

suffered much, but he had gone on suffering rather than face an operation. He had an enormous inguinal hernia, the sac of which traversed the middle line for about an inch and the contents of which were irreducible. At first I thought this might lead me into some unlooked-for difficulty and some modification of my method, but I am glad to say it did not and my traction method of dealing with the bladder was successful as before.

Let me first say that I make use of no precautionary measures or preparatory steps. I neither pack the rectum nor distend the bladder. I stand on the left of my patient and cut upwards about two inches and a half, starting immediately over the ridge of the pubic arch, exposing the tendon at one sweep. I then cut the tendon transversely for about an inch close to the bone and cut it up centrally for an inch and a half. I then pass my left forefinger down between the bladder and the pubic arch, and following it with a pair of forceps I gently rend the tissue till I can feel the bladder wall. This can easily be determined by its peculiar feeling and by the fact that once the forceps grip it they hold, and they do not hold merely cellular tissue. Having fixed one pair I then fix another close to them. My assistant takes them right and left and gently pulls them apart, as in abdominal section. A notch of the knife follows and a rush of water declares the road into the bladder for the forefinger to be open, or the educated finger ascertains the fact for itself. The rest is all finger work and consists, as in abdominal section, of a gentle but firm extension of the opening into the bladder till the lithotomy forceps can follow it. The forceps seize the stone, the forefinger arranges it as may be judged best for its extraction and it is gently removed. All my cases have recovered without the slightest trouble, and though up to the present I have used a glass drainage-tube passed into the bladder and secured by stitches I am of opinion that this will prove an unnecessary precaution and that probably it will be quite safe to close the bladder immediately by deep sutures. In Mr. Eliot's case, by keeping my left forefinger carefully between the hernial sac and the knife, I did not even encounter the sac and the anticipated complication had no real existence. The patient was quite well in six days.

The ease with which the bladder can be pulled up and cut into is so great that I feel I have only one caution to give, and that is that those who may try my method should not pull the bladder up too much and make the opening too low down in the front wall, where they may meet with radicles of the prostatic plexus.

Birmingham.

Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL AND THERAPEUTICAL.

A SEVERE CASE OF PUERPERAL ECLAMPSIA; RECOVERY.

By P. W. YOUNG, L.R.C.P., L.R.C.S. EDIN., L.F.P. & S. GLAS.

On Monday morning, May 8th, I was called at 1 A.M., the message being most urgent, to see a woman aged thirty-four, residing in the village. On my arrival I found the patient in bed lying on her back; the pulse was full and bounding, the temperature 101.3°, the pupils widely dilated, and there was an anxious expression of countenance. She complained of intense frontal headache, rather more severe on the right side of the head than the left, and of a dull pain extending all over the occiput. Up to this time, however, the patient had not had a fit. After having given thirty grains of bromide of potassium I left with strict injunctions that I should be immediately sent for if there were any change for the worse in her condition. At 6 A.M. I was hurriedly summoned and had scarcely entered the patient's room when she was seized with a convulsive fit, struggling so violently that it was with difficulty she could be kept in bed. The attack was most sudden in its onset, commencing with tonic spasms, lasting for a few seconds, and followed by most violent clonic spasms and muscular contractions. The expression of the face was completely altered, the mouth and teeth were firmly clenched, whilst frothy saliva was collected around the angles of the mouth.

The eyelids were closed and on my raising them showed the whites of the eyes turned upwards. The arms and hands were quite stiff and rigid and the legs were drawn up towards the body, the leg being flexed on the thigh and the thigh on the abdomen. The breathing during the attack was hurried and irregular. I had only time to note these symptoms when the attack, which had lasted about four minutes, subsided and the patient rapidly passed into a state of almost complete coma. She recovered consciousness only to pass into another fit at 6.50 A.M., almost as severe in character as the first. At 7.30 she had a third fit, which was followed by others during the day at 9, 9.50, 10.30, 11.10, 1.30, 2.15, 3.40 and 5 o'clock, the intervals between each attack and its duration being carefully noted. At 5.40 P.M. she passed into a state of complete coma and lay perfectly still, the breathing being stertorous in character. During the next forty-eight hours she remained in much the same condition. On Wednesday afternoon, there being evidence of cerebral congestion, I applied leeches to the head. The same night, at 9 P.M., I observed slight movement in the wrist and fingers of the right hand and at midnight there were signs of returning consciousness. Early on Thursday morning the patient, who had been closely watched, spoke and made signs of recognition to her nurse, but rambled and moaned in her speech. I kept her under the influence of bromidia that night and the following two nights, with highly satisfactory results. On the 12th the bowels were freely opened with castor oil. A previous examination of the urine showed albumen in large quantities. The same afternoon she took a small quantity of liquid nourishment through the mouth. There had been no trouble with the milk, the secretion of which I checked in the earlier stages of the trouble. The patient has within the past few days (May 22nd) improved in a most remarkable manner, she complains only of slight giddiness. The pulse and temperature are normal. With care and nourishment I anticipate a complete and, I trust, permanent recovery. I examined the eyes with the ophthalmoscope and found slight optic neuritis.

Scalloway, Shetland Isles.

CASE OF INCOMPLETE MISCARRIAGE OR ABORTION.

By CHARLES H. MILES, L.R.C.P. LOND. &c.

A WOMAN aged thirty-two, married thirteen years, and the mother of five children, the youngest being aged three and a half years, sent for me on Feb. 17th complaining of losing large quantities of blood from time to time ever since she had had a miscarriage four months previously. The patient stated that she was about four months pregnant when the miscarriage took place and from that time up to the present date she was constantly losing blood, therefore she thought it necessary to seek medical advice. On examination the uterus was found to be somewhat enlarged, being about the size of a small orange, distinctly felt above the pubes; blood was flowing freely from the vagina, and on passing the sound through a speculum the depth of the uterus was found to be about three and a half inches. After examination, and consideration of the history and symptoms, the case was diagnosed as one of retained placenta. The vagina was first syringed out with a solution of carbolic acid (1 in 40); a large sponge tent rendered aseptic by being placed in a mixture of ether and iodoform was passed through the speculum into the cervix, and the vagina was plugged with sponges soaked in carbolic solution (1 in 20). The patient was seen again in twelve hours, when the bleeding had ceased. The sponges were removed, the vagina was syringed out with carbolic acid (1 in 40) and the sponge tent was taken out. The right hand was washed in carbolic solution and the fingers were lubricated and passed through the cervix. The placenta could be plainly felt fixed to the fundus, and without any anaesthetic the whole of it was completely removed bit by bit by means of the fingers. After every particle of it had been removed the interior of the uterus was thoroughly mopped out with pure tincture of iodine and the vagina and uterus were afterwards washed out daily with a solution of iodine (1 in 80). From the date of operation the bleeding ceased. The discharge lasted about ten days. The temperature remained normal throughout, the patient making an uninterrupted recovery, without a single bad symptom. The first menstruation which occurred afterwards was rather more than usual, but not excessively so; the next was normal.

Remarks.—Much has been said with respect to the disadvantages and dangers attending dilatation with sponge tents, but if every precaution be taken to see that the tents used are aseptic many of the dangers are avoided. The tents should always be kept air-tight if possible till required for use. I find a clear stoppered bottle answers best. When required, the tents should be thoroughly soaked in a fresh solution of ether and iodoform or glycerine and carbolic acid, the vagina should be syringed with some antiseptic, and then the tent should be passed through the speculum, taking care that they do not come into contact with the vaginal walls and thus carry septic matter into the interior of the uterus. The advantages of tents in such cases as the above are: Firstly, general practitioners are more accustomed to using them than any other dilators; secondly, they are less expensive than Hegar's dilators; thirdly, they are less likely to cause laceration; fourthly, dilatation, although slower, is less painful; fifthly, the operation can be performed in many cases without anæsthetic, and this in itself is a consideration to the country practitioner who may have no assistance at hand in these cases.

Stantonbury, Bucks.

LOCALISED INFLAMMATION OF THE POSTERIOR SUPERIOR QUADRANT OF THE TYMPANIC CAVITY.

By R. LAKE, F.R.C.S. ENG., L.R.C.P. LOND. &c.,
PATHOLOGIST AND REGISTRAR TO THE HOSPITAL FOR DISEASES OF THE THROAT, GOLDEN-SQUARE.

RETENTION of inflammatory exudation behind the upper posterior quadrant of the membrana tympani is shown by redness and bulging of that part and is usually accompanied by a normal condition of the remainder of the membrane. This localised retention closely resembles that which takes place in the attic, in which pent-up fluid points through Schrapnell's membrane. If the tympanic cavity is carefully laid open by removal of its posterior wall, one can see how this shutting off of its posterior superior portion occurs; the various structures which effect this are the tendon of the tensor tympani, the descending process of the incus, the stapes, stapedius and pyramid, and the chorda tympani. Any cause setting up inflammation in this region would, on account of the accompanying swelling, shut off this part from the general tympanic cavity. As this sub-chamber communicates directly with the antrum, all the secretion from this cavity is pent up behind the membrane and one may remove a very large quantity of mucus by irrigation through the Eustachian tube after incision. There is a slight risk of dividing the chorda tympani. I think it occurred to me in a case of the above variety, for after paracentesis there was numbness of that side of the tongue of several weeks' duration. The treatment consists of incision of the bulging membrane, with subsequent irrigation through the Eustachian tube by means of a catheter with a $\frac{1}{2}$ per cent. salt solution.

Seymour-street, Portman-square, W.

DR. J. RUFUS TRYON, Fleet-Surgeon to the flag-ship *Chicago*, has been appointed Surgeon-General of the American Navy. He entered the Service thirty years ago.

BRITISH MEDICAL TEMPERANCE ASSOCIATION.—The seventeenth annual meeting of the British Medical Temperance Association was held on Friday, the 19th inst., at the Temperance Hospital, Hampstead-road, London, Dr. B. W. Richardson, F.R.S., presiding. The annual report stated that there are 418 members in the Association, eighty-six student associates and one lay associate, all being personal abstainers. Twenty-eight new members had joined during the year, and there was a net increase of three. A northern counties branch has just been formed, of which Dr. Coley of Newcastle is president. After the business of the meeting a discussion on Cholera in relation to Alcohol was opened by Dr. Richardson. He dealt with it under five heads: (1) the negligence produced amongst the people at large who rushed to drink through fear; (2) its misuse by those affected; its effect being always mischievous; (3) the absence of any physiological reason for giving it; (4) its uselessness during the acute stage; (5) its injuriousness during the stage of reaction. The discussion was continued by Brigade-Surgeon Pringle, Dr. Norman Kerr, Surgeon-General Francis, Dr. Morton and Dr. Ridge.

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.

WEST LONDON HOSPITAL.

CHRONIC ULCER OF STOMACH; PERFORATION OF DIAPHRAGM;
EMPHYEMA; REMARKABLE ABSENCE OF GASTRIC
SYMPTOMS; DEATH.

(Under the care of Dr. DONALD W. C. HOOD.)

CHRONIC ulcer of the stomach sometimes produces most unexpected symptoms after perforation, and frequently it is quite impossible to diagnose the cause of the puzzling condition presented by a patient; this is more especially so when there has been nothing in the history of the patient to lead to a suspicion of gastric disease, and a notable feature in the history of this case was the complete absence of the usual symptoms which would have drawn attention to the stomach as being the primary source of disease. During the five weeks the patient was under constant observation there was no gastric pain or any inconvenience referable to digestion. The dense fibrous band which divided the viscus into two distinct cavities was evidently of very old standing, and probably dated from that ulcerative process which gave rise to the initial hæmatemesis three years before. From the thickened cicatricial appearance of the walls of the cardiac end of the stomach it was concluded that ulceration had been in process for many months, if not from the time of the primary hæmorrhage. This part, cut off from the other, had gradually lost its function, and food passed almost direct from the œsophagus into what had become the only true stomach, thus coming but slightly into contact with the area of ulceration. The usual pain of gastric ulcer was absent. The globular swelling which appeared during the illness was probably due to the cardiac portion of the abnormal stomach distended with gas. The opening from the œsophagus was closely adherent to the fibrous ring dividing the two parts of the stomach, and it is quite possible that during life there had been but little, if any, communication between the two cavities; otherwise there would have been a large escape of gas on passing the tube.

A well-nourished, healthy looking girl was admitted into the West London Hospital on Dec. 14th, 1891. She was suffering severely from the ordinary and well-marked symptoms of acute pleurisy affecting the left side. The illness commenced suddenly seven days before her admission, the primary symptoms being a sharp, stabbing pain, accompanied by vomiting. The girl, a barmaid, appeared to have led a very abstemious life and stated that her general health had been excellent. Three years before this illness she had suffered from an attack of "bleeding from the stomach" and at that time had been dyspeptic. After the hæmorrhage her digestion had improved and she had since then been in good general health and had had no inconvenience referable to dyspepsia. From the general condition of the patient and the extreme severity of the symptoms it was concluded that the effusion, which appeared to fill the left chest, was purulent. After having been under observation in hospital for a few days, the chest was aspirated, thirty-eight ounces of pus of extreme fetor being removed. After the operation there was no change in the condition of the patient, the temperature remained high and there was no amelioration in the general symptoms. At this date a peculiar resonant globular swelling appeared in the epigastric region. Apart from the shape there could be but little doubt that it was the stomach distended with gas, but the markedly globular shape seemed to weigh against this opinion. The swelling remained for three or four days without giving rise to discomfort. On one occasion a tube was passed into the stomach, but without any discharge of gas or diminution in the size of the swelling. As no relief followed the withdrawal of the fetid pus it was decided that Mr. Keetley should freely incise the chest. Unfortunately the operation was postponed owing to an attack of diphtheria