

less pain and distension, and he was altogether more comfortable. A nutrient enema was given every four hours and hot water only by the mouth for forty-eight hours more. On the 11th the stitches were removed and he was allowed one ounce of milk with water every three hours, in addition to the nutrient enemata. Slow but steady improvement followed, a little pus occasionally escaping by the wound. On the 17th faecal matter passed by the rectum and he was allowed eggs and light puddings. On the 19th a small collection of pus was evacuated from the smaller wound on the right side, which then quickly healed. On the 21st the bowels were acting regularly, whilst faecal matter still flowed freely from the wound, which was contracting and granulating. The temperature was subnormal, the pulse was 74 and the patient was gaining strength daily. On the 26th he was allowed to get up and my note-book records: "Wound smaller, appetite good, bowels open daily with simple enema, faecal discharge through wound much less, dressings changed only three times a day, walks out for half an hour and sits in the sun." On April 10th he had a sudden relapse; bilious vomiting set in with pain in the epigastrium, the bowels became constipated, and there was a slight rise of temperature, followed by a fall to 95.6° F., with a weak pulse of 62, and no faecal matter escaped by the wound. These symptoms persisted in spite of active treatment till the 13th, when the vomit became stercoraceous and he had much hiccough. It was clear that some obstruction existed above the wound, due probably to some twisting of the gut. Mr. Bruce-Clarke, who saw the patient on the 13th, was of this opinion, and thought that a second operation would be necessary, but he decided to try warm water injections through a tube passed some distance into the wound whilst the patient was turned over from side to side and the abdomen was briskly massaged. These measures were successful; some faecal matter through the wound followed, and in the evening there was an action per rectum. The abdominal pain ceased and the vomiting and hiccough disappeared. From this time the improvement was steady and continued. The wound closed, the bowels acted naturally, and the patient's strength increased daily. On the 22nd he was able to walk a mile and on the 24th he left the College for the seaside on sick leave. A month afterwards he was able to walk ten miles and was reported to be in general good health.

*Remarks.*—This case is one of considerable interest, illustrating the value of enterotomy as an aid to the evacuation of pus from the peritoneum. Before the operation the bowels were all but paralysed, and there was great reason to believe that the patient would sink from intestinal stasis. The immediate relief which the incision afforded was very marked. The intestines were too much matted together to allow of the exact cause of the abscess being made out; it seemed to be most probable, however, that a strain acting on a piece of adherent bowel had torn it and had caused some of its contents to become extravasated and so had given rise to the formation of pus.

## CASE OF ACUTE INVERSION OF THE UTERUS.

By W. R. ORR, M.D., M.Ch., M.A.O. R.U.I.

THE extreme rarity of this accident—it having occurred but once in over 190,000 cases of labour in the Rotunda Hospital since 1745—and the fact that it has a bearing on the proposed registration of midwives constitute my apology for recording the case. On Aug. 15th I was hurriedly called to see a young woman aged twenty, who had just given birth to her first child. I arrived on the scene about an hour after delivery and found the patient in a state of great collapse and quite unconscious, the pulse being small and rapid, the skin cold and clammy and the breath coming in gasps. The midwife informed me that it was a case of "false conception"; whatever she meant by the phrase I cannot say. On examination I found the uterus completely inverted and beyond the vulva, with the placenta still adherent. The uterus was quite flaccid, and there had been but a small quantity of blood lost. I stripped off the placenta, a matter of little difficulty, and replaced the uterus with ease. The patient, however, died some two minutes afterwards, altogether about an hour after the accident. I think there can be no doubt as to the immediate cause of the acci-

dent. The woman had had a tiring day and was much fatigued when labour commenced. After the expulsion of the foetus the midwife—according to her own account and that of a bystander—pulled strongly on the cord, and almost simultaneously the uterus and its contents were protruded. Here the primary cause seemed mechanical, but as there was a strong expulsive effort on the part of the patient it was probably assisted by muscular contraction. I think I am safe in saying that the presence of a medical man would have prevented the occurrence of such an accident.

Wanstead, N.E.

## 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. Prooemium.

### ROYAL FREE HOSPITAL.

CEREBRAL ABSCESS DUE TO OTITIS MEDIA; REMARKS.

(Under the care of Dr. SAINSBURY and Mr. ROUGHTON.)

THE relation between disease of the middle ear, with its bony annexes, the mastoid antrum and mastoid cells, and cerebral or head symptoms is well recognised and is sufficiently puzzling. The association of this disease with well-marked head symptoms, including optic neuritis, such as, apart from the ear disease, would unhesitatingly be ascribed to intra-cranial mischief is well-known. How far the symptoms are actually due to concurrent intra-cranial disease it is perhaps impossible to decide, but we are certainly familiar with the presence of the symptoms to a pronounced degree and with their complete and rapid subsidence on treatment of the bone disease only. For this reason it has been urged that in the above class of cases the minor operation of removal of the diseased bone in the walls of the middle ear and around it should be first performed and, in case of subsidence of the head symptoms not occurring, that the major operation of opening the skull should be then entertained. The following case suggests that it is best not to be too systematic in procedure, that each case should be treated on its own merits, and that perhaps the major operation should in some be performed at once.

A man aged fifty was admitted into the Wynn Ellis Ward of the Royal Free Hospital on Saturday, Aug. 12th of this year. The patient was sent in for the association of head symptoms with deafness of, and discharge from, the left ear. The family history had no bearing on the case. The personal history recorded a discharge from the left ear extending back to youth. At the age of thirty this seems to have ceased. The patient's habits were intemperate. On Saturday, Aug. 5th, he was exposed to a draught whilst travelling in a railway carriage. He seems to have noticed a slight deafness in the left ear the same day, and in the evening he vomited. On the 9th the deafness was noted as being worse, there was a complaint of pain in the ear, and in the afternoon of this day there was some discharge of blood from it. On the 10th there was less pain, but some discharge of matter. He consulted a medical practitioner on this day, and whilst at his house he had a convulsive fit. He seems to have recovered partially and was removed to his home, but there lapsed into an unconscious state, which lasted some hours. After recovery from this fit and during the next day, he was distinctly not himself; his memory was bad, he could not find words and he described his feeling as being one of vacancy. At one time he appears to have been distinctly aphasic. After admission into hospital on the 12th his speech was noted as being thick, and the face on the right side as weak. The arms and legs were moved equally by the patient, the knee-jerks were absent on both sides, there were no sensory symptoms. On further examination the deafness in the left ear was found to depend on disease of the middle ear. At the time of the patient's admission there was moderate fever, the maximum temperature being 101.2° F. On the following day the temperature fell to normal and it remained so till the 18th. During this time there was decided