this irregularity of pulse, now beating at from 80 to 90, then suddenly mounting up to 120 or 130, then suddenly falling again to 90 or 100—I have never observed this condition except where flooding was present. I have therefore learned to attach far greater importance to irregularity than to mere rapidity of the pulse. Again, one of the worst cases I ever had was where the pulse, from beating at its normal standard, 80, suddenly fell to 50. This I have observed only in one case. In one or two cases the pulse was distinctly intermittent. The common injunction given in books on midwifery is not to leave a patient when the pulse is above 100. But I have often done so, provided it is beating steadily; whereas a rapid and irregular pulse would have caused grave anxiety and solicitude.

Another interesting question in regard to post-partum hæmorrhage is the relative frequency with which it is met by different practitioners. Dr. Playfair, in his recent work on Midwifery, says on this point: "When I hear that a medical man is constantly meeting with severe post-partum hæmorrhage, I hold myself justified, *ipso facto*, in inferring that he does not know, or does not practise, the proper mode of managing the third stage of labour." Now the method of "expression" of the placenta described by Dr. Playfair is substantially the same as I have always practised, and yet I have met with a large proportion—upwards of thirty cases—of post-partum hæmorrhage. Conversely, a friend of mine who has attended upwards of a thousand confinements, has never met with a case of flooding of any kind whatever; and on comparing notes with him, I find that he, for the most part, practises the very mode that Dr. Playfair says ought not to be practised. I suspect that there is an element of luck in regard to the meeting with hæmorrhage, as there is in regard to puerperal fever; for it is a fact that many practitioners conduct large practices for years without ever meeting with a case of the kind, while others, without any assignable cause, are constantly meeting with them.

Park-road, Regent's-park.

FUNGUS HÆMATODES OF LEG, TREATED WITH CHROMIC ACID; CURE.

By A. E. BARRETT, M.R.C.S. &c.

MATTHEW S—, aged fifty-two, farm labourer, a somewhat cachectic-looking man, applied to me on the 21st of March, 1876. He states that he has never had syphilis, and that none of his relatives have had malignant disease. Twelve years ago he slipped from the wheel of an engine, and scraped off the skin over the middle of the left tibia. He continued at work, and took his beer freely. The sore became inflamed, and he had to lay up for six weeks. Before it was quite healed he resumed work; the wound reopened, and emitted a sanious discharge. After again resting, it cicatrised; but a hard, dark-coloured, movable lump remained at the injured spot. This continued, without causing much inconvenience, until five months ago, when it was evidently increasing. A month since he knocked it against a barrow; and the following day, as it was swollen and painful, he came to me, and I enjoined rest in a raised posture, thinking that the swelling might be connected with a varicose state of the veins. As rest did not reduce it, but as it appeared to be bulging in the centre, I passed needles under it and applied a ligature; but after separation the growth recurred, and assumed all the characters of fungus hæmatodes.

Dr. Lowe, consulting surgeon of the West Norfolk and Lynn Hospital, kindly examined the case for me at this time, and recommended the application of crystallised chromic acid. The following is his description of the case. "The fungation was prominent; about an inch in diameter, dark-coloured, and at times bleeding freely. The surrounding skin was indurated and dark, with venous congestion. Occasional sharp pains were felt, but generally there was a dull aching in the limb."

On the 5th June chromic acid was applied in the following manner:—A ring of gutta percha, having been fitted round the sore and sealed to the skin with cerate, was filled with

crystals of chromic acid, which were allowed to deliquesce and remain in contact with the tissues for fifteen minutes. As this did not quite suffice to destroy all the growth, a second application was made fourteen days afterwards. In a fortnight the dry, leathery eschar, which always results from the application of chromic acid, separated; healthy granulations commenced, and the sore rapidly and firmly cicatrised. It remains sound at the present time, the surrounding induration having quite disappeared.

King's Lynn.

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.

ST. MARY'S HOSPITAL.

BULLET WOUND OF CHEST; HÆMOTHORAX; ABSCESS OF LUNG; RECOVERY.

(Under the care of Mr. HERBERT W. PAGE)

THE following history, condensed from notes taken chiefly by Mr. Coumbe, house-surgeon, is of interest, not only as a record of a case unusual in this country, but also as showing how a lung may recover from conditions perilous to life. The absence of hæmoptysis is no evidence of the lung itself not having been wounded. The experience of surgeons during the American civil war is decisive on this point; and in the first volume of the Medical and Surgical History of the Rebellion it is stated as "quite erroneous to suppose that hæmoptysis is a usual sign of wound of lung, its appearance being noted in only 492 of the 8715 cases observed." The successful issue of the present case is perhaps due as much to the previous good health of the patient as to the treatment carried out, which consisted, in the main, in ensuring rest, and the internal administration of what are usually termed expectorants and tonics.

J. C—, brought to the hospital on the morning of Nov. 9th, 1876, had been shot at a few minutes before, by one of his mates, with a revolver, at a distance of about six yards. At the third shot he fell to the ground. On admission, at 5.15 A.M., there was marked collapse, and a small wound corresponding with a hole in his clothes was found about three-quarters of an inch to the inner side of the right nipple, just below the inferior border of the fourth rib. The wound, from which a small piece of coat was taken, just admitted the tip of the little finger, and a probe passed into it to the depth of about an inch indicated its direction as perpendicular to the surface. There was no hæmorrhage externally and no hæmoptysis, nor could any trace of the bullet be found, though it was clear that it had penetrated and was lodged in the interior. Three hours after admission the collapse was even more pronounced, and led to the belief that bleeding was going on internally. His temperature at midday was 97° F. He rallied during the day, and on the following morning his temperature was 100° F., his pulse 112, and his respiration 50. The physical signs were now definitely marked. Absolute dulness with absence of breath-sounds over the posterior inferior part of the right chest, commencing two inches above the inferior angle of the scapula, comparative dulness anteriorly, and increased breath-sounds over the upper part of the lung, pointing to compression of the base of the lung by fluid in the pleural cavity. This was no doubt blood. During the next few days he suffered much from difficulty of breathing and from troublesome cough, and the temperature on the morning of the 12th was 103.4° F. On Nov. 16th it was again normal, and he was in many respects improved, though he had a good deal of pain about the upper border of the liver, and was jaundiced. This lasted for several days, and as the temperature again rose and continued between 101° and 103° F., fear was felt that the bullet might