

affected and another were each bitten by the same dog through the clothing and escaped scot-free.

3. *Prophylaxis*.—So great is the immunity conferred by clothing that the use of gloves for those attending hydrophobic patients should be insisted on. Recent wounds may be treated by cupping; suction by the mouth is clearly objectionable for reasons already stated. Excision of the wound may be practised; in some cases amputation might be resorted to, if, for instance, a finger were the part involved. Of caustics, though the acid nitrate of mercury, nitric acid, caustic potash, and other escharotics are advocated, yet there seems ample reason for recommending nitrate of silver.¹¹

With regard to surgical treatment of the wound during the period of recrudescence the question arises, Has the virus remained dormant during the incubative stage, and been localised at the seat of the injury? Or has it infected the system *ab initio*? I believe those who hold the latter view are few in number—certainly Marochetti was one; and his doctrines have received the support of Trousseau. The followers of Marochetti will therefore carefully examine their patients for lyssi during the first three weeks of the period of delitescence; if found, they can be treated as prescribed by their discoverer. But if they be not found; if the disease progress; if the character of the wound and the prodromic symptoms leave no doubt as to the malady being fairly established, what treatment can be adopted? Though unusual for the lymphatic system to be manifestly infected, nevertheless this is proved to have occurred.¹²

On the supposition that the disease is entirely of a neurosal character, resection of centripetal nerves leading from the wound has been recommended, tried, and failed. The question of amputation must certainly be considered. A tourniquet has been applied to the bitten limb of a hydrophobic patient, and the "symptoms quickly improved, and even seemed to cease altogether." The symptoms returned on the removal of the tourniquet, but disappeared on its reapplication.¹³

The actual cautery might nearly always be applied to the wound, and, if tried sufficiently early, with some hope of success. Whilst advocating this as a reasonable mode of procedure, we must lament that our therapeutic knowledge on this subject is scarcely a whit more advanced than it was in the time of Celsus.

A CASE OF TRANSFUSION OF BLOOD.

By ARTHUR EDDOWES, M.R.C.S.,

AND

J. B. PIKE, M.R.C.S.

AT 4.30 A.M. on the 29th of July last, I saw Mrs. W—, and found that she had expelled a foetus of about three months' growth the night before at seven o'clock, and had been flooding ever since. With some difficulty I extracted the membranes, having previously given a full dose of ergot and brandy. Hæmorrhage still continuing slightly, I introduced my finger several times into the uterus, having dipped it in a solution of perchloride of iron. The hæmorrhage stopped, but the patient seemed to be sinking in spite of the free use of brandy.

I then sent for Mr. Eddowes, asking him to bring his transfusion apparatus (Aveling's). Mr. Eddowes arrived about half-past five, and after a little time we decided that transfusion offered the only chance of saving the patient. She was pulseless at the wrist, or with only the faintest flicker, and breathing with difficulty. Mr. Eddowes exposed the median cephalic of the patient, and inserted the cannula. I then opened the median basilic of the husband, and we inserted the second cannula with rather more difficulty. The syringe, full of warm water, was then attached, and between two and three ounces of blood injected. There was immediately a slight, but still marked, improvement in the state of the patient, the pulse reappearing perceptibly at the wrist, and the breathing being less laboured.

She remained in a very precarious state until between three and four o'clock in the afternoon, when reaction set in, and continued for a few days. The temperature did not, however, rise above 100°. The patient was most care-

fully nursed during the critical day by Mr. Eddowes, myself, and the district nurse, stimulants and beef-tea being given at short intervals, and warmth applied to the body. No doubt to this fact, combined with the stimulus of the fresh blood, she owes a recovery which has been rapid and satisfactory.

Loughborough.

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.

GREAT NORTHERN HOSPITAL.

RECURRENT FIBROID MAMMARY TUMOUR.

(Under the care of Mr. GAY.)

AN interesting case of this kind recently came before Mr. Gay. He had removed the mammary gland a twelve-month previously. There was no axillary complication, and the wound healed well in about three to four weeks. The patient was a lean person, aged fifty-four years. When she presented herself again, two painful growths had recurred on the axillary side of the site of the former operation, and had ulcerated on their surfaces. The bases were of almost a scirrhus hardness, but unadherent to the subjacent structures. The ulcerated surfaces were flattened, and had the appearance of being made up of eversion, from central gaps of the skin and, might be, allied structures.

Mr. Gay said he deemed the case one of considerable interest, as illustrating a by no means uncommon instance of fibro-recurrent or recurrent adenoid growth, such as he had described repeatedly in the *Pathological Transactions*, and which has a history, both clinical and pathological, of its own. Mr. Gay had no difficulty in distinguishing the case from absolute cancer, although it appears to stand close on the immediate confines of that disease. Originally a growth from the mammary fibrous structures, its recurrence is never prevented by the ablation of the gland. It is but slightly infective, so that the axillary glands do not show any marked disposition to enlargement, either by contamination or sympathy; and in the event of their becoming enlarged, the swellings usually either subside, or ulcerate after the fashion of the parent growths. It is at certain stages spindle-cell shaped in its histological characteristics. The tendency of these tumours to grow, as well as to ulcerative degeneration, is in the direction of the skin. They admit of removal in any stage of their career, and certainly with much temporary advantage to the patient, as the disease seems to have a specifically local character, and does not usually invade vital organs. On the other hand, with removal, the patient is very prone to improve in constitution, and to get healthy and fat. Such cases must have come under the observation of other surgeons; but, as far as Mr. Gay was informed, have not met with much attention.

RECURRENT CANCEROUS (?) DISEASE IN SCROTUM AND CORD AFTER ABLATION OF A SCIRRHOUS TESTIS, WITH SKIN ULCERATIONS, EXPOSING "TUMEURS GOMMEUSES" IN FRONT OF THE STERNUM.

The patient, a pale weakly-looking man, aged forty-three, submitted to the removal of the right testis three years ago for supposed cancer. The parts healed, and he went to his usual employment. Ten or twelve months since the cicatricial line of the scrotum became the seat of slow but superficial ulceration—i.e., an ulcer penetrated the skin, the edges of which in some parts became somewhat indurated, whilst in others they thinned and somewhat overlapped the sore, or, rather, the sore undermined the skin edge. At the same time the end of the cord thickened, and became painful on handling. There was no glandular complication. As this disease broke out in the scrotum, a swelling took place over the upper part of the sternum. The skin over it ulcerated so as to enclose a growth of pinky and redundant granulations below, which

¹¹ Watson, op. cit., p. 622.

¹² Idem, p. 609.

¹³ Trousseau, *Clinical Medicine*, vol. i., p. 712.