

prognosis in pneumonia does not depend so much on the extent of lung affected as on the amount of toxic symptoms present and the absence of a healthy reaction in the individual attacked. A low range of temperature is not necessarily a favourable sign, especially if accompanied by delirium, scanty expectoration, little cough, and a dry brown tongue.

From my limited experience of the action of pilocarpine I believe that it will occupy a leading place in the treatment of pneumonia. It relieves pleuritic pain and breathing within a few hours of its administration and also seems to hasten resolution, probably by exciting glandular secretion. Its administration is in the majority of cases followed by a rise of temperature of from half a degree to one and a half degrees. One-tenth of a grain hypodermically does not cause profuse perspiration but rarely fails to reduce the temperature within an hour or two. It also cleans the tongue and stimulates the flow of saliva. I have not noticed its repeated administration attended by any undesirable or unpleasant results. One precaution is necessary—namely, to keep the patient warm and especially the feet. I regret that owing to the loss of some notes and temperature charts I have to generalise instead of giving full statistics and details of the cases, but I trust that from the above rough notes—jotted down while on active service in South Africa—I have succeeded in drawing attention to a drug which will frequently prove of practical value in cases of pneumonia.

Bournemouth.

## Clinical Notes:

### MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

#### METHYLENE BLUE IN THE TREATMENT OF MALIGNANT MALARIAL FEVER.

BY J. M. ATKINSON, M.B. LOND., M.R.C.S. ENG.,  
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As is well known, quinine has practically no effect on the crescent bodies met with in malignant malarial fever. It is these bodies which, when ingested into the stomach of the mosquito, undergo those changes which terminate in the formation of the germinal rods or sporozoites. These are carried in the body fluid of the mosquito to its salivary glands and are the actual source of infection in man. Hence the importance of finding some drug that will destroy them. I have recently been trying the effect of the internal administration of methylene blue on a Chinese boy, aged 15 years, who was admitted into the Government Civil Hospital on Jan. 24th, 1903, suffering from malignant malarial fever. On examining his blood numbers of crescents were found and as quinine administered for a week had no effect in diminishing these, on Feb. 9th two grains of methylene blue were given thrice daily in the form of a pill. On the 16th, after careful examination, no crescents were to be found in his blood. As the patient was now suffering from gastric disturbance, nausea, vomiting, &c., which I thought might be due to the drug, it was discontinued. The blood was again examined on the 17th and 20th and was found to be free from crescents.

The above is only one case, I admit, but knowing the importance of reporting the effects of any drug which will kill these crescents I send this note.

Hong Kong.

#### A CASE OF RUPTURED OVARIAN CYST.

BY ALFRED CLARK, F.R.C.S. EDIN.

ON March 14th, 1903, I was called to see a married woman, aged 25 years, who had been suffering from severe abdominal pain and metrorrhagia at about fortnightly intervals for three or four months. She had one child three and a half years old and had never been pregnant since. I found her in bed, blanched, restless, with sighing respiration, a feeble pulse of 130 per minute, and a temperature of

102° F. Her abdomen was slightly distended, acutely tender, and rather dull on percussion. The left iliac region was a little more full than the right and was more resistant on palpation. With a hypodermic injection of one-fiftieth of a grain of strychnia her pulse improved somewhat and I had her removed at once to a private hospital where at 10 P.M. Dr. T. G. S. Hodson administered chloroform and I opened the abdomen with an incision four and a half inches in length, the patient being in the Trendelenburg position. There was a large quantity of blood clot in the abdominal cavity. After removing this I found an ovarian cyst on the left side about as large as an ostrich's egg with a straight rent in its anterior aspect about three inches in length. Venous oozing was still going on from the edges of the rent. The cyst wall was thick and very adherent to the bladder and small intestines. A piece of cyst wall was so intimately adherent to the latter that I had to leave it lest I should tear the bowel. Then I removed the left ovary and examined the right. This had a thin-walled serous cyst as large as an orange, so I removed this also. The operation lasted about 45 minutes as the adhesions made it tedious and the patient was removed to bed in a bad condition and with a very feeble and fluttering pulse, but she rallied after a hypodermic injection of one-fiftieth of a grain of strychnia. She had rather troublesome vomiting of bright-green material for a couple of days and on the second and third days passed some blood-stained mucus from the bowels. Otherwise she made an uninterrupted recovery. I removed the sutures on the fourteenth day and she was discharged a few days later. A fortnight later she called at my house and said she felt better than she had done for a year or more.

Bitterne, Hants.

## 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.

#### SOUTH WIMBLEDON AND MERTON COTTAGE HOSPITAL.

A CASE OF CÆSAREAN SECTION FOR CONTRACTED PELVIS;  
RECOVERY OF THE MOTHER AND CHILD.

(Under the care of Dr. MARTIN RANDALL and  
Dr. A. H. GERRARD.)

IN this case, which was one of full-term pregnancy, the patient was a primipara, aged 21 years. The pains commenced slightly on August 24th, 1902. On the 26th the patient was seen by Dr. A. H. Gerrard when he found the waters broken and the head presenting above the brim. He came to the conclusion that the pelvis was greatly contracted and he asked Dr. M. Randall to see the case with him. The patient was a small woman but not obviously malformed. Her general condition was good. The pains were regular and strong, the membranes were ruptured, and the os was of about the size of a five-shilling piece. The head could be felt freely moveable higher up. The sacral promontory was very large and projecting, the diagonal conjugate being under three inches. The estimate on measuring was two and seven-eighths inches; this would indicate a true conjugate of not much over two and a half inches. As the head appeared on abdominal palpation to be of normal size, the alternative of craniotomy or Cæsarean section was put to the patient and her friends and the latter was chosen. The patient was removed to the hospital. Dr. D. Findlay administered ether and Dr. Gerrard and Dr. T. Brice Poole assisted at the operation. A hypodermic injection of one-twenty-fifth of a grain of strychnine was given and the vagina was washed out with a 1 in 1000 solution of biniodide of mercury.

After opening the abdomen a piece of stout elastic tubing was passed behind the uterus to the cervix. This was rendered very easy by a thick copper wire passed along the bore of the tubing; the wire was removed as soon as the

rubber was *in situ*. Gauze sheets having been packed round the uterus this was quickly incised and opened, the child was seized by the back and removed, and the cord was clamped and cut. Bleeding was free for a few seconds and then the ligature was tightened. The incision at its upper end just notched the placenta which was situated at the fundus. The placenta and membranes were stripped off and the inside of the uterus was swabbed out with biniodide of mercury lotion. The uterine incision was sutured in two layers. Fishing gut was used for the deep sutures which were passed only through muscle and submucous tissue, the peritoneum and mucous membrane being excluded. The peritoneum was then sewn together by interrupted stitches of fine silk so as to bury the knots of the deep sutures. The uterus was now well contracted and was returned into the abdomen. A piece of one Fallopian tube was excised between ligatures but Dr. Randall regrets to say that the other tube was only ligatured once. The peritoneal cavity was found to be unsoiled, so the abdominal wound was sewn up by silkworm-gut sutures. The recovery of the mother and child was normal, the baby being suckled and the mother being desirous of getting up on the third day.

*Remarks by Dr. RANDALL.*—I must express my thanks to Dr. Gerrard for his skilful after-treatment of the case and for the opportunity of operating on the patient. The only points to which I would draw attention are the ease with which the wire allows the elastic tube to be passed round the uterus—the idea is not original—and the unorthodox, but successful, method of suturing the uterus.

## BRISTOL GENERAL HOSPITAL.

A CASE OF TUBERCULOUS PERICARDITIS NECESSITATING FREQUENT ASPIRATIONS.

(Under the care of Dr. J. ODERY SYMES.)

A YOUTH, aged 19 years, was admitted as a surgical patient to the Bristol General Hospital under the care of Mr. C. A. Morton on Jan. 10th, 1903. There was a small superficial abscess in the anterior axillary line over the fourth rib and this was incised and drained. It did not communicate with the pleura, but an exploring needle which apparently was inserted into the right pleural cavity (with great difficulty owing to the falling in of the chest wall) drew off a little pus. Dr. J. Odery Symes saw the patient in consultation with Mr. Morton on Jan. 11th. The pericardium was tapped and five ounces of blood-stained fluid were withdrawn. The boy was transferred to the medical wards under the care of Dr. Symes on the 12th. With regard to the patient's history, he had had no illness of any sort until a fortnight before Christmas, 1902, when he noticed a swelling rise over the front of the right chest. On Christmas Day there were pains in the left chest and back and these had continued since. There was breathlessness on exertion and the patient had to give up work but had not been confined to bed. Cough was slight and no wasting was noticed. On Jan. 12th the condition was as follows. The patient was a delicate-looking, wasted lad. The right side of the chest was flattened and immobile, the lower ribs having fallen in and lying in contact with one another. The left front was unduly prominent, especially over the præcordium. On the right side there were signs of consolidation of the upper lobe of the lung and of fluid in the pleural cavity below. Over the left lung, back and front, the vesicular murmur was harsh, exaggerated, and bronchial and fine râles were heard; the posterior pericardial patch of dulness and the posterior pericardial patch of tubular breathing and ægophony were well marked. The respirations were 38. There was bulging of the præcordial region and dulness extended above as high as the first rib, to the right one inch from the sternal border and to the left to the anterior axillary fold. The heart sounds were almost inaudible and a rough friction sound occurred with respiration in the third left space in front. The pulse was 120, weak, and irregular in force and frequency. The pulsus paradoxus was at times present. The liver was enlarged, being especially prominent in the epigastric region, where, too, it was thought a mass of thickened omentum could be felt. There were fluid in the peritoneal cavity and a trace of albumin in the urine. In consequence of the re-accumulation of fluid in the pericardium tappings were made on the following dates: on Jan. 16th, six and a half ounces were drawn off; on the 31st, five and a half ounces; on Feb. 13th, seven ounces; and on

the 20th, 12 ounces. The spot chosen for the punctures was the fourth left costal interspace close to the edge of the sternum. The fluid was blood-stained, the specific gravity was from 1020 to 1024, it was alkaline, cloudy, and when centrifugalised showed in addition to leucocytes a large number of tubercle bacilli. After each aspiration there yet remained a considerable quantity of fluid in the pericardium and for this reason it would have been better to have attacked the sac by puncture up through the epigastrium and this might have been done with a cannula and trocar as the fluid was under positive pressure. The cardiac failure and dyspnoea were much relieved after each aspiration. The progress of the case does not call for much comment. An unsuccessful attempt was made to draw off the fluid from the right base by means of an aspirator but the space between the ribs did not permit of a needle being passed. The friends refused to have any operation performed necessitating the administration of an anæsthetic. Considerable oedema of the right leg and thigh developed and to a lesser degree the left limb was similarly affected. Brief intervals of delirium were noted and for a few days there were symptoms of an abscess pointing at the base of the right lung in front. The red oedematous swelling, however, subsequently subsided. The temperature was of a hectic type throughout. The urine was scanty and albuminous. The patient's strength gradually failed and he died on March 3rd. The friends refused permission to make a post-mortem examination.

*Remarks by Dr. SYMES.*—The case was apparently one of primary tuberculosis of the right lung, secondary empyema and collapse of the lung, and tuberculous invasion of the pericardium and peritoneum. It is remarkable that the patient was apparently but little inconvenienced by the pulmonary collapse, which from the condition of the chest wall on admission must have been of old standing. He could give no history of a previous illness and had not been incapacitated from work. The pericardial effusion which had apparently been accumulating for over a fortnight, though incapacitating him for work, had not prevented him walking about. The ease with which tubercle bacilli could be demonstrated in stained films of the exudate is a striking testimony to the value of the electrical centrifuge as an aid to bacteriological examinations. I have to thank the house physician, Dr. C. C. Shaw, for the notes on the case and for performing the required aspirations.

## Medical Societies.

### ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

*The Differentiation of the Continued and Remittent Fevers of the Tropics by the Blood Changes.*

A MEETING of this society was held on May 12th, Mr. ALFRED WILLETT, the President, being in the chair.

Sir DYCE DUCKWORTH, who had represented the society at the International Congress of Medicine in Madrid, gave a short account of the work of the Congress.

Captain LEONARD ROGERS, I.M.S., M.D., read a paper on the Differentiation of the Continued and Remittent Fevers of the Tropics by the Blood Changes. The paper dealt with a series of some 200 cases of continued and remittent fevers worked out during the last two years in the European and native hospitals in Calcutta with both the serum tests and the differential leucocyte count. The question was discussed as to whether there were any hitherto undifferentiated fevers to be met with, such as were described by Dr. Crombie in his address before the Indian Medical Congress in 1894, which had not previously been put to the test of modern methods of diagnosis. In all the cases the differential leucocyte count had been carried out, as Captain Rogers had shown that by its means very valuable aid could be obtained in differentiating typhoid from malarial remittent fevers, this being of the greatest value in this research on account of the impossibility of finding parasites in most cases of malarial fevers which had been given quinine before they came under observation, as was nearly always the case with European patients. 50 consecutive cases of typhoid fever were first dealt with; a short clinical account based on the analysis of the notes and tables of the results of the serum test and the leucocyte counts were given. The latter bore out Captain Rogers's