

some degree insusceptible to syphilis" and to have become "as a usual thing" "immune towards syphilis in a certain sense." It matters nothing as I see it, and changes nothing, to regard a mother who gets a chancre from her syphilitic child as getting a second attack or a second infection of syphilis, which seems to be Mr. Hutchinson's view, that is, if I understand him correctly. A woman receives from vaccination something which renders her different from an unvaccinated person in respect of exposure to infection from small-pox—just as carrying a syphilitic foetus does to the woman who carries it in regard to infection from syphilis—but I do not suppose that any one would advise a vaccinated woman to put herself unnecessarily in the way of being infected with small-pox, nor would we, if she did expose herself and became infected, call it a "second attack" or "second infection." I admit that "the something" which is received from vaccination and "the something" which is received from carrying a syphilitic foetus may not be of the same potency as regards infection from small-pox and syphilis respectively. But the difference is one only of degree; and at the most the mother of the syphilitic foetus is only less liable to infection from syphilis than the vaccinated woman is to infection from small-pox. My position is that, as the protection of the mother from syphilis is not complete, she ought never to be exposed to the risk, even if the reason for doing so were much stronger than that which is adduced by Mr. Hutchinson, and which seems to me altogether insufficient.

Welbeck-street, W.

## TRANSFUSION OF SALINE FLUID INTO THE AXILLARY CELLULAR TISSUE IN CASES OF SEVERE HÆMORRHAGE.

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THE credit of this method of treatment is due to Mr. Thomas H. Morse of Norwich, and it was owing to his suggestions some time ago that I became aware of it. The instrument used is a very slight modification of Mr. Arbuthnot Lane's transfusion apparatus, made by Messrs. Down Brothers, the only difference being that a sharp-pointed needle of a little stouter make is required instead of the blunt one used for introduction into a vein, and the ordinary saline solution is used—i.e., a teaspoonful of common salt to the pint of boiled water cooled down to the proper temperature (100° F.). Having fitted the needle, tube, and syringe together, fill the latter with the solution, then force the steel point of the needle through the skin of the axilla deep enough to move freely into the cellular tissue, and slowly and gently force the fluid into the cellular tissue. Refill the syringe and proceed again until a pint or more has been used. The following are brief notes of a successful case in my own practice.

In February last I was sent for one evening about 7 P.M. to attend a multipara, as the nurse was alarmed at the excessive hæmorrhage which had taken place during the preceding two hours without apparently any progress being made in the labour. I found the patient had lost an enormous quantity of blood and was in a dangerous condition, being blanched and pulseless, and the pains, which had been going on regularly for several hours previously, had now entirely left her. Upon examination I found the os only partially dilated and the membranes protruding, but no presentation detectable. I ruptured the membranes, a large quantity of liquor amnii escaping, and I found that the cause of the hæmorrhage was right partial placenta prævia. She was now in an exceedingly critical condition, vomiting, in a cold clammy perspiration, with sighing respirations, the bowels acting involuntarily, and she was pulseless, semi-conscious, and apparently rapidly sinking. Two subcutaneous injections of ether were given without the slightest improvement. Dr. Treutler, who kindly saw the case with me and lent me his assistance, agreed that no further interference in the labour was at present justifiable. Remembering Mr. Morse's suggestions, and having my instrument within easy distance, we performed transfusion according to his method, injecting about

a pint, although I must confess without the remotest idea of benefiting the patient, as we considered the case beyond our assistance. However, after a very brief interval there were indications of slight improvement and a very feeble pulse was detectable at the radials. During the next two hours small quantities of warm milk and brandy were able to be taken at frequent intervals. After that time there were decided symptoms of rallying and benefit from the transfusion and pains returned. By examination a vertex presentation could be made out, and ergotinine ( $\frac{1}{160}$  gr.) was injected and we delivered with forceps.

It may be interesting to note that the child (female) was stillborn and very large, weighing eight pounds and three-quarters and measuring twenty-one and a half inches in length. It was in a state of well-marked rigor mortis, the stiffness of the limbs and body adding considerably to the difficulty of completing delivery, which was accomplished at 12.45 A.M. The movements of the child were last felt at 6 P.M. The placenta was easily removed, and the position of the part whence the hæmorrhage occurred found well-marked on its border. The patient made an uninterrupted recovery, assisted by taking iron in the form of Bland's pills (bi-palatinoids) for several weeks.

The results of the transfusion were rapid absorption of the saline fluid (hardly any swelling remaining at the end of two hours) and decided and rapid improvement of the urgent symptoms, thus enabling the patient to take minute quantities of nourishment; and its advantages are the quick, ready, and easy application of the method which could be managed any time single-handed. Mr. Morse has had two successful cases, one being for a pulseless patient, due to hæmorrhage as a result of extra-uterine foetation, and he says "that the pulse became quite a good one in fifteen minutes," and he further suggests the use of this method "before certain operations in collapsed conditions due to hæmorrhage," and on future occasions he intends performing the operation in both axillæ.

West Brighton, Sussex.

## Clinical Notes: MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

### CASE OF OBTURATOR HERNIA SUCCESSFULLY TREATED BY COPIOUS ENEMATA.

BY C. W. MONRO GRIER, M.B., C.M. EDIN.,  
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ON June 25th, 1895, a fisherman aged thirty-eight years was carried home from his boat suffering great pain along the line of the adductor muscles to the knee of the left leg. The day before he had hobbled to his boat in pain in the same region, and had been obliged to remain on his hands and knees until he was carried ashore, as stated. The bowels had not been moved for two days. A slight sense of fulness to the inner side of the femoral vessels, inability to extend the thigh, the great pain at the groin, complete loss of appetite, and a sense of nausea, with the tongue dried in the centre, suggested the diagnosis, the inguinal and femoral canals being clear. Having tried moderate taxis without result I ordered an enema of a gallon of warm water, which was injected almost without the patient being aware of it, so complete was the loss of sensation in the lower bowel. After a quarter of an hour, there being no desire to defecate, he was asked to make an effort to move the bowel, with the result that about a pint of hardly discoloured water was passed. He was then put on morphia, belladonna, and tincture of chloroform, which somewhat relieved his pain and induced sleep for an hour or two. On June 26th, 10 A.M., I found that nothing had been passed by the bowel during the night. The tongue was drier and the condition was evidently worse. The temperature was 101° F. and the pulse was 112. I gave another enema of a gallon of warm water and applied taxis, with the result that I fancied I heard and felt a slight gurgle under my thumb. He now stated that he was not suffering so much pain. There was still loss of sensation in the lower bowel, but on the patient's trying to evacuate the enema about two pints were passed with a

few hard fæces, which I thought (from his passing so small a portion of the enema) must have been lying below the seat of injury. The morphia was continued. In the evening there was considerable pain, but no further motion by the bowel; a considerable amount of urine was passed. The tongue was still dry. I ordered elixir of cascara sagrada, two drachms, to be repeated in four hours. On June 27th no motion had been passed during the night, but much urine. The tongue was still dry and the pulse, temperature, and condition were generally about the same as they had been on the previous morning. The fulness at the inner side of the femoral vessels had disappeared and the pain at that part was not so severe. I considered that the hernia had been reduced and that there was probably stricture of the gut in the region injured. I again gave an enema of a gallon, rolled the patient gently from side to side of the bed, and kneaded the abdomen. The combined efforts induced considerable peristaltic action, with much pain and desire to defecate, with the result that there was a free motion of the bowels with plenty of fæces. On June 28th the patient was generally better; the bowels had been moved once freely during the night, but there was still some abdominal distress. On the 29th and 30th he was better, and on July 1st he went out for a walk. The diet throughout consisted of well-boiled gruel, beef-tea, and milk.

Polpier, Mevagissey, Cornwall.

#### CASE OF CHRONIC NEPHRITIS IN WHICH THE SEVERE DROPSY DISAPPEARED AFTER PERSISTING FOR NEARLY TWELVE MONTHS.

By MATTHEW SHIRLEY, L.R.C.P. EDIN., L.F.P. & S. GLASG.,  
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A MAN aged thirty-two years was in the Skipton Union Workhouse in November, 1893, and onwards for thirteen weeks under Dr. Wylie and Mr. Welsh. He was swollen to the waist from below upwards and his urine on boiling was nearly solid with albumin. In March, 1894, he was under Mr. Atkinson of Romalldkirk, near Barnard Castle. On Sept. 19th his condition was rather worse and he went to the General Infirmary, Leeds. His urine was examined then, but his condition did not improve. On the 20th he came into the Union Workhouse at Hunslet, when his condition was as follows. There was anasarca from head to foot; the urine on boiling became solid; the patient was very restless; he had a dry, hacking cough; and was sleepless and muttering. Pilocarpine was given. On Oct. 4th there was no change for the better. The patient had been sweating, was still swollen, and very restless. The pilocarpine was given up. On the 11th the anasarca had become somewhat less. He was more cheerful and felt better. The urine was in the same condition and there were casts. On the 14th the anasarca was less all over and the urine was the same. On the 15th there was no albumin on boiling, but about one-fifth albumin on settling after adding nitric acid. The anasarca was quite gone and the improvement continued. On the 25th the patient was up and partook of eggs, liquor carnis, a mutton chop, and some milk. He was cheerful, and there was no return of any symptom. There were no casts and the albumin was lessening.

#### A NOTE ON FIFTY CASES OF INFLUENZA.

By H. W. WEBBER, M.S., M.D. LOND.

SEVERAL interesting points with regard to the symptoms and complications occurring in influenza have at times been raised by correspondents of THE LANCET, notably—(1) throat affections, (2) the presence of skin eruptions, and (3) the treatment of the disease. My experience in fifty consecutive cases of influenza observed during the last epidemic is that throat trouble has been present in the majority, although the subjective symptoms of this have been slight, no pain on swallowing (or very little) being complained of. On examination the fauces, uvula, soft palate, and pharynx showed a general redness of peculiar dusky colour and dry appearance; the intensity of the inflammation has been fairly proportionate to the degree of

pyrexia, though its slow subsidence has been in marked contrast to the usually rapid (from twenty-four to forty-eight hours) fall of temperature. I have not observed swelling of the tonsils beyond a slight congestion accompanying the above condition in any case. In twenty-two of the cases redness of the skin was present. This was of the nature of a congestive erythema, well-marked when pyrexia was at its height and then of deep-red colour, the skin being burning hot to the touch, this disappearing with the fall of temperature and leaving the patient anæmic. In nearly all the cases it was most intense on the face, arms, and hands. No desquamation of any sort has followed in any case. In four of the cases I have observed vesicular herpes; in three this made its appearance on the fall of temperature, in the fourth the patient when first seen was still going about, having a temperature of 102.2° F. on the fourth day of the disease. In one case the eruption was profuse, involving the alæ and columna nasi and both lips; in the other three a crop of vesicles about the size of a sixpence was situated on the lower lip. My treatment with all has been—(a) during the acute stage confinement to bed, liquid diet, and a mixture of salicylate of soda, bicarbonate of potash, and liquor ammoniæ acetatis, with the addition of a little sal volatile; the latter counteracts the depressing tendency of the salicylate of soda and the influenza virus and seems to lessen the headache, and this, when persisting after the acute stage, I have always found relieved by five-grain doses of antipyrin given every four hours if required; (b) after the subsidence of pyrexia by quinine with strychnia; and (c) special complications, such as bronchial catarrh, which has been frequent, require suitable treatment.

Plymouth.

## 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 ROYAL EYE HOSPITAL, SOUTHWARK.

#### A CASE OF DIPHTHERITIC CONJUNCTIVITIS.

(Under the care of Dr. W. J. COLLINS.)

THE following notes of a case occurring in Dr. Collins's practice at the Royal Eye Hospital, Southwark, deserve record as showing very completely how the local, constitutional, and bacteriological phenomena which we recognise as diphtheritic have their exact counterpart when the seat of the initial lesion is the conjunctival mucous membrane instead of the faucial. The disease is said to be most common in Germany, but we sometimes get very severe cases in this country as evidenced by the record of this one. We are indebted to Dr. J. W. H. Eyre, clinical assistant, for the notes and the account of the bacteriological investigation.

The patient was a male child aged two years and was first seen by Dr. W. J. Collins on Feb. 10th, 1896. The history given by the mother was that the child's left eye had begun to be inflamed three days previously. The right eye became affected the next day, but it was not until the day previously to her visit to the hospital that the lids had swollen to any extent. When first seen both eyes were affected, the lids being swollen, red, and painful, and difficult to separate on account of the brawny infiltration of the surrounding subcutaneous tissues. On separating the lids by means of retractors the ocular conjunctiva was found to be injected and much chemosed; the palpebral portion was congested and thickened and presented patches of pale greyish-yellow membranous exudation, giving one the impression that a strong caustic had been recently applied. This membrane stripped off easily, leaving a raw bleeding surface below. The corneæ were slightly hazy, but the surface epithelium remained unbroken. A thin milky-white discharge, slight in quantity, exuded from