Expression anxious; neck stiff and bent forward; head immovable; voice a hoarse whisper; breathing difficult; deglutition almost entirely impeded. Pain in p^osum Adami, especially in middle of right ala; digital examination of the fauces revealed nothing to account for the urgency of the symptoms. As the signs and symptoms pointed to laryngitis, active measures were adopted to reduce the inflammation in the larynx. As this was not acute, and as there was no fever, I thought that the best plan would be to paint the external surface of the larynx with blistering fluid to cause a sudden diversion of the nerve-force from the inflamed structures. Had the inflammation been acute I should not have done this. About ten hours afterwards the patient expressed himself as better. I ordered inhalation of steam, and nutritive enemata. The next morning he felt worse; complained of great hunger and thirst; breathing was more difficult. The paroxysms of coughing were becoming more frequent and violent. Towards the afternoon he said he felt respiration easier, but towards night the case looked very alarming. Digital examination revealed nothing. Tracheotomy was indicated, but I could not trust myself to its performance by candle-light. Two hospital assistants were appointed to watch over him during the night. The next morning tracheotomy was performed above the thyroid isthmus. Respiration was relieved. Trachea tubes were inserted; the patient was placed in a warm corner of the hospital (which was made of bamboo, mud, and grass), and was fed by nutritive enemata. The next morning I expected to find some relief in deglutition; but the patient thought the difficulty increasing. I was alone in this station, and there was no one whom I could call in consultation. I was rather perplexed. Forty-eight hours after the operation I began to suspect some other cause, and again subjected the patient to a digital examination of the fauces. The finger at once detected a smooth, tense, projecting protuberance behind the tongue. The case became at once evident. The abscess was immediately opened, and about five or six ounces of thick and yellowish offensive pus were evacuated. The abscess extended *low down* into the pharynx. Shortly after the operation the patient swallowed half a pint of milk and brandy, for he was exceedingly thirsty and hungry. The trachea tubes had to be kept in a day longer. They were then removed, and the opening began to close up rapidly. The abscess discharged pus for two or three days.

When I was leaving the regiment on furlough to England he was quite well, and making preparations to proceed to his native village on convalescent leave.

Remarks.—The case is peculiar in that the abscess had its origin *so low down in the pharynx* that it was beyond the reach of the finger. The pressure of the abscess against the larynx excited subacute inflammation, and the abscess did not become apparent until it had grown and risen to be within the reach of the finger.

TWO CASES SIMULATING DELIRIUM TREMENS.

By SURGEON-MAJOR G. YEATES HUNTER,
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ABDOOL AHMED and Ally Hoossain, two strongly built Arab sailors, who were undergoing a sentence of five years rigorous imprisonment in the House of Correction, at Bombay, for taking part in the Parsee and Mahomedan riots in February, 1874, were admitted into hospital in June with symptoms closely resembling those of delirium tremens.

It was difficult to obtain a complete history of these men because, being Arabs, neither understood a word of Hindoostani, but information has been gathered to the effect that they had both been very temperate, hard-working men, had suffered from no serious previous sickness, and had always been large eaters.

On admission and throughout their illness the symptoms of excitement were prominent and were succeeded by most remarkable depression. There were delusions, the muscles of their limbs were tremulous, as also was the tongue, and the head of Abdool was constantly shaking from side to side. The appetite of both was voracious; they simply could not be satisfied; squatting down they shoveled the food in as fast as they could, and had while doing so a peculiar wild-beast kind of appearance. For the rest, temperature was 99° F., pulse soft, skin perspiring, tongue creamy, sleeplessness was marked, bowels confined, breathing, sighing, and a nervously alarmed fidgety state was present. I may add that, although much excited, they were readily controlled and showed a disposition to obey orders.

Treatment.—Head shaved and kept cool, bowels thoroughly opened, and secretions corrected. Quinine and acid and bark and ammonia were given, and bromide of potassium, chloral, and hypodermic injections of morphia to compose. The native diet was exchanged for European, and extras were freely allowed, such as beef-tea, milk, sago, arrack, &c.

I extract the following from Ally's case:—"June 16th.—At 8 p.m. yesterday (ten days after admission into hospital), this man all at once jumped out of bed and tried to make his way downstairs, talking loudly, and shouting out that he was a shaitan (devil), and that three other shaitans, natives of his country, were on the top of the house. He looked pale and excited, singing, laughing, and abusing people. Eyes had a maniacal stare, pupils natural, body cool and perspiring, tongue moist, pulse soft and weak (78). He continued in this state until 3 a.m. this morning, when he dropped off to sleep, bromide of potassium having been given to compose him. To-day he looks tired and is weak, and has no recollection of last night's occurrence. There is tremor of the head and limbs."

After three weeks' treatment in Abdool's, and two months' in Ally's, case, they were transferred to the Lunatic Asylum, as I have no adequate establishment for the treatment of mental derangement, and I have since heard that they completely recovered.

These cases are, I think, noteworthy as presenting symptoms of delirium tremens without any history of alcoholic blood-poisoning or of the use of narcotics. The tremor of the various muscles, those of the tongue included, was very marked; delusions were present, and the symptoms generally were characteristic of delirium tremens, with the sole exception of appetite, which, instead of being lost as is usual in delirium tremens, was enormous. I may observe that the peculiar train of symptoms I have described did not set in until after three months' incarceration.

I find in Abdool's diary the following notes: "This is a singular case, giving the appearance of delirium tremens, and I can only account for the tremors by concluding that a semi-starvation diet, compared with his former ration, has caused great nervous exhaustion." Doubtless there is a similarity in the symptoms of these two cases to those of starvation. From their first admission into the county gaol they complained of the diet being insufficient, upon which the Marshal, exercising a wise discretion, took upon himself to order European diet. Upon their transfer to the House of Correction, to which all long-term prisoners are sent, they were rationed in the usual manner, receiving the native diet of rice, dhall, &c.

The scale of diet in use in the two Bombay gaols is ample to meet ordinary requirements, but it appears to me that the cases I have glanced at show that it is impossible to frame dietary tables, as to the quantity, to suit all; at all events, I shall take care that in future Arabs are rationed on the more liberal scale.

I almost omitted stating what I think confirms the hypothesis that insufficient food-supply was answerable for these attacks—viz., that Ally recovered after about six weeks' treatment, and on being discharged with some of the extras cut off, was readmitted in about a fortnight with similar symptoms.

It may be well to state that Arabs lead a roving free-and-easy kind of life, and are peculiarly liable to suffer from imprisonment, which tendency, superadded to privation, may more easily account for a train of symptoms I have ventured to think of sufficient interest to bring to notice.

Bombay.