

may not be so. Under such circumstances the development of events in the ensuing 24 hours, 36 hours, or 48 hours may furnish the needed indications for prognosis and treatment. In the milder cases symptoms will tend to recede or at least to become more localised. On the other hand, if the affection be of a severe type the symptoms will persist or become intensified, though sometimes only after a treacherous remission which may very readily mislead.

## II.—PROGNOSIS AS TO RECURRENCE.

Statistics vary as to the frequency of recurrence: some authorities place it as high as 47 per cent., others at below 30 per cent.; in my series it was 31 per cent. It may, then, be expected in about one-third of the cases. We also know that the tendency to recurrence usually manifests itself within two years, and most commonly within one year, of the first attack. Besides such general facts to guide us the following clinical features will aid in forming an opinion as to the likelihood of recurrence in any particular case. 1. The nature of the first attack.—If there were local suppuration the probability of recurrence is relatively slight; on the other hand, a mild first attack is frequently followed by recurrence. 2. Convalescence from the first attack.—If the condition clear up but slowly and local pain, local tenderness, or slight swelling persist for some time the probability of relapse sooner or later is very great. 3. Condition in the interval between attacks.—If there is occasional pain or discomfort with irregularity of the bowels and definite local tenderness or resistance a chronic appendicitis probably exists. The palpation of the enlarged and thickened appendix will render the latter diagnosis certain, which means a chronic tendency to relapse so long as the appendix is allowed to remain there.

Upper Berkeley-street, W.

## A NEW AND MORE PERMANENT METHOD OF MOUNTING AMYLOID SECTIONS, STAINED WITH IODINE.

By ALAN B. GREEN, M.A., M.B., B.C. CANTAB.

THE following process of mounting amyloid sections stained with iodine gives more permanent results than any other method which I have met with. Some sections stained and mounted in this way have, after seven weeks, apparently not deteriorated in the least; no change can be distinguished. Whether the method is permanent in its results time alone can show, but I hope that this will prove to be the case. The following solutions are required:—(a) Weigert's iodine. (b) Pure liquid paraffin (30 cubic centimetres) and iodine crystals (one gramme). The purest liquid paraffin used for lamps is the best for this purpose. (c) Xylol (30 cubic centimetres) and iodine crystals (one gramme).

First place on a coverslip a small quantity of pure white vaseline ready for immediate use for mounting the stained section. Float the section from water on to a glass slide and drain and blot away as much water as possible.

From a drop-bottle pour a few drops of solution (a) on the section until it is sufficiently deeply stained. Then drain away excess of solution and from a second drop-bottle pour a fine stream of solution (b) over the section. This dehydrates the section without removing any iodine from it. Now drain away excess of solution (b) and remove the last traces of it by pouring over the section from a third drop-bottle a stream of solution (c). Finally, drain away excess and blot quickly to remove the remaining solution (c). Then at once place the coverslip with the vaseline on it in position over the section. The coverslip may afterwards be ringed.

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**SHEPTON MALLET DISTRICT HOSPITAL.**—The annual meeting of this institution was held on Jan. 27th under the presidency of Sir R. H. Paget. The medical report showed that 132 in-patients had been treated, against 124 in 1898. There were also 116 out-patients and 55 casualties treated, both being in excess of the preceding year. The financial statement showed an increase under all heads and the balance was satisfactory.

## Clinical Notes:

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

#### NOTE ON A SUCCESSFUL CASE OF ENTERECTOMY FOR GANGRENOUS HERNIA.

By ARTHUR H. BURGESS, M.B., M.Sc. VICT.,  
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A BOY, aged 15 years, was admitted to the Manchester Royal Infirmary on Dec. 13th, 1899, with a strangulated inguinal hernia on the right side, the symptoms of strangulation having existed for four days. Taxis had been attempted by a medical man but had failed. On admission his general condition was found to be extremely grave, all the chief signs of acute intestinal obstruction being present. There was a small tense swelling in the right inguinal region without any impulse on coughing, the skin over which presented a dusky red appearance and pitted slightly on pressure. Under chloroform the sac was opened and about one ounce of a feculent fluid escaped. A knuckle of small intestine about two and a half inches in length was found tightly strangulated and in a gangrenous condition, a perforation of the size of a threepenny-piece at the summit of the loop having allowed the intestinal contents to escape into the sac. On dividing the constriction at the neck of the sac and drawing down the coil a second but smaller perforation was found in the entering limb of the loop opposite the constriction. The wound was enlarged upwards, the coil was drawn out of the abdomen as far as possible, clamps were applied on either side, and about four inches of intestine, including the gangrenous piece, were incised along with a V shaped portion of the mesentery. The divided ends of the gut were then united by direct suture, the mucous membrane being first joined by a continuous suture of the finest silk, then the sero-muscular coats by a continuous Lembert's suture, lastly the divided mesentery also by a continuous suture. The gut was reduced, the sac was isolated and ligatured near its neck and cut away, a radical cure being afterwards rapidly performed by Mr. Joseph Collier's method. The wound was closed except at the lower angle in which a gauze drain was inserted. The patient made an uninterrupted recovery without an unfavourable symptom, the temperature of 99° F. on the second night being the highest recorded. The bowels acted slightly two hours after operation, again six hours later, and again 13 hours later. Only warm water was allowed for 36 hours, then warm tea, and milk and soda-water. Benger's food was given on the twelfth day and then a gradual return to ordinary diet was permitted. The wound healed without suppuration and all the sutures were removed on the fourteenth day. The patient was allowed up at the end of three weeks, and was sent to a convalescent home at the end of five weeks. For permission to report the foregoing case I am indebted to Mr. F. A. Southam for whom I was acting at the time.

Bowdon, Cheshire.

#### A CASE OF COMPLETE INVERTIO AND PROLAPSUS UTERI.

By F. L. POCHIN, M.B., C.M. EDIN.

ON the evening of Dec. 27th, 1899, I was called to a primipara, aged 20 years. The midwife who sent for me stated that one child was born but that there was another child, dead, which she was unable to deliver. On examining the patient I found a firm fleshy pyriform mass of a dark claret colour and of about the size of the foetal head projecting from the vulva. To the exact apex of this mass about one-fifth of the maternal surface of the placenta was still adherent. On digital examination per vaginam the finger passed at once into a cul-de-sac formed by the stretched and inverted vaginal walls. No uterus could be felt through the abdominal wall. The tumour did not harden on

taxis. Despite the fact that hæmorrhage had not been excessive the patient was very much collapsed. The face was cadaverous, the lips were bloodless, the pulse was rapid and hardly perceptible; the breathing was quick and shallow, and the extremities were cold. Having detached the placenta and bathed the uterus well with hot boiled water I returned the mass without any difficulty by squeezing it well with both hands and at the same time exerting steady upward pressure in the pelvic axis, following up the uterus with my closed fist until its normal position was reached and the inversion was quite rectified. I then administered sterilised ergot and brandy subcutaneously and slowly injected a quart of hot saline solution per rectum. The patient was also surrounded with hot bottles. Under this treatment her condition quickly improved, the pulse became markedly stronger, perspiration broke out on the skin, and the extremities became warm, while the patient expressed her relief. The puerperium was comparatively uneventful. The lochia became slightly offensive and the temperature rose to 101° F. on the second day, but an intra-uterine injection of one-half per cent. of lysol solution put all right again.

This accident is an extremely rare one. It only occurred once in 190,800 deliveries at the Rotunda Hospital, Dublin (Playfair). In the clinic of Braun and Spaeth no complete case was observed in 250,000 births (Lusk). The case mortality is about 42 per cent. (Crosse). The condition has been ascribed to traction on the cord either by the midwife or as a result of the funis being twisted round the child's neck. Insertion of the placenta exactly at the fundus is considered to predispose to the accident. In this case the patient had been intensely anæmic for a long time before delivery, there had been "some trouble with the afterbirth," and the midwife had "pulled the cord a little." The cord was not twisted round the child's neck.

Fakenham, Norfolk.

## 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 FOR SICK CHILDREN, PLAISTOW, E.

#### A CASE OF DIPHTHERIA OF THE VULVA.

(Under the care of Dr. E. E. WARE.)

THE diagnosis of diphtheria is always much facilitated by the identification of the bacillus and when also paralysis supervenes the diagnosis is certain. It is a little remarkable in this case that although the diphtheritic patch was situated on the vulva the muscles first paralysed were those of the palate, but the same combination has been noticed before. The explanation is probably to be found in the fact that even slight paresis of the palate muscles would be noticeable long before the same amount of weakness in the leg muscles would become evident. For a similar reason strabismus is often a very early sign of diphtheria. The local antiseptic treatment of diphtheritic patches on external parts of the body is always advisable, though when the palate is affected the harm which the child suffers from fear and struggling probably outweighs the benefit which might result from the antiseptics. The antiseptic employed, however, should not be very strong, otherwise the damage to the tissues may weaken their power of resistance. For the notes of the case we are indebted to Mr. W. W. Farnfield, late resident medical officer.

A girl, aged four years, was admitted into St. Mary's Hospital for Sick Children, Plaistow, E., on Jan. 26th, 1899, with the following symptoms. During the five days preceding admission the patient had suffered great pain on passing urine, the act sometimes taking a quarter of an hour owing to frequent involuntary stoppages. She had not

seemed to be as well as usual, she had lost her appetite and had been listless. She had had no previous illness. The patient was a well-nourished child. The temperature on admission was 100° F., the pulse was 120, and the respirations were 28. On examination of the vulva there was seen to be undue redness of the parts which were evidently very tender. The urine was acid; its specific gravity was 1015 and it contained no albumin, pus, or blood. The act of micturition was very painful, the patient screaming while passing urine, but the pain did not continue after the act.

On Jan. 29th the A.C.E. mixture was administered and the bladder was examined both with the sound and bimanually, the forefinger of the right hand in the rectum and the left hand on the abdomen, but the result was negative. It was then noticed that two circular white patches were present on the vulva, one on the vestibule and the other on the right nympha, each being about one-eighth of an inch in diameter; they were considered to resemble diphtheritic membrane, and accordingly a blood-serum tube was inoculated. There was no affection of the throat or eyes. As typical Klebs-Löffler bacilli in pure culture were present on the blood-serum the patient on Jan. 30th was injected with 2000 units of anti-diphtheritic serum. On Feb. 1st the membrane had disappeared and the redness of the vulva was less marked; there was very little pain on micturition. The temperature was 98° and the pulse was 120. On the 8th micturition was quite painless and the vulva was perfectly normal in appearance, but the patient was still very listless. On the 19th the temperature rose to 102·8° and the pulse was 150, and the child vomited. A hypodermic injection of three minims of liquor strychninæ hydrochloridi was given. Nasal regurgitation of fluids on drinking was noticed. By the 21st her general condition had improved. The nasal regurgitation occurred only occasionally. The temperature was 99° and the pulse was 120. From this time recovery was uninterrupted and on Feb. 25th fluid no longer regurgitated through the nose. On March 11th the patient was sent to the convalescent home at Southend.

*Remarks by Mr. FARNFIELD.*—There is no doubt that this was a case of true diphtheria of the vulva, for even had there been no bacteriological examination the onset of paralysis of the soft palate may be taken as sufficient proof. The symptoms were misleading and pointed to the probability of stone in the bladder, this being the commonest cause of severe pain on micturition in a child, and it was thought that the local redness was due to handling in consequence of reflex irritation. I am indebted to Dr. Ware for permission to publish this case.

### SUSSEX COUNTY HOSPITAL.

#### A CASE OF INTERSCAPULO-THORACIC AMPUTATION.

(Under the care of Mr. T. J. VERRALL.)

AMPUTATION of the whole upper extremity with removal of the scapula and part of the clavicle (or as it is often called "interscapulo-thoracic amputation") has been specially described by Paul Berger.<sup>1</sup> The chief dangers of the operation are hæmorrhage and shock. Hæmorrhage is in great part controlled by the preliminary ligature of the subclavian artery and vein, but this does not affect the hæmorrhage from the supra-scapular and posterior scapular vessels. This is the most thorough operation which can be performed for malignant disease of the upper part of the humerus and recurrence does not occur in a very fair proportion of the cases. Of 43 cases in which interscapulo-thoracic amputation was performed 34 patients recovered from the operation; in 10 of these the ultimate result was uncertain. In 14 of the remainder recurrence occurred; in 11 of the 14 the recurrence appeared within 12 months of the operation.<sup>2</sup>

A married woman, aged 39 years, was admitted into the Sussex County Hospital on March 21st, 1898. Five months previously she noticed that the upper part of the left arm would show swelling which persisted for a day or two and then disappeared. There was always some pain in the arm, especially on movement, which was not so free as was natural. For two months work had been impossible, but it was only three weeks since the swelling took a definite shape and

<sup>1</sup> L Amputation du membre supérieur dans la contiguïté du tronc, 1887.

<sup>2</sup> Jacobson's Operations of Surgery, second edition, p. 157.