Consideration of these figures must show us the inadvisability of using the mixture of ether and chloroform. To be giving an inhalation which may vary between 100 to 0·9 and 100 to 75 is clearly a most dangerous proceeding. It appears to me that for ordinary cases ether is by far the safer anæsthetic of the two; that when this is contra-indicated, pure, unmixed chloroform should be used, every precaution being taken as in the case of all anæsthetics, to give it carefully; but that to use the two mixed is unscientific and unsafe. In these remarks I have had in view administration by Clover's inhaler. In giving the mixture by dropping it on to an open flannel mask the vapours would doubtless be more evenly distributed.

Derby-road, Nottingham.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF TRAUMATIC INTRA-PERITONEAL HÆMORRHAGE.

BY E. H. WAGSTAFF, M.R.C.S. ENG.

IN connexion with Mr. Battle's case of Intra-peritoneal Hæmorrhage in THE LANCET of Jan. 26th a sketch of the following case, which occurred recently in my practice, might be of interest.

A man met with an accident under the following circumstances. On Dec. 19th, 1893, whilst driving in an ordinary spring cart his horse stumbled and fell, whereupon he jumped from the cart and fell on the road on his left side. Assistance was immediately at hand, and he was conveyed—in a sitting position in another cart—to his home, a distance of about two miles and a half. I saw him immediately on his arrival and found that he had sustained a fracture at the junction of the middle and upper thirds of the left femur, which was promptly put into position. A careful examination was made, but no further injury could be made out. It was remarked at the time that there was an entire absence of shock. The patient was warm, and the pulse, temperature, and respiration were normal an hour after being put to bed; indeed, he was extraordinarily cheerful considering the circumstances. The friends report that, though a generally healthy man, he suffered from flatulent dyspepsia and want of appetite, evidently the result of alcoholism, his tendencies in that direction being well known. All went well until Dec. 21st, when slight vomiting set in with flatulence, the former relieving the latter. No abdominal pain was complained of. There was no dulness or undue distension of the abdomen. As the bowels had not been open since the accident an aperient was given, but without effect. The vomiting recurred at intervals until the morning of the 22nd, when it ceased, but the bowels continued obstinate. The vomiting recommenced in the early morning of the 23rd, and continued at intervals throughout the day. During the whole of this time the pulse varied between 72 and 85, and the temperature between 97·8° (after vomiting) and 99 4° F.; the tongue was moist and fairly clean, and the respiration was normal. At 8.45 P.M. on the 23rd the patient complained of faintness, and, on my visiting him at 9.30, to my surprise I found him cold, pulseless, and collapsed, in fact *in extremis*, from which condition he never rallied, but died at 10.45. The necropsy (twelve hours after death) revealed nothing of moment on first opening the abdomen. There was no peritonitis. The stomach bowels, spleen, liver, and kidneys were healthy, the latter wonderfully so, considering the alcoholic habit. A small length of bowel above the cæcum was collapsed, but there was no undue fæcal accumulation. On tracing the bowel upwards to the duodenum with a view to its removal a large retro-peritoneal hæmorrhage was discovered in connexion with the pancreas. It was impossible to define its precise origin, as the whole organ was so bruised and lacerated as to break up on handling. Here was evidently the cause of death, an accident in itself perhaps worthy of record; but I venture to suggest that the chief interest lies in the absence of any of the ordinary symptoms attending so extensive a lesion of so important an organ. The bruising and laceration of course occurred at the time of the accident, whilst the hæmorrhage probably occurred a few hours before death as the result of inflammatory changes or the effort of vomiting.

Leighton Buzzard.

INVERSION OF UTERUS; DEATH.

BY THEODORE MAXWELL, M.D. CAMB., F.R.C.S. EDIN.

THOUGH I can hardly think that cases of complete inversion of the uterus are as rare as one in 150,000, as has been stated, they are quite rare enough and fatal enough to justify my recording the following one. I find a similar case mentioned by Dr. J. L. Kerr[1] of Crawshawbooth, Manchester, where, however, the woman died ten minutes after replacement from shock and hæmorrhage, and where there was a suspicion that the midwife had pulled at the cord, which I feel sure she did not do in my case. I was called at 6 A.M. on Jan. 26th last by a midwife to a young woman in her first confinement, and found the child, which was somewhat premature, born, the woman very pale and low, and the afterbirth, which was to a large extent invested by the membranes, hanging out of the vulva. On this mass gentle traction had no effect. Pinching it near the vulva caused pain, and there was no tumour to be felt above the pubes. I then passed my finger cautiously into the vagina, and found, as I suspected, that there was no os, but that the mass was continuous with the fornix and consisted of the inverted uterus, with the placenta partly attached. I found no difficulty in peeling off the latter, and very little in replacing the uterus by the pressure of three fingers. It was, however, so soft and flabby that it could not be felt through the abdominal walls. I syringed out the vagina with a hot solution of creolin and administered a little ergotin and some egg and spirit, but death occurred in about an hour. There was no hæmorrhage at any time. The midwife said that the labour was a breech case and extremely easy, there being very little pain. The child was born about 5 o'clock, and as the afterbirth did not come and there was no pain or hæmorrhage she proceeded to wash the infant. While doing so the placental mass appeared. She had once seen a case of inversion, and had a suspicion of what had occurred and therefore sent for me at once.

Woolwich-common, Kent.

CASE OF ACUTE ALCOHOL POISONING.

BY NORMAN KERR, M.D. GLASG., F.L.S.

A WOMAN aged forty-one years, wife of a labourer, a periodic inebriate, on Dec. 19th, 1894, in London, drank one and a half pints of whisky 22 over proof (47 stronger than whisky as usually retailed). As this is nearly double the ordinary retail spirituous strength, she must have swallowed more than two and three-quarter pints of the latter. The spirit was taken right off. In a few minutes she was found lying on her back insensible, and never recovered consciousness till she died five and a quarter hours later. The post-mortem appearances thirty hours after death were venous engorgement of the head, with subarachnoid effusion, in addition to old-standing congestion, with white, milk-like film on the surface of the pia mater. The walls of the heart were fatty, pale, and thickened. The cavities contained about half an ounce of fluid, tarry-like blood in the right ventricle. There was slight pleural effusion in the lungs, and patches of extravasation of blood in both. The walls of the stomach, which were thinned in parts, with patches of mucous membrane semi-detached, presented brownish-black ridges, with a red, fiery, tree-like aspect, on a translucent, pale, interspersed with red ground, corrugated inflammatory appearances extending into the duodenum. The stomach contained eight ounces of grumous fluid with a faint odour of alcohol. The spleen was engorged. The capsule of the kidneys was semi-adherent. While the patient was alive the face was pale, the eyes suffused and dull, the skin cold and clammy, with cold perspiration, the pulse thin and compressible, almost imperceptible, and the breathing stertorous. Throughout the pupils were dilated. The temperature fell 7° F. below normal.

Regent's-park, London, N.W.

[1] THE LANCET, Oct. 28th, 1882.