

cavity, which led to the frequent expulsion of the contents of the cavity—a washing out not wholly desirable. Next we have the occurrence of an abscess in the left cerebral hemisphere, which we must take to be secondary to the lung disease, without there having been any symptoms of blood poisoning. The temperature throughout was but little raised, the maximum rarely exceeding 100° F., the minimum touching or falling slightly below normal; there were at no time rigors or sweatings.

TAUNTON AND SOMERSET HOSPITAL.

DISLOCATION ON TO THE DORSUM ILII IN A CHILD; REMARKS.

(Under the care of Mr. FARRANT.)

DISLOCATIONS at the hip-joint are of such rarity as to make them interesting, especially when they occur in childhood, for in children the femur is very easily broken, yielding to a force which would otherwise be sufficient to produce rupture of ligaments and displacement. Malgaigne gives a list of fifty-one dislocations of the femur, but out of these only one was under the age of fifteen years. Sir Astley Cooper collected a series of fifty-six dislocations of this joint; in forty-five of these cases in which the age is mentioned, only seven were under twenty years of age. Hamilton gives the proportion of dislocations of the hip-joint in children (i.e., under fifteen years of age) as fifteen out of a collection of eighty-four. For the notes of this case we are indebted to Mr. W. B. Cosens, house surgeon.

Chas. T—, aged seven, was taken to the casualty room of the hospital on July 26th, 1889, the father saying that the boy's "hip was out." At the same time he gave the following history of the injury. Whilst playing at a "three-legged race," his right leg being fastened by means of a handkerchief to his companion's left leg, he stumbled and fell, his left leg being under, the other boy falling across him. He felt something "go," and on attempting to rise found his leg powerless. On admission the following was his condition. He complained of pain over the left hip-joint, and the left thigh was semi-flexed, adducted, and rotated inwards, the ball of the great toe almost resting on the dorsum of the right foot; the great trochanter was above Nélaton's line. On attempting to extend the leg, the boy immediately cried out with pain. The head of the femur was easily felt, resting on the dorsum ilii. The dislocation was easily reduced by flexing the thigh on the abdomen, rotating outwards, and quickly bringing the leg down to a straight line with the body, the head of the femur entering the acetabulum with an audible click. A long outside splint was applied and the boy kept in bed for three weeks.

Remarks by Mr. FARRANT.—I think little apology is needed for recording the case owing to the extreme rarity of dislocation of the hip-joint in young children. Erichsen mentions two cases in his book on Surgery—one on to the pubic bone in a child aged one year and a half, another on to the dorsum ilii in a boy of six. In THE LANCET of 1868 Mr. Powdrell recorded a case in which the head of the femur was displaced into the foramen ovale at the age of six months, and reduced by manipulation. The case recorded above has done well, there being good movement in the joint at the end of three weeks, and, at the end of six weeks, the boy was running about as if nothing had happened.

BRECKNOCK INFIRMARY.

A CASE OF TRAUMATIC TETANUS; RECOVERY; REMARKS.

(Under the care of Mr. D. V. REES.)

WE publish below the account of a case of traumatic tetanus which came on five days after the receipt of injury, and terminated, rather more than four weeks after its commencement, in recovery. The symptoms throughout appear to have been of subacute character, excepting for the attacks which affected the muscles of the glottis. In the editorial remarks to a case successfully treated by¹ nerve excision and chloral hydrate, we mentioned at some length various methods of treatment which had been employed, and drew attention to those which had proved most successful. Of these, chloral hydrate was at the head

of the list, the larger proportion of recoveries having followed its exhibition alone, or associated with other remedies. The effect produced by the salicylate of eserine will be noted with interest. For the following account we are indebted to Mr. J. R. J. Raywood, late house surgeon.

T. V—, aged seven years, was admitted on May 7th, 1888. He was a fairly well-nourished boy, and had never had any serious illness. On April 30th he burnt his left leg with a hot flat-iron just below and external to the head of the fibula; the wound inflamed and suppurated, though not sufficiently to prevent his going to school. On May 5th his father noticed the boy's face "drawn," and he complained of stiffness about his jaws, and had some difficulty in opening his mouth. On May 6th he was seen by the visiting surgeon, who found his condition as follows. Risus sardonius and trismus well marked, muscles of back, neck, and abdomen rigid and fixed with occasional tonic spasm; bowels confined; tongue coated with thick white fur; pulse 80 per minute; temperature 98.8°; intellect clear; he spoke in a whisper, and screamed and called out when the spasms came on. There was a small wound just below the head of the left fibula about two inches long by an inch and a half wide, granulating and suppurating. He was ordered five grains of calomel at once and five grains of bromide of potass in two drachms of water every four hours. When admitted on May 7th all the above symptoms were present, and there was also occasional spasm of the glottis and opisthotonos. The spasms came on very often, during which time the heart beat tremulously and the whole body was bathed in perspiration. A hypodermic injection of salicylate of eserine ($\frac{1}{100}$ gr.), every three hours, was now ordered, and the following mixture: ten grains of bromide of potass, half a drachm of the syrup of chloral hydrate, in half an ounce of water; to be taken every three hours, the medicine being given an hour and a half after each injection. Diet, beef-tea and milk.

May 8th.—Slept at intervals during the night; several very severe spasms of the glottis, all the other symptoms the same. Bowels confined. Temperature 99°. To have an enema of warm water when necessary.

9th.—Sleeps continually except when spasms come on; takes nourishment well but mouth firmly fixed and nearly closed. Temperature 98.6°; pulse 76; respiration 17. In the evening had a severe spasm of the glottis, which lasted nearly two minutes, but rallied after warm fomentations to the chest and neck. The injections of salicylate of eserine to be increased to $\frac{1}{50}$ gr. every three hours; the mixture to be continued as before.

10th.—The spasms are less frequent; he is very drowsy; breathing slower; some stertorous breathing, and he sneezes frequently; pupils minutely contracted; the wound on the leg is healthy and dressed with zinc ointment. Temperature 98.8°; pulse 78.

11th.—Sleeps nearly all the time. Spasms not so frequent. Still sneezes frequently; this is followed by a general tonic spasm of muscles of abdomen, back, &c. Pulse weak and compressible. The risus is not so marked, and he opens his mouth a little better. Temperature 98.8°. To have two ounces of brandy daily.

12th.—Two injections were omitted during the night. The spasms are more frequent again; the other symptoms continue the same. Bowels act every day after an enema. Temperature 98.8°.

13th.—Much improved. Rigidity of muscles not so great. Temperature 98.6°.

15th.—The spasms only affect the back and the face now. Pulse strong. Takes nourishment well. Temperature 98.6°.

18th.—Rigidity of abdomen still continues. Can open his mouth widely. There are a few moist râles at both bases of lung. Temperature 99.4°. To omit medicine, and inject eserine ($\frac{1}{30}$ gr.) three times a day. Wound quite healed.

19th.—Risus and trismus almost gone. Had only three slight spasms to-day. Temperature 98.6°; pulse 86; respiration 19. Took a little solid food to-day.

30th.—Can sit up in bed without assistance. Is taking food well. Omit the injection.

June 7th.—All rigidity has now gone. To get up.

17th.—Left to-day quite well, and has gained in weight considerably.

Remarks by Mr. RAYWOOD.—The success attending the treatment of this case is worthy of notice, for in nearly all the published cases of tetanus eserine was either not given, or if given it was not pushed until the physiological effects

¹ Mirror of Hospital Practice, THE LANCET, vol. ii., p. 114, 1889.

of the drug were shown. Here its action was most marked; for although the bromide and chloral may have assisted to recovery, yet these drugs had no direct control over the spasms, for whenever a dose of eserine was omitted the muscular spasms were stronger and more frequent, and no relapse occurred when the bromide and chloral were discontinued. It was also noticeable that the temperature was never above 99.4°.

Medical Societies.

OBSTETRICAL SOCIETY OF LONDON.

A MEETING of this Society was held on Wednesday, Oct. 2nd, Dr. A. L. Galabin, President, in the chair.

A report was read on Mr. Stewart Pollock's specimen of Dermoid Ovarian Tumour from a mare, exhibited before the Society in July.

Dr. WILLIAM DUNCAN exhibited: (1) A Dermoid Ovarian Tumour; (2) an Ovarian Cyst; (3) Pyometra and Pyosalpinx, with Suppurating Kidney and Thrombosis of the Renal Artery, from a patient subject to syphilitic disease of the rectum.

Dr. J. PHILLIPS showed some Blue Urine from a case of cyanuria.

Dr. CULLINGWORTH exhibited a Hæmatosalpinx from Rupture of a Varicose Vein in the Fallopian Tube.

Mr. WOODLEY SLYMAN brought forward an Acardiac Fœtus with Rudimentary Heart.

Dr. J. SHAW exhibited a Uterine Douche.

A Contribution to the Anatomy of the Pelvic Floor.—A paper on this subject was read by Dr. HERMAN, in which measurements were detailed which show the great normal variations in the conformation of the parts which form the floor of the pelvis. It was shown that the projection of the pelvic floor varies from none at all to as much as two inches, and that in healthy nulliparæ the distance between the coccyx and anus, the length of the perineum, the distance between the fourchette and the symphysis pubis, and the length of the vagina, are subject to wide variations. It was pointed out that since these variations exist in healthy nulliparæ, peculiarities observed in parous women should not be assumed to be changes due to childbearing unless it has been ascertained that they were not present previous to pregnancy. The clinical importance of these anatomical variations in their bearing on the liability to rupture of the perineum and to prolapse, the adjustment of pessaries, and some forms of dyspareunia and sterility, was indicated.

On the Changes in the Pelvic Floor which accompany the Slighter Degrees of Prolapse.—This subject was also introduced by Dr. HERMAN, who described the descent of the pelvic floor which takes place during effort in health and is morbidly increased in prolapse. Measurements were given which showed that this descent in health probably does not exceed three-quarters of an inch. This descent takes place partly by stretching of the sacral segment of the pelvic floor in an antero-posterior direction, and partly by its recession downwards and backwards from the symphysis pubis, a movement which implies transverse stretching. In the antero-posterior stretching the perineum and the part posterior to the anus take part to about the same proportionate extent. This normal descent of the pelvic floor is accompanied with descent of the uterus into the vagina to the extent of about five-eighths of an inch. These changes may be morbidly increased and their relative extent morbidly altered. The descent of the pelvic floor may exceed two inches. This morbid increase of descent of the pelvic floor may be present without increased descent of the uterus into the vagina. In other cases it may be accompanied with descent and protrusion of the anterior segment of the pelvic floor, with or without the uterus. In such cases, when a protrusion at the vaginal orifice has taken place, further effort increases this protrusion, but does not increase the descent of the sacral segment of the pelvic floor. Backward displacement of the uterus is often present without more descent of the uterus or of the pelvic floor than is present in most healthy women; but in most cases of backward displacement of the uterus the descent of the uterus and pelvic floor is increased. Backward displacement of the uterus is not associated with shortness of the vagina. Although the

symptoms of descent are usually relieved by suitable mechanical support, yet the amount of descent of the uterus or of the pelvic floor is not the measure of the severity of the symptoms. There may be symptoms with slight descent in some patients, much descent without symptoms in others, and in the same patient the symptoms may be present at one time and absent at another, although the amount of descent has not varied; showing that the symptoms are conditioned more by the state of the nervous system than by the local mechanical changes.—Dr. GRAILY HEWITT considered that Dr. Herman deserved much credit for his analysis of the phenomena observed in cases of slighter degrees of prolapsus. The subject was of vast importance, for the effects of so-called minor displacements, though not dangerous to life, destroyed all enjoyment of it. The patient's sufferings often became intensified, so that in later years serious impairment of the uterine functions often followed neglect of the symptoms of minor displacements in their earlier stages. Dr. Hewitt was glad to find himself in agreement with Dr. Herman on many points in reference to descent of the uterus and its effects in producing suffering. He believed, however, that in these cases the principal cause of the suffering was the exaggeration and intensification of the version or flexion of the uterus more frequently associated with descent of that organ. Descent of the uterus pure and simple was rare, but descent accompanied with flexion or version was very common. In estimating the effects of the displacement it would be necessary to find out how much of the suffering was due to the mere descent and how much to the increased flexion or version. So far as backward displacement was concerned, Dr. Herman noted that descent was thereby increased. Nothing had been said about antelexion. Dr. Hewitt believed that antelexion not yet rigidly set in that shape, the uterus being still fairly movable, might be regarded as not abnormal. The case was quite different when the organ was sharply bent forwards, the fundus low down, and the uterus firmly resisting alteration of shape and position. Dr. Herman noted several cases of cystocele. In these cases the antelexion was probably an important causative element. Descent of the pelvic floor was chiefly important because it brought about increase of flexion, and consequent increase of discomfort.—Dr. HERMAN regarded antelexion as one of the natural shapes which the uterus might assume. He had investigated the frequency of antelexion in the healthy uterus, and laid the results before the Society.¹ Vedeler had made a similar research, with substantially the same result—namely, that acute antelexion was very common in health. No one else had investigated the question. Backward displacements caused symptoms in but a small minority of cases; not by any effect of the bending of the uterus, but by the torsion and pressure on the broad ligaments which returned the blood from the uterus. In a case described that evening a patient was kept for two months in hospital, and all her symptoms went away, yet the retroflexion remained exactly as it was on admission, showing that it was not an important feature of the case.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

THE opening meeting of the eighth session of the above Society was held on Friday, Oct. 4th, in the board room of the West London Hospital.

Mr. KEETLEY showed some Loose Cartilages removed from two knee-joints; also a portion of a Kidney crushed off by a waggon wheel, and removed through a lumbar incision.

Mr. PERCY DUNN showed some recent additions to the Museum of the West London Hospital.

The PRESIDENT (Dr. H. Campbell Pope) then gave his address on "The Beginnings of Disease." He began by congratulating the members of the Society on its increasing success, and then proceeded to state what was to be understood by the term "beginnings of disease." He quoted Dr. Andrew's remark in his Cavendish lecture, that "all disease begins, mediately or immediately, in the environment," and went on to speak of Dr. Harry Campbell's statement, in his work "On the Causation of Disease," that "the environment is in the last resort the sole cause of

¹ Transactions, vol. xxiii.