

clearly established that fibroids are particularly liable to undergo degenerative changes during pregnancy; why this is so we do not know. Necrobiosis is generally regarded as the result of vascular lesions, but as to what is the nature of these lesions, or what are the factors which determine their onset we possess no certain knowledge. The process is, as far as we know, neither infective nor thrombotic, and it is difficult to explain why it should occur at a time when the vascular supply of the uterus is richest.

The onset of the symptoms was strikingly sudden. At the time of operation I looked carefully for torsion of either the tumour or the uterus, but I could find none. There was extensive local peritonitis and this may account for the severity of the pain in this case, but a necrobiotic fibroid is often *per se* a painful tumour, and in some instances where the pain has been great no adhesions or other evidences of peritonitis have been found. The constitutional symptoms, the raised temperature, the frequent pulse, the furred tongue, and the loss of flesh are evidences of the profound toxæmia associated with the change. Finally, I would draw attention to the fact that during the involution of the uterus the fibroids in its walls became smaller.

Wimpole-street, W.

ERRATUM.—In the last sentence of an article by Dr. A. Eddowes and Dr. J. G. Hare published in THE LANCET last week (p. 282) an error has occurred. It was Dr. M. K. Hargreaves who was speaking and not Dr. Eddowes or Dr. Hare, and the sentence should run: "In a second case Dr. Hargreaves is indebted to Dr. Alan B. Slater for carrying out the treatment at the patient's own home."

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTE ON A CASE OF ACUTE PULMONARY ŒDEMA.

By J. M. PEARSON, M.D.

It is somewhat curious that the English-speaking medical profession should have had to wait until the early years of the twentieth century for a clear recognition of such a well-defined dramatic affection as acute pulmonary oedema. A very typical case occurred in my practice in the years 1901-02 and, like Dr. Leonard L. B. Williams, I searched, but searched in vain, through a somewhat limited field, it is true, for any adequate mention of such a condition.

The patient was a woman about 50 years of age, stout, ruddy, and energetic. The most diligent search between attacks, for she had several, failed to reveal anything grossly wrong with either heart or kidneys. The subject of arterial tension had not then risen on my medical horizon. The attacks took place invariably at night—two in a month at one time and then four or five months' freedom. She would retire to bed early in apparently the best of health, to be awakened soon after midnight with shortness of breath. By the time I arrived on the scene she would be sitting up in bed quite unable to speak, with her face livid, beads of perspiration on her forehead, her chest heaving for breath, and a pint or more of frothy, slightly blood-tinged sputum in the basin held in front of her. The family got into the way of applying hot things to her chest and back, and on general principles I used to give strychnine hypodermically. The pulse was small and rapid. In an hour or less the severity of the attack would be over and she would be put back to bed, well propped up with pillows. Next day all would be well and two or three days would see her at her usual occupation, minding a small shop. From first to last the condition went on for 12 months, and I have records of five attacks during that time. Finally the end came, the old lividity was there but the weakened or tired respiratory muscles failed to respond with their accustomed vigour, and after a few sighing breaths she died two or three minutes after I reached her bedside. There was no necropsy and I left the case as mystified at the end as at the beginning. I noted that the serous fluid appeared to be poured into the lungs practically all at once, and that when it was cleared away there was no continued secretion. I also learned that

the patient ought to be kept in an upright posture, which is the attitude the patients naturally tend to assume.

Blood-letting might suggest itself but reflection shows that all the mischief is done before the medical man arrives. The bleeding has already been accomplished and certainly the pulse has none of the attributes usually associated with the necessity for the operation.

Vancouver, British Columbia.

THE FREE USE OF AMYL NITRITE IN PULMONARY HÆMORRHAGE.

By ALEXANDER LUNDIE, M.B., CH.B. EDIN.

It fell to me three years ago to treat an extremely profuse pulmonary hæmorrhage, and after very much misgiving about taking it in hand at all I determined to use amyl nitrite. The results were such as I never regretted, but I was personally rather sceptical about the rôle of amyl nitrite in their production until I saw articles on the subject in THE LANCET in 1906. My reason for using this agent may therefore be of interest to others. I knew at that time of the lung reflex of Abrams but thought it had no bearing on the subject. I thought, like an ancient Greek historian, that it was entirely a matter of hydrostatics that had to be dealt with. Recollecting the story of a Greek, probably one of the "ten thousand," wounded in battle and bleeding profusely till he fainted and remained long unconscious, his wound becoming staunch meanwhile, so that he eventually recovered, I determined to imitate this condition, seeing my case was just as desperate. I hoped to lower the blood pressure and bring about a condition temporarily like surgical shock, trusting to clotting taking place meanwhile in the wound. I accordingly administered amyl nitrite on a towel like chloroform without regard to official dosage, guiding myself entirely by the pulse and the general condition. It quickly produced slight transient anaesthesia, with an insignificant preliminary stage of excitement. The pressure in the radial artery was very much lowered, the pulse being almost imperceptible, and I stopped at this stage as the respirations became very shallow. The results were good and a satisfactory recovery followed.

Dalmuir, Dumbartonshire.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

MEDICAL SECTION.

The Kinematograph in Medicine.—Pathology and Treatment of Chronic Constipation.

A MEETING of this section was held on Jan. 28th, Dr. S. J. GEE, the President, being in the chair.

Dr. H. CAMPBELL THOMSON gave a demonstration of the Use of the Kinematograph in Medicine. He showed films demonstrating certain gaits in nervous complaints. These will be found described and illustrated in the first number of THE LANCET of this year.¹

Dr. A. F. HERTZ read a paper on the Pathology and Treatment of Chronic Constipation. He said that the treatment of chronic constipation was experimental. One method was tried and then another until by chance the method suitable to the individual case was discerned. That unsatisfactory state of affairs was due mainly to the fact that it had hitherto been impossible to determine the actual part of the intestines in which the delay causing the constipation occurred. In the case of medicinal treatment the difficulty was made greater by the lack of trustworthy information as to the relative effects exerted by any given purgative on different parts of the alimentary canal. Hence there were no rational guides to indicate what drug, if any, should be employed in a case. It seemed probable that enemata would prove of value in those cases in which the delay occurred somewhere between the splenic flexure and the anus. For that reason it might perhaps be assumed that

¹ THE LANCET, Jan. 4th, 1908, p. 12.