

in the altered direction of the cilia, no traces of operative interference remain. A Snellen's clamp is applied to the lid, care being taken, before the screw is tightened, to stretch the skin upwards, and so tilt the margin of the lid forwards. With a Beer's knife the tarsal cartilage is split along the whole length of its free edge, up to a distance of two millimetres from the puncture, and to a depth of about four millimetres. An incision is made through the skin and connective tissue of the lid, parallel with the row of cilia, from three to four millimetres above it. The surface of cartilage exposed is cleared from connective tissue and an incision is made into it, through about a third of its thickness, parallel with the lower edge of the skin wound and from two to three millimetres above it. The point of the knife is inserted through the first wound in the edge of the cartilage, and brought out at the middle of the second incision in it, above the cilia. Carrying the knife in the same plane, the incisions are connected in their whole length. Thus the row of cilia and a piece of the tarsal cartilage are separated from the lid except at each end. A section of the separated tissue would appear wedge-shaped, the edge of the wedge upwards. The wedge of tissue is then rotated so that the edge of it points downwards and inwards, and is in contact with the eyeball, while the row of cilia points outwards and upwards. The skin wound is united with three or four fine sutures, the clamp removed, and an ordinary dressing applied. The sutures should be removed about the third day. The measurements mentioned are only approximate, and must vary with the thickness and size of the lid to be operated on.

I have ventured to describe this as a new operation. I apply the epithet "new" with a certain amount of diffidence. Whether it be so or not the central idea of it—namely, the rotation of the wedge-shaped bridge of tissue and the complete alteration in the direction of the cilia which it effects—is the outcome of my observation of and practice on many a score of cases of entropion during the last ten years.

Sydney, N.S.W.

THE GARIEL AIR-BALL PESSARY AS A PLUG IN ABORTION.

BY J. CHALMERS ROBERTSON, M.B., C.M.

I WISH to call the attention of practitioners to the use of the Gariel air-ball pessary as a plug in early abortion. The idea is not original. I saw it casually mentioned some years ago in one of the medical papers, but, as far as I can ascertain, few are aware of the advantages of this instrument. In those cases where the ovum is not completely detached, and is, moreover, out of reach, and hæmorrhage more or less alarming is going on, the best results follow the use of the air-ball pessary. The ordinary process of plugging by pledgets of wool or by prepared tampons is laborious and precious time is lost. On the other hand, one can introduce the air-ball pessary and inflate it in half a minute; the upper vagina is most effectually plugged, and the patient can be left with safety for a couple of hours or more. The presence of the pessary is a powerful excitant of uterine action, and one usually finds at the next visit the ovum detached and lying on the top of the pessary. I have used this instrument on several occasions, and always carry one in my obstetric bag. Before insertion it is well washed with a solution of corrosive sublimate, and then smeared with an antiseptic lubricant.

Wandsworth-common, S.W.

STRANGULATED INGUINAL HERNIA COMPLICATED WITH DOUBLE HYDROCELE AND RETENTION OF URINE.

BY G. BELBEN FLUX, M.D.

ONE day in November of last year I was called at 3 P.M. to see a man aged seventy-two, who could not pass his urine. On arrival, I found the patient in bed, with stercoraceous vomiting and very collapsed. His bladder was distended nearly to the umbilicus, the scrotum was enormously enlarged, and the penis was to be observed as a mere dimple. The fluid in the scrotum extended right up to the external abdominal rings. There was no impulse on coughing, and

the distended scrotum was dull and translucent. The right cord was obscured, but appeared to be thickened.

The urine was drawn off with a flexible silk catheter without difficulty. Then with a small trocar I removed about a pint and a half of fluid from the left hydrocele. The right side still being translucent and dull, and giving a sensation of fluctuation to the touch, it was also punctured and about a pint of clear straw-coloured fluid withdrawn. The fluid being removed from both hydroceles, I found on the right side an inguinal hernia, evidently strangulated. Taxis for a few minutes failed to reduce the bowel, and was then given up temporarily; the patient vomited less during the night and slept for some hours. In the morning taxis was again tried and was at once successful, and the vomiting ceased entirely. Three days later, during violent coughing, the hernia again descended and became strangulated, well-marked stercoraceous vomiting again coming on. Chloroform was administered and the bowel was returned at once. The vomiting ceased immediately, and the patient improved rapidly. A suitable truss having been obtained, the patient recovered, and was able to resume his ordinary work as an agricultural labourer.

Highworth.

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.

THE LONDON HOSPITAL.

A CASE OF TETANY IN PREGNANCY, WITH NEPHRITIS AND CANCER OF THE PYLORUS; REMARKS.

(Under the care of Dr. HERMAN.)

THERE are many points of interest in this case, which we give at some length. The occurrence of tetany as a complication of pregnancy is unusual. With regard to the influence of nephritis in the mother on the life of the child, Cohn¹ estimates the mortality as 87 per cent., due to endarteritis of the placenta, with death of the connective tissue. For the report of the case we are indebted to Dr. Hugh Smith, resident accoucheur, and Messrs. A. Bullied and A. Halliday Smith, clinical clerks.

J. M. J—, aged thirty, first menstruated when fourteen years old; has always been regular; quantity moderate; no pain. Was married at eighteen; six children, two miscarriages; last confinement a year and ten months ago. Morning sickness in each pregnancy, but in no previous one beyond the third month. Labours easy; free hæmorrhage afterwards. Suckled each child fourteen months. Never had any kind of fit. Expected to be confined at the end of January. During this pregnancy she suffered from vomiting, not limited to the morning, often eight or nine times in the twenty-four hours. During the last four or five months there have been loss of appetite, constipation, and wasting; and she has had cramps in the calf of the left leg. In other respects she was well until Dec. 9th. She then noticed in the morning that the thumbs were drawn into the palms of the hands, and the fingers were stiff. The hands felt numb and tingled, and she was unable to use them. The wrists were bent, and the hands fixed with the palms downwards. Both hands were affected alike. After about an hour the hands became less stiff, but on attempting to use them the spasms recurred. During the spasms of the upper extremities there was some stiffness and numbness of the feet, but only momentary inability to move them. There was some stiffness at the back of the neck, which was slightly drawn back, and the back and sides of the head were numb. Similar spasms recurred throughout Dec. 10th, 11th, and 12th; more persistent on the latter day, and about 4 P.M. she was admitted.

On admission, both hands and forearms were in tonic spasm. Elbows flexed, but flexors in upper arm not rigid.

¹ Sajous, vol. ii., part 12.

Forearms strongly pronated. Hands flexed at the wrists and drawn towards ulnar side. Flexor tendons in wrist (especially the flexor carpi ulnaris) and palm prominent and firm. Thumbs drawn into palm, opposing fingers, phalanges extended. The little fingers partly flexed at metacarpophalangeal joint, phalanges extended. Other fingers more flexed at metacarpophalangeal joints, and less flexed at the inter-phalangeal joints. Great resistance to attempts at extension. Feet not affected. Knee-jerks present on both sides; no ankle clonus. No unusual position of the head was noticed. At 7 P.M. the fingers freely movable, but hands still flexed and drawn to the ulnar side, and forearms pronated. Flexor tendons at wrist still rigidly contracted. At 9 P.M. patient could extend arms, forearms, hands, and fingers, but flexor tendons at wrist remained prominent on doing so. No numbness. Trousseau's phenomenon could not be produced.

The patient was apathetic, silent, complying with directions given and answering questions, but slowly and as if with difficulty. She was not greatly emaciated. Not anæmic. Tongue dry and brown. Slight sordes about gums. Nothing abnormal on ophthalmoscopic examination. No œdema. Breathing slightly hurried. Pulse 104. No abnormal chest signs. No evidence of past rickets. Uterus four fingers' breadth above umbilicus; the fetal heart heard two hours before admission, but not now. The head was in the pelvic cavity, the os uteri the size of half-a-crown, membranes unruptured. No pains. At midnight, no labour pains being present, an elastic bougie was introduced between membranes and uterus and left there.

Dec. 13th.—The patient has only had short snatches of sleep. No labour pains. No spasm of arms or forearms, or any tingling. Flexor tendons still slightly tense. Os uteri a little larger. 2 P.M.: Patient naturally delivered of a stillborn child, beginning to decompose. No great hæmorrhage, but about 6 P.M. there was recurrence of hæmorrhage, which was easily stopped by kneading the uterus and the subcutaneous injection of ergotin. No spasm to-day; patient taking food well when offered to her. No vomiting.

16th.—Expression dull. Appears to take no interest in what is going on around her. Never asks for food, but takes it well when offered to her. No vomiting; tongue dry and furred. Bowels costive. Hands and fingers quite free from spasm. No numbness or tingling. Pulse 96.

17th.—Patient not so dull; answers questions more readily. Complains of thirst. No pain or headache.

18th.—An eruption of urticaria. Condition otherwise much the same.

20th.—Rash almost disappeared. Tongue clean in centre. Patient has quite lost her former apathy.

27th.—Discharged.

The temperature throughout never exceeded 99°.

The urine was examined on the morning after admission, and found to contain one-sixth of albumen and casts. On the 14th the amount of albumen had risen to one-fourth. From this date to Dec. 23rd the whole of the urine was collected daily, and the amount of urea in it estimated by the Russell-West process. The following are the amounts noted:—

Date.	Urine.	Urea.	Stools.	Diet.
Dec. 15	55 oz.	434 grains	—	{ Milk, beef-tea, 3 eggs.
" 16	69 "	564 "	1	"
" 17	68 "	391 "	2	"
" 18	55 "	739 "	1	Fish.
" 19	52 "	597 "	—	"
" 20	52 "	697 "	3	"
" 21	40 "	556 "	2	"
" 22	40 "	518 "	—	"
" 23	39 "	393 "	—	"

The record of the number of stools will give a rough idea of the quantity of urine lost with them. The effect of diet is seen in the augmentation of the amount of urea following fish diet.

The quantity of albumen in the urine quickly diminished after the 14th, there being only a trace on the 17th and none at all on the 23rd. The specific gravity ranged from 1012 to 1016. On Dec. 15th the paraglobulin was separated and the cloud of paraglobulin was found about six times as large as that of the serum albumen.

The patient was readmitted on Jan. 18th. She had not vomited for four days after leaving the hospital; after that from two to six times daily. No appetite; flatulence; no

headache. Slight pain in back when sitting up, none when recumbent. No œdema. A trace of albumen in urine.

The further history need not be given in detail. The patient steadily wasted; vomited frequently both by day and night. The abdomen was repeatedly and carefully examined by different persons, but no tumour was detected, nor was there either abdominal distension, pain, or tenderness. The vomit never contained blood. The quantity of albumen remained a trace only till the day before death, when it increased to a fifth, serum albumen and paraglobulin being in about equal proportions. The amount of urine averaged about thirty ounces a day from Jan. 18th to Feb. 2nd. From Feb. 3rd till death it was only about half as much as this. The patient became more and more apathetic. There were occasional tinglings and spasmodic contractions of arms and legs, but no persistent spasms of tetany. Feb. 9th the patient died. The necropsy was made by Dr. Anderson, and showed a tubular mass of hard cancer about two inches long surrounding the pylorus, and so narrowing it that the little finger could not be passed along it. Its inner surface was ulcerated. The stomach was slightly dilated. The cancerous pylorus was situated quite deeply behind the liver. The kidneys showed subacute nephritis. The other organs were healthy.

Remarks by Dr. HERMAN.—This case is interesting on account of the rarity of tetany in pregnancy, although its frequency during lactation is recognised. In the systematic works of Gowers and Ross, pregnancy is mentioned as a predisposing cause; but Meinert,² in a monograph on tetany in pregnancy, has only been able to put together six indubitable cases, including one observed by himself. In most of these, as in the present one, the spasms of tetany ceased after delivery. In the case now reported the antecedent conditions were essentially similar to those usually preceding tetany in other subjects—conditions of enfeeblement, here from vomiting due to cancer of pylorus, with pregnancy. Gowers quotes authors who have observed transient albuminuria in tetany, and Meinert, in his otherwise accurate paper, quotes a case as presenting albuminuria and œdema; but on reference to the original³ I find that the quotation is incorrect, and that in the case in question there was no albuminuria. The case is also not without interest as one of those cases of malignant disease of stomach in which the absence of a tumour renders the diagnosis of the cause of the vomiting peculiarly difficult, the more so here because the presence of albuminuria and of the tetany suggested that the vomiting might possibly not be due to disease of the stomach. Lastly, there is yet another point of view from which the case is instructive—viz, as an item of evidence illustrating the clinical history of nephritis in pregnancy and puerpery, a morbid condition our knowledge of which is far from complete, and which is a very important one, from its occasional association with the grave event of eclampsia.

COUNTY ASYLUM, LANCASTER.

A CASE OF HÆMORRHAGE INTO THE SUPRARENAL CAPSULES OF BOTH SIDES; REMARKS.

THE following account is an interesting contribution to our literature on the subject of diseases of the suprarenal capsules, as the patient was under observation both during the onset and progress of the hæmorrhage, and the condition of the parts as found post mortem is added. 'The cause of apoplexy of these bodies was referred by Royer to want of firmness in their medullary structure and in the fragility of the veins which it contains. Moreover, the large size of the chief vein of the capsule, according to Mattei, exposes it to pressure, which the numerous small arteries escape, so that any afflux of blood while pressure exists on the veins may tend to accumulation and rupture.'⁴ In four out of six of Royer's cases the extravasation of blood occurred on the right side. Mattei met with two cases, in each of which the extravasation was on both sides; one was a stillborn child, the other a man of sixty. In Greenhow's case⁵ the affection was also symmetrical; this was a man aged twenty-nine, the subject of inter-

² Arch. für Gyn., Band xxx. ³ Gauchet, L'Union Méd., 1860.

⁴ Brit. and For. Medico-Chir. Rev., vol. i. 1864.

⁵ THE LANCET, vol. i. 1877, p. 350.