

were crowded either with epithelium or with granular or globular material. Not a healthy tubule was seen, although the examination was very thorough. Urine taken from the bladder coagulated neither by heat nor nitric acid. The other organs were healthy, but the cartilage of the left hip was mostly destroyed and the exposed bone red, as in acute inflammation.

This case is by no means so conclusive as the other, as the diseased joint may have had some influence in producing the symptoms, but the excessive vomiting could hardly be explained by it.

CASE III.—In April, 1868, I examined a man, 24 years of age, who died under the care of Dr. Palmer. He first saw him on April 9th. There was slight cough, with some mucous râles in the chest like those of bronchitis. The principal complaint was of severe chills, which persisted in spite of the administration of quinine. There was also vomiting, but both of these symptoms diminished, and in five days he had a pulse of 72, and there was some appetite. Three days after, he began to vomit dark-green matter, containing blackish specks. There was neither pain nor tenderness, but the vomiting persisted, and he died in six days.

The tubuli of the kidneys were crowded with cells, which also filled the field. Large masses of the same were also seen, resembling portions of tubes.

The other organs were normal, with the exception of the spleen, which was somewhat enlarged and softened.

ARE ARTIFICIAL TEETH CAPABLE OF PRODUCING SALIVATION?

By P. A. O'CONNELL, M.D., Boston.

My attention has been called to a case which points to the possibility of the occurrence of *salivation* and the *constitutional effects of mercury*, from the use of artificial teeth, and the importance of the circumstance has seemed to be sufficient to justify a mention of it; so that inferences may become either corrected or confirmed by the observations of others of the profession.

The patient, in the case referred to, was a lady, who had used the artificial teeth that are now accused of having produced trouble, between two and three years. Before using them, her general health was good. While using them, her health became poor (*wasting away*), and proceeded gradually from bad to worse, resisting every mode of treatment. She exhibited no special cause of illness, until the occur-

rence of salivation and sore mouth drew attention to the teeth. Then it was found that the plate upon which the teeth were mounted, which was a suction plate of the red rubber kind, presented a corroded appearance on the surface which came in contact with the roof of the mouth. And the circumstance that this kind of rubber plate is made up to a great extent of the sulphuret of mercury, suggested the possibility of the general ill health resulting from this cause.

The teeth were removed, of course. The mouth became well speedily; and without any further treatment the lady's general health began to improve immediately in a very remarkable manner.

Upon mentioning this case to some medical gentlemen, it recalled to the mind of one of them another instance of salivation, resulting, apparently, from the same cause. Here, too, the disuse of the red rubber plate allowed the mouth to become well; and a set of teeth mounted on dark rubber was used afterwards without any inconvenience resulting.

The red rubber which is used in making the plates upon which artificial teeth are mounted, receives its color from the sulphuret of mercury, which is mixed with it very intimately, and constitutes generally about one-third of the mass. This preparation of mercury is very insoluble, resisting, in the chemist's laboratory, the strongest acids; and it is difficult to understand what combinations can have taken place in the mouth to render it liable to absorption.

It is rendered soluble by mixture with the sulphide of potassium, but one would suppose that it would be protected sufficiently by the rubber with which it is thoroughly mixed and baked.

Are artificial teeth, under any circumstances, capable of producing salivation?

Selected Papers.

TWO CASES OF TWINS.

By JOHN BRUNTON, M.A., M.D., Surgeon to the Royal Maternity Charity.

THE narration of the following cases will, I think, on account of their rarity, be of some interest to this Society. Cases of placental presentation and their treatment, successful or unsuccessful, ought always to be recorded. If successful, our guide to treatment is established; if unsuccessful, we

are warned as to the dangers which we might meet any day.

CASE I.—On the 28th day of December, 1867, I was sent for to attend Mrs. H—, æt. 28, in her fifth confinement.

When I arrived I found that the liquor amnii had escaped with a gush, followed by the head of the child. The next pain delivered the child, and then ensued a tremendous gush of blood, the loss of which caused my patient to faint. I at once grasped the uterus with my left hand, and on doing so, discovered the uterus to be large, and evidently containing another fœtus.

Examination, per vaginam, disclosed placental presentation with the second child; the vagina was full of blood, and a considerable stream was coming away.

I at once slipped my left hand past the placenta, through the membranes, into the uterus, turned the child and delivered it. The placentæ were delivered in a few minutes; the mother rapidly recovered the shock, and ultimately did well. There was no succeeding hæmorrhage; the second child was born alive, and is alive now—the first was dead. One of the placentæ, for there were two, was covered with clot, indicating previous separation. There had been no hæmorrhage before the birth of the first child. The children were females, each in its own set of membranes.

CASE II.—On the second day of December, 1869, at 6 o'clock, I was sent for to Mrs. F—, æt. 29. She was in the eighth month of her pregnancy. On arrival I learned that she had had some diarrhœa, and when at the closet she felt a rush of fluid issuing from the vagina; on getting up stairs to examine herself, she found that it was blood. She had been bustling about a good deal that day.

On examination, I found the vagina full of blood, the os uteri closed, and that there was no labor. I administered an opiate, ordered her to keep still in bed, and to send for me if the bleeding came on again.

At 10, P.M., I was summoned; the hæmorrhage had set in alarmingly about a quarter of an hour before. As she lived close to my house I was present with her in a few minutes. She had had a little uterine pain.

On examination, I found blood coming away rapidly, the os uteri the size of a crown-piece, with a bag of membrane protruding. Introducing my hand into the vagina in order to make a proper search for the placenta (for the child was still above the pelvic brim, vertex presenting), I could not find it, though I passed my finger well

into the uterus and round the neck. As the hæmorrhage still went on, and there was a dilatable os with a little labor-pain, I gave a full dose of ergot, and ruptured the membranes. The hæmorrhage at once ceased; by manual dilatation, accompanied by abdominal frictions, I delivered a dead male child at 10.45, P.M. The delivery was succeeded by great hæmorrhage. On endeavoring to ascertain the cause of the hæmorrhage, I found the uterus large and only partially contracted, and that evidently another fœtus was in it. On examination, per vaginam, the os uteri was filled up with the placenta, which was partly adherent; I introduced my left hand, detached the whole placenta, and brought it out on the bedside. It was double battledoor and clotted over half its extent, as in the former case. On the removal of the placenta the hæmorrhage at once ceased. By stimulating the uterus to contract by means of abdominal frictions, a second child was soon born (in about five or six minutes), wrapped in its membranes. The child was alive, and lived thirty-six hours. The uterus contracted well, and the mother has done admirably.

Twin males in separate sacs.

Remarks.—First of all, whence the hæmorrhage? Evidently from the uterine sinuses which were left open in the semi-contracted state of the uterus after delivery of the first child. In both cases the hæmorrhage might be called accidental. In the first case, probably the hæmorrhage was in utero before the birth of the first child, and was concealed accidental. In the second case the hæmorrhage was early, and, as the placenta could not be found on examination, we might call it pure accidental.

Secondly, what about the placenta? In the first case we may conclude that the placenta of the first child had been separated during labor, and not before, as there is no history of strainings or hard work in this case. That this is probable is borne out by the history—sudden fainting of the mother, great hæmorrhage, and dead child, the second child being alive.

In the second case, where there was one placenta, or, more properly speaking, two placentæ joined into one, it is probable that the mother caused separation of that part of the placenta belonging to the first child some time before labor set in; hence the early hæmorrhage and the death of the first child; and it is very likely that the previous detachment of part of the placenta, aided by pressure of blood-clot and uterine contractions, caused the whole placenta to be detached and to slip down or turn over

upon the os uteri. I have mentioned that I felt the placenta partly adherent; this adhesion was in all likelihood membranous. It is interesting in this case to find the second child alive, even though the placenta was so long on the bedside.

Thirdly, I have said that the placenta presented with the second child. I do not mean to say that these cases were such as are usually denominated placenta prævia, where the site of the placental attachment is partly or wholly over the os uteri, but only that a condition existed, belonging to both cases, viz.: that on examination there was extensive hæmorrhage, and a placenta occupying the os uteri.

Such cases as I have narrated are extremely rare: I have searched the works of numerous obstetricians, and have been unable to find such.

Dangerous as accidental hæmorrhage is, and more so accidental concealed, I should say that hæmorrhage arising from causes such as I have narrated is much more dangerous, because, when one child is in utero, we usually get good uterine contractions set up, and consequent closure of the mouths of the uterine sinuses; but, in cases of twins, there is often a considerable period of time between the birth of the first and the second child, and so we can easily see the extreme danger that might arise were the first placenta to become detached, and the uterine contractile action to cease. One can fancy with horror such a case.

Now as to treatment: I did not lose any time when the urgent symptoms were declared. In the first case, I "turned and delivered," giving ergot, and stimulating the uterus to contract by manual frictions over the abdomen. In the second, I followed Professor Simpson's plan, and detached the entire placenta, and followed out similar secondary treatment to that in the first case.—*American Journal of Obstetrics*, from *Transac. London Obstetrical Society*.

Reports of Medical Societies.

BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.

F. B. GREENOUGH, M.D., SECRETARY.

MARCH 13th.—*Case of Uræmic Poisoning.* Dr. H. K. OLIVER reported the case.

Widow, æt. 53, nurse to an invalid gentleman for five or six years; work laborious; usual health good. In early part of January had what she supposed a series of

colds. Afterwards chilly, pains in back, loss of appetite and nausea, night sweats. Vomited first on 31st. Symptoms mentioned continued (as also the vomiting) daily, and took to bed on February 5th. On that day had a regular chill. Some increase of fulness and frequency of pulse. Typhoid fever was suspected. No abdominal symptoms. Bowels costive rather than loose. Tongue moist, with some coating. On 7th, erysipelas of right side of face, spreading gradually to left side. Chills daily in afternoon, followed by excessive perspiration, without noticeable febrile stage, and lasting an hour. Sometimes two chills, with an interval of an hour. Vomiting once daily, though occasionally twice. Quinine given till specific effect, at end of two days, and kept up for three days more, without effect, the chills even appearing in forenoon. Great complaint of sleeplessness for two or three past nights.

16th.—None of the symptoms mitigated. Tinct. ferri muriat. given after quinine was given up. Began Fowler's solution at date.

18th.—Chills less severe. Bowels more free; otherwise as before. No letting up of sleeplessness or perspiration. Pulse still full, and 120 per minute. Tongue moist, but coated. Examination of urine to-day: acid and turbid; specific gravity 1012; albumen in considerable amount; casts in large quantity. Quantity of urine somewhat diminished. Drink cream-of-tartar water *ad libitum*.

19th.—No chill, but has felt chilly, and perspired a good deal. Took chloral in very small dose (about three grains), and slept a little. Feet and legs pit slightly on pressure. Joint of great toe of right foot red, tender and painful during past forty-eight hours.

20th.—Two light chills. Still vomits, but principally when hawking up phlegm, which seems to collect rather freely in the throat. Pulse 106.

21st.—Omit arsenic and give cream of tartar.

R. Tinct. digitalis, 5i.;
" squills, ʒss. M.

Twenty drops every three hours.

22d.—Took 7½ grs. chloral, and reported no good sleep. Had yesterday A.M. (before taking chloral) palpitation of heart, which continued through the night. Pulse 112, regular, but of unequal strength. Tongue brown for first time. Still chilly, and has still occasional chills. Still perspires freely.

23d.—Great loss of power of left upper