it, and in each case it did good. If ever I go to sea again I shall certainly lay in a stock of chlorobrom. I quite believe, too, in the liver being acted upon before going on board and in cases where the cooking is likely to be bad. I am sure a stock of "comforts," which can be had nowadays in many attractive forms, is a wise investment. Further, I should say where a cross berth does not exist, one might be improvised with a bed-stand chair or a hammock, for I am sure it is the pitching that does the mischief. In support of this it just occurs to me that when I was on board a whaling ship the year before last in the Falkland Islands I asked the captain about the crow's-nest, and he said that when he was up there he did not mind the rolling; but as soon as the ship began to pitch he got sick and had to come down.

There are different views about the causation of sea-sickness; but, in my opinion, it begins in the brain. I noticed a rather curious thing when I was at the Falkland Islands that might, I thought at the time, have some slight bearing upon the view that sea-sickness was due to movement of the cerebro-spinal fluid. The great bulk of my journeys was done on horseback, and in consequence of the roughness of the ground the horse's paces were so irregular that "posting" in the saddle was impossible. We therefore rode military fashion—i.e., sat down and allowed the horse to pitch us up and down in the saddle by his movements. Horses were "rough" or "easy," according to the height of their lift, and there was a vast difference in the fatigue of riding them. But I have noticed repeatedly after riding a long journey (say, thirty miles) on a rough horse (when I had been sitting in my chair for about half an hour) a curious sensation as though somebody had put a hand against the back of my head and suddenly pushed it forwards, and it was always accompanied by a sickening sensation. It only lasted about a second or so, and I might get it twice in the course of the first half hour after getting off horseback, and then no more till after the next long journey on a rough horse. I believe—though, of course, I cannot prove it—that it was caused by cerebro-spinal fluid, which had been drawn down in excess of the normal into the spinal canal by the succussions in the saddle, suddenly escaping back into the fourth ventricle. I think the fact of chlorobrom influencing sea-sickness is a pretty good proof that the latter starts in the brain.

Welling, Kent.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

ANURIA IN THE COURSE OF MALIGNANT UTERINE DISEASE.

BY J. J. STACK, L.R.C.P. EDIN., L.R.C.S. IREL.

A WOMAN aged sixty-eight years, a widow, consulted me in November, 1893, complaining of uterine hæmorrhage, a sense of weight and "bearing down" feeling, together with being generally "out of sorts." She had previously been under the treatment of a medical man in her neighbourhood, and had also been operated upon for cataract by Mr. Nettleship. On examination per vaginam there was found to be some slight tenderness and bleeding; the cervix was quite hard, and the womb immovable. There was some erosion round the os uteri. There was no perceptible abdominal swelling, but I thought I felt some abnormal hardness and enlargement of the ovaries. My diagnosis was that of carcinoma, but to what extent the tissues were involved I was unable to say positively; the patient being very nervous and irritable, I was restrained from pursuing my examination to the extent that I should wish. Her past history was that of a dyspeptic, and her chief complaint was constipation and piles. She suffered a good deal during her child-bearing days, and was worried also by financial mishaps. I could get no history of cancer in any of her family. Considering all the circumstances, I advised palliative treatment, believing that surgical interference was out of the question. The bleeding ceased after a hypodermic injection of $\frac{1}{50}$ gr. of ergotinine. I ordered vaginal injections of a warm solution of boric acid with a little cherry-laurel water. These were continued to the last; and under the circumstances she seemed to get on comparatively well, suffering no pain whatever but an occasional bearing down, which nearly always ceased when some slight hæmorrhage took place. She went to the country on a visit in the early part of September, 1894, and returned on the following month. During her visit she suffered from constipation, and an attack of jaundice supervened, which she attributed to the rich food of which she had been partaking. I again saw her on her return to town. She was then jaundiced and seemed to be very weak. She complained of passing very little water, and owing to her anxiety on that point I gave her two powders of symphorol, in conjunction with other diuretics, without any appreciable effect. Very little water, about a dessert-spoonful, passed for two days; then the kidneys refused to act altogether from Nov. 21st to 29th. I introduced male and female catheters frequently without any result, and am confident that the bladder was quite empty. She took powders containing compound powder of jalap and compound powder of elaterium, and also had half a grain of pilocarpine by the mouth. The latter produced violent diaphoresis, and the combination, I believe, averted uræmia, and distinct improvement followed their administration, though she felt very weak and depressed. I had a medical man's assistance on the 27th, who prognosed immediate death. She was taking champagne and brandy as stimulants. On Nov. 29th copious urination took place—a very cataclysm—and with it the patient's condition was completely changed from a semi-comatose state to that of great excitement, irritability, and want of sleep. She remained quite conscious for a few days, after which she lingered on till Dec. 7th. The jaundice, I believe, marked the incidence of metastasis. Her liver was much enlarged when she returned from the country. But what was the cause of the suppression of urine? Was it due to the presence of bile in the blood? The kidneys seemed to be quite normal, being free from sugar and albumen. There was no post-mortem examination. I cannot recall a similar case, either from observation or from medical authorities.

New-cross, S.E.

TWO CASES OF PHENACETIN RASH.

BY R. MILBOURNE WEST, L.R.C.P. LOND.

AS there still seems some uncertainty about the existence of a "phenacetin rash," the following two cases may help to clear up the doubt.

Case 1.—A man aged twenty-eight years was taken with slight rigor, violent headache of a neuralgic character, and a feeling of nausea. As the headache formed the most prominent and painful symptom two five-grain phenacetin tabloids were administered. Three hours later I again saw the patient, who expressed himself as feeling better; his face, chest, and arms were, however, covered by a dense scarlatiniform rash, slightly raised from the skin surface, and causing a tingling, smarting sensation, as though, to use the patient's own words, he had "been exposed to a violent storm of sleet." Two hours after the onset of the rash it had disappeared, and next morning he was well. On several subsequent occasions I have administered phenacetin to him in doses varying from five to fifteen grains, and on each occasion the same rash, more or less pronounced, according to the dose, has made its appearance.

Case 2.—A young woman, subject to attacks of facial neuralgia, was in the habit of taking phenacetin for their relief in doses varying from five to fifteen grains. On each occasion, from between one to two hours after administration of the drug, an urticarial rash, presenting raised wheals, chiefly on the face and neck, and accompanied by a sensation of heat and tingling, appeared, lasting usually a couple of hours. In neither of the above cases were any other unpleasant symptoms caused by the drug.

Ealing.

AT the inaugural meeting of the Inverness Medical Society held in December, 1894, Dr. Mackay read a paper on a case of Myxœdema treated with Extract of Thyroid Gland and practically cured. Dr. Wilson Black contributed notes of two cases of Psoriasis in which the same remedy was administered; in one case it was successful, and in the other a temporary improvement resulted. We congratulate our brethren in Inverness on the foundation of a new medical society.

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.

EAST LONDON HOSPITAL FOR CHILDREN.

A CASE OF ACCIDENTAL ABLATION OF THE LEG WITHOUT FRACTURE; AMPUTATION AT THE THIGH; REMARKS.

(Under the care of Dr. ERNEST E. WARE, late resident medical officer.)

THIS account of the appearance of the contused and lacerated thigh stump and the after-effects on the patient of evulsion of the lower extremity illustrate an unusual case. The appearance of wounds following ablation of a limb varies according to the manner in which separation has been effected, whether the wound is at the part struck (or caught by machinery) or at a distance. As a rule in civil life when part of a limb is torn from the body the injury is done by machinery and the upper extremity is the one which suffers. This case, therefore, is additionally interesting, as the separation occurred through the knee-joint, the strong ligaments of that articulation being torn through. There was thus no ragged bony projecting point in the midst of the lacerated muscles, and no bone-gravel to be ground into the tissues.

On Aug. 11th, 1894, a boy aged seven years was admitted to the East London Hospital for Children suffering from complete ablation of the right leg. On admission he was quite conscious, and related, as far as he was able, the manner in which the accident had occurred. The pulse was full and regular, the hands warm, and there had been no vomiting. There was very slight hæmorrhage from the stump, and apparently the boy had not lost much blood. On examination it was found that the right leg had been completely severed from the thigh through the knee-joint. The skin of the lower third of the thigh was extensively bruised and lacerated, and the muscles exhibited torn and bruised ends, blood being extravasated into the sheaths. The femoral artery was occluded apparently by torsion, and was seen lying free in the remnant of Hunter's canal. The sciatic nerve was also ruptured. The patella was situated in the stump, and the ligamentum patellæ was not ruptured, but had been detached from the tibia by the separation of a small portion of the tubercle; the crucial ligaments also were entirely separated from their femoral attachments and the lateral ligaments of the joint were completely torn away. The lower end of the femur was thus completely exposed, and the external and anterior surface of the bone had been denuded of periosteum. Under chloroform Dr. Ware performed immediate amputation of the thigh at about the junction of the upper two-fifths with the lower three-fifths, the extensive laceration and bruising of the skin and muscles rendering a high operation imperative. The boy bore the operation well and quickly rallied from the shock. Two days after the accident he was playing with his toys, but was extremely bad tempered. The wound healed by first intention and recovery was uneventful.

Remarks by Dr. WARE.—On examining the leg, which was brought to me after the operation, I found that the semilunar cartilages remained *in situ* and that the crucial ligaments maintained their attachment to the tibia. The long external lateral ligament was still attached to the fibula and at the point of separation from the femur had denuded an adjacent extensive surface of bone of its periosteum. On dissection no fracture of the tibia or fibula could be detected, and there was no epiphysial displacement; the insertions of the hamstring muscles also remained uninjured. The accident, which as far as I can ascertain is rare, appears to have been caused in this wise. The boy was riding behind a four-wheeled cab when his thigh became impacted between the axle and the spring. In his struggles to extricate himself his leg became entangled in the spokes of the wheel. The cab was moving at a medium pace and the boy's thigh being firmly fixed under the spring and his leg forcibly wrenched by the moving wheel his limb was torn off at the knee-joint. I am indebted to Mr. H. B. Robinson for kind permission to publish this case.

CROMER COTTAGE HOSPITAL.

TRAUMATIC ANEURYSM; LIGATURE OF THE AXILLARY ARTERY; REMARKS.

(Under the care of Mr. FENNER.)

ALL cases of wound of the larger arteries are of interest, especially when pressure or other treatment has proved successful in arresting primary hæmorrhage but a traumatic aneurysm has developed at a later date. Mr. Fenner's case presented signs of the circumscribed variety of traumatic aneurysm, and the treatment—that of ligaturing the main artery above and near to the swelling—was successfully adopted. It is possible that application of the ligature in the position of the third part of the axillary artery may have deprived the arm of the use of the superior profunda artery as a collateral channel, and so caused the additional deficiency in the blood-supply to the parts beyond, which led to the gangrene of the middle finger.

A strong, able-bodied man, aged thirty years, was assisting on Nov. 29th, 1893, in the operation known as "pig-sticking," when his foot slipped and he fell upon the point of a knife. The knife pierced the outer aspect of the right arm in its middle third. Profuse hæmorrhage followed, but the man walked through the town, a distance of half a mile, bleeding copiously. When seen he was partially collapsed. The bleeding ceased upon removing a handkerchief which had been wound tightly round the arm below the wound. The wound was cleansed and dressed antiseptically, and the arm was bandaged from the hand upwards. The patient was sent home, but at night severe bleeding again set in. The wound was plugged and a sedative given. The following night hæmorrhage again occurred, which renewed plugging easily arrested. The wound did well for five days, but on the sixth day moderate bleeding again occurred. No further hæmorrhage took place, and the wound gradually healed. The patient was kept under careful observation. At this time, beyond pain and difficulty in flexing the forearm owing to the constrained position, no loss of power or sensation was discernible. On Dec. 20th the patient complained of a small swelling on the inner aspect of the arm, at the posterior margin of the biceps muscle. Pulsation, with a distinct thrill, was apparent. The tumour was about the size of a pigeon's egg, and was opposite the seat of the original wound, but on a higher level. In a few days a double bruit was distinctly audible, and all the symptoms of an aneurysm were present. The tumour increased rapidly in size both upwards and downwards, soon occupying the whole of the inner and anterior aspect of the upper arm; the thrill was most intense, and could be distinctly felt even, on the outer aspect of the arm. Œdema of the hand and loss of sensation of the fingers, and especially of the middle finger, supervened and increased rapidly. As a preliminary measure the effect of distal pressure was tried. The elbow was flexed, pads were placed in the flexure of the joint and over the tumour, and the arm was fixed by an elastic bandage in this position. Distinct diminution of size, as evidenced by measurement, was at first apparent, but œdema increased. The thrill extended upwards to the axilla, and the pain was so intense that it was deemed advisable to deligate the artery in its third part. The operation, which took place on Jan. 12th, 1894, was somewhat difficult owing to the enormous distension of the axillary vein, which completely enveloped the artery. One strong carbolised catgut ligature was used; the nerves of the brachial plexus were clearly seen and easily kept clear of the dissection. Pulsation immediately ceased in the tumour. Thirty hours after the operation a dusky discolouration was noticed on the terminal phalanx, and another at the base of the thumb on the palmar aspect, although every precaution had been taken to prevent a possible onset of gangrene. The wound did not heal by first intention, although maintained aseptic throughout, but gradually healed by granulation and was fully healed by Feb. 12th. In spite of all precautions, the distal phalanx gradually passed into a state of dry gangrene, a large bulla forming