

times a day. In spite of this the temperature remained constantly over 102° , and on the sixth evening it was 103° , with pulse 106 and shivers, the lochia being scanty but not in the least offensive. The uterus was again explored under chloroform and some small polypoid excrescences were scraped away with the finger-nail, and a lysol douche at 120° was given as the bleeding was rather brisk. Under the microscope the scrapings showed no trace of chorion or chorionic villi but consisted mainly of decidua (its glands showing inflammatory changes), some fibrinous clot, and a few scattered shreds of muscle-fibre. On the following morning the temperature was 99.6° . On the seventh evening it went up to 101.8° and, assuming a hectic character with morning remissions, it gradually rose to 104.4° , with pulse 128, by the eleventh day. The uterus was now thoroughly scraped with a blunt curette and the whole of its lining was carefully swabbed with pure izal. The temperature dropped to 98.6° but mounted again to 104.4° on the following evening. However, from this time onwards the fever rapidly decreased, the shivering fits ceased, and recovery was only interrupted by two relapses of the temperature—one to 104.4° on the fourteenth day (probably due to emotion caused by a family excitement), and the other to 101.8° and 103.2° on the sixteenth and seventeenth days respectively (when solid food was taken for the first time). After this there was no more fever and recovery was complete.

CASE 2.—A woman, aged 32 years, a multipara, was attended by the same midwife and pupil in the interval between the confinement of the patient in Case 1 and the appearance of puerperal fever. She developed a temperature of 102° , with pulse 100, on the third day after confinement. The bowels and breasts were rectified but after a morning remission to 99.6° , the temperature on the fourth evening ran up to 104.4° , with pulse 130 and a rigor. The lochia were decreased in amount, were not offensive, and everything pointed to an infection similar to that of the previous case. Without delay the patient was anæsthetised and the uterine cavity was explored, but no trace of secundines was palpable. The walls were thoroughly scraped with a blunt curette (the blade guarded by a forefinger) and the raw surface was swabbed with pure izal. After the operation the temperature fell to 99.6° , with pulse 88, and there was no recurrence of the fever. Vaginal douches of biniodide of mercury 1 in 2000 (followed by sterilised water) were given for a few days as a precautionary measure and recovery was uninterrupted.

In neither patient was any lesion found in the vaginal canal, or any tenderness or thickening in the pelvic fascia or peritoneum.

Worcester.

A NOTE ON A NEW METHOD FOR THE REPAIR OF PERFORATION OCCURRING DURING THE SUBMUCOUS RESECTION OF THE NASAL SEPTUM.

By F. D. GULLIVER, M.D.,

ATTENDING SURGEON TO NOSE AND THROAT DEPARTMENT OF FORDHAM HOSPITAL; ASSISTANT SURGEON TO NEW YORK THROAT, NOSE, AND LUNG HOSPITAL.

WHEN examining the nose of a patient who has undergone a submucous operation on the nasal septum a perforation is not infrequently discovered. Such an occurrence is not only a source of some annoyance and inconvenience to the patient but is always an eyesore to the operator, although he may not be in fault. Indeed, in the case of a patient whose mucous membrane has been destroyed on one or both sides by the removal of a spur or by an ulcerative process, in performing the submucous operation on the nasal septum it is often impossible to avoid a perforation. Some few months ago when resecting a septum with an extreme angular, longitudinal deviation I found when proceeding to put the flaps of mucous membrane together that both sides had been perforated and that there was a hole in the resulting septum. There being an excess of mucous membrane in the flap on the convex side, I decided to endeavour to utilise part of it for the repair of the septum. Accordingly I cut off a piece of mucous membrane, in size about a quarter of an inch square, and after carefully cleansing with a warm normal saline solution I interposed the excised piece between the flaps of mucous membrane in such a

manner as to cover completely the perforation. The packing was allowed to remain in the nose for 24 hours. When the packing was removed I found that both flaps approximated and that the grafted mucous membrane covered the hole perfectly. The after-treatment consisted merely of cleansing the nasal cavities with a weak alkaline solution. I saw the patient three months after the operation; the grafted mucous membrane was in the same position in which it had been originally placed and had united with the mucous membrane of both sides of the septum. Three months ago I had another successful result in a similar case. What really occurred in both the above cases was a union of the two perichondriums on the one side and a union of mucosa and perichondrium on the other side.

New York.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

CLINICAL SECTION.

Dr. James Mackenzie's Ink Polygraph.

A MEETING of this section was held on Jan. 8th, Sir THOMAS BARLOW, the President, being in the chair.

Dr. JAMES MACKENZIE demonstrated the use of his Ink Polygraph for taking and interpreting graphic records of the movements of the circulation. He said that the necessity for obtaining graphic records of the movements of the circulation was now universally recognised, but there had hitherto been a difficulty in obtaining a suitable instrument. Apart from the trouble of blackening and varnishing tracings, the present methods were not convenient, especially when long tracings were required. The ink polygraph met the necessary requirements as it enabled tracings to be taken of any length, and after a little experience it was very easy to use. In investigating any movement caused by the circulation it was necessary to record at the same time some standard event the position of which in the cardiac cycle was fixed and determined. Hence it was necessary that two events should be simultaneously recorded—the one to be investigated and the standard movement. The best and most trustworthy standard movement was the arterial pulse, radial and carotid; with the ink polygraph those movements could be recorded by one lever while the movement to be investigated was recorded by the other lever. Other movements, as those of the respiration, could also be recorded. The most important parts of the instrument (see Fig. 1) were: the body A, containing the paper-rolling and time-marker movements. The writing tambours BB, with supporting bar Bl. Wrist tambour C, with attachment Cl, for strapping on to wrist. Paper-roll bracket D. Paper-roll Dl. Cup receivers EE. Pens FFF. The body A had also a few other details requiring description. At the end of the machine were three keys. The large one (1) was for winding the paper-rolling movement. The top smaller stud-key (2) for winding the time-marker movement and the bottom one (3) regulated the speed of the paper passing through the rollers, the direction required being indicated by the letters F and S (fast and slow). On the top were the writing table (4), friction rollers, and tension spring (5) for passing along the paper. Behind those, to the right, was the start-and-stop lever (6) and to the left the fork (7) carrying the time-marker pen F. That fork vibrated at the rate of 300 per minute, an equivalent to one-fifth of a second. Attached to the case were two sockets. The square one in front (8) was for holding the writing tambours, whilst the other behind (9) supported the paper roll bracket. The writing tambours with their pen levers (11) were fitted with friction joints (10), enabling the pens to be adjusted to any desired position on the paper or lifted entirely away when not writing. The pen levers had each a small spring at the end which pressed on and held the pens in the grooves cut out to receive them. The rubber membrane was held in position by the ring which encircled it. Both tambours had inlets (23) for attaching connecting tubes (22). The wrist tambour C was in two parts. First the splint (16) which was strapped on the wrist was fitted with spring tongue and button (19), that rose and fell with the action