

have been almost lauded as specifics. But I am obliged to say my experience of their power for real good is not satisfactory.

As regards outward applications, the conclusion I have drawn from careful observation is that an ice-bag placed on the chest is a valueless proceeding. I have never yet convinced myself that the application of such excessive cold can astringe a ruptured vessel through a pad of muscular tissue, of bones, and also (if the hæmorrhage be deeply seated) of condensed lung. Further, the ice-bag is almost invariably planted over the front of the patient's chest, wherever may be the seat of the hæmorrhage. I am more than doubtful how this application, with its damp depressing discomfort when placed on the parietes of a man's thorax, even over the supposed seat of a hæmorrhage, can have any effect in arresting the same. We seem by this step to overlook the one great factor, rest, in stanching an internal bleeding. It precludes the patient from sleep, his mind is disturbed in consequence, and he apparently loses rather than gains from the treatment. Does it not seem more probable that the cold, acting on the superficial vessels of the chest-wall, would rather tend, if anything, to increase an internal engorgement? On the other hand, I can with confidence recommend an opposite line of treatment—viz., the application of warmth. In three cases recently of severe hæmoptysis I have seen beneficial results from such steps. I applied hot flannels (at about 120° F.) over the angles of the ribs from summit to base of the thorax—in other words, over the sympathetic ganglia,—and in each case with speedy and happy results. I cannot claim that this method of treatment is by any means novel. It was advocated by Dr. John Chapman<sup>5</sup> in 1875 in an able paper; and I submit that it has not been adopted by practitioners so frequently as it deserves. We see the same principle adopted by obstetricians in cases of uterine hæmorrhages, and there is scarcely a week passes but the medical journals contain reports of successful treatment of flooding by hot-water injections into the uterus, as opposed to the old-established practice of applying ice.

Turning now to medicinal remedies, I must confess that we have only a few drugs which we may really regard as controllers of pulmonary hæmorrhage; but these few are really valuable. We too often overlook the clinical fact that in hæmoptysis one of the most urgent conditions to treat is the great restlessness and mental disturbance of the sufferer. He is in a state of great excitement and alarm, a condition also imparted to his friends, and by them as it were reflected on the patient again. This point requires our skill and attention. We have at our command a drug, opium (and its derivatives) which acts like a charm. So far as my experience goes it should not be given if administered internally with any other remedy likely to retard or interfere with its full action. Give it in such doses that its physiological effects are produced. If the hæmorrhage be very profuse digitalis may be added, but also in large doses, such as fifteen minims to twenty minims of the tincture, till its specific action on the heart is manifest and the frequency of the pulse materially diminished. As a result the patient is calmed, his excited circulation controlled, and he falls into a much-needed sleep. There is yet another method of administering the sedative—viz., by hypodermic injection; and I have found this plan most useful and efficacious. Four minims of the injectio morphine hypodermica are introduced into the subcutaneous tissue of the arm, or, as I have sometimes preferred, into the subcutaneous tissue of the chest immediately over the presumed seat of the hæmorrhage, and repeated if requisite. The advantage of this method of exhibiting the remedy is its speedy action; the momentary and trivial discomfort of the operation is more than counterbalanced by the good results which ensue. Of the forty-seven cases the notes of which I have before stated form the basis of this paper, eighteen were adult patients suffering from severe pulmonary hæmorrhage occurring in the second or third stages of phthisis, and were treated by opium and digitalis internally or by morphia hypodermic injection, with good results in all. So far as I am able to judge of the effects of remedies the above method of treatment is happier in its immediate results than the administration of astringents and so-called styptics, which mainly affect the intestinal tract. Indeed, one of my chief desires in making this communication is to protest against the ordinary practice of prescribing drugs which probably do nothing more than

produce a constipation, or the action of which on the circulatory system is more than open to doubt. There are, however, two other drugs which I have found extremely useful when opium is contra-indicated. I allude to oil of turpentine and the liquid extract of ergot. The former may be given by the mouth, the latter either by the mouth or by subcutaneous injection. I have seen excellent results from both in a few cases. The objection to turpentine is its nauseating effect, but its action in controlling hæmorrhage is undoubted. My experience of ergot has not been extensive, but I found it a powerful remedy in four cases of severe and continued blood-spitting.

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## TWENTY-EIGHT CASES OF ABDOMINAL SECTION; CONSECUTIVE AND COMPLETED.

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THE cases for which abdominal section was performed consisted of ovarian tumours, varying from 344 oz. to 46 oz., 10; parovarian cyst, 1; chronic ovaritis and pelvic inflammation, 10; fibroid tumours, the adjuncts being removed, 3; pelvis cellulitis, 1; obscure tumour of uterus, 1; obscure cyst of abdominal cavity, 1; hydro-peritoneum, 1. In addition to these there were two cases of exploratory incision, one for chronic peritonitis in a girl aged eighteen, where the abdominal cavity was washed out and drained, the patient being relieved—she left the hospital afterwards; the other was a single woman aged thirty-eight, who had a fibro-cystic tumour of the uterus undergoing malignant degeneration; she ultimately died.

In Case 4, a woman aged forty, the ovaries were adherent and atrophied, weighing ten and ten grains and a half respectively. In the other cases of chronic inflammation the ovaries and tubes were all more or less adherent and enlarged; in two the tubes were dilated, containing pus and clear fluid. In the cases of removal of the uterine adjuncts for fibroid tumours associated with protracted hæmorrhage marked relief has followed, though in each instance the patients have had irregular attacks of metrostaxis since. In Case 16 the patient was married, sterile, aged twenty-four, and had a tumour the size of a goose's egg, sessile to the left of the uterus, in structure much like a myomatous growth. Case 18, a married woman, aged twenty-four, had a large cyst filled with clear yellow fluid among the intestines, probably of mesenteric origin, though its exact attachment could not be traced at the time of operation. In the case of hydro-peritoneum, the patient was nineteen years of age, single; the ovaries and tubes were intact, and no cause could be found for the large quantity—about sixteen pints—of fluid contained free in the cavity. There was no history of peritonitis, renal, hepatic, or cardiac disease. I have seen one similar case before, in which a single tapping cured the patient. Three cases of death should be mentioned:—One, a married woman aged thirty-three, with a large, sessile, ovarian tumour, died on the sixth day, apparently from continued sickness; there was nothing found at the post-mortem examination to justify any other conclusion. Cases 10 and 11 died of peritonitis on the third and fourth days respectively; one was a large ovarian tumour weighing 321 oz., the other had a tumour of each ovary, very solid and adherent.

*Anæsthetics.*—In two cases where chest symptoms were present chloroform was given; in one bichloride of methylene, in all the others ether. In one of the chloroform cases there was sickness from the first, which failed to be relieved by any treatment, and which apparently produced exhaustion ending in death.

*Incisions.*—The smallest incision compatible with the object to be attained was practised. The majority of the cases of chronic ovaritis had an average length of two inches. I am satisfied that a longer incision tends to favour subsequent ventral hernia, of which I have seen a number of cases with much attendant inconvenience and distress. In one of the above series this was present, the protrusion was not larger than a walnut, and was remedied early by a suitable belt and pad. Two of the cases had been operated

<sup>5</sup> Medical Times and Gazette, 1875, p. 650.

upon previously, one for an ovarian tumour which affected the remaining ovary; and one for an enlarged ovary weighing 280 grains, where the previous ovary had been removed without abatement of symptoms.

*Dressings.*—In all the dressing was simply carbolised gauze, in thickness of seven or eight layers wrung out of carbolised water (1 in 40), covered by salicylic wool and an elastic bandage. The antiseptic spray was used in four of the early cases, but afterwards discontinued. Regard was paid to absolute cleanliness, the hands being washed, the instruments placed in a warm solution of carbolic acid (1 in 40), and the sponges—always a personal matter—carefully cleaned and soaked in the same solution; and, above all, no fingers but those of the operator were ever admitted into the abdomen.

*Drainage.*—Fourteen of the cases were drained with a glass tube, the mouth of the tube covered with a hollow sponge soaked in carbolic acid (1 in 20), and this again with oiled silk, the tube emptied frequently according to the quantity of fluid present, and washed out with a solution of saturated boracic acid. I am convinced beyond doubt that the use of drainage in this manner is of eminent value, and where it is efficiently practised I always feel a degree of confidence that time only brings in other cases. The temperature never rises so high, and success can be predicted with a greater degree of assurance as to the progress of the case.

The above contribution to the operative treatment of diseases of women represents the work of one year's practice derived mainly from the General Hospital. One ward only is used, and never more than one patient allowed in it at a time. After each operation it is thoroughly cleansed and fumigated with iodine. The results show a fair degree of success, and, while pointing to the fact that attention to the minutest details is an element of much consideration, it shows also that a large institution may be made to answer the intentions of its supporters in the treatment of this class of cases.

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## LARGE ENCEPHALOCELE.

BY FREDERICK S. PALMER, M.D., L.R.C.P. LOND.

EARLY in the evening of Feb. 22nd a message reached me from Mrs. A— (a primipara), who had engaged my services for her confinement. Labour had commenced several hours before, and a sharp gush of hæmorrhage was said to have occurred just before the messenger was despatched. On arrival I found a large mass protruding from the ostium vaginae. Further examination revealed the head in the right oblique diameter of the pelvis, forehead backwards (the first cranial position). Having made out the presentation, I proceeded to draw the mass, which appeared to take its origin from the posterior fontanelle, gently downwards. The uterine contractions were regular, the parturient canal relaxed, and everything promised a speedy termination of the labour. The tumour was about eight inches long, the size of a small cocoanut, partly covered by skin, and partly by a fibro-serous membrane. The latter covering had been ruptured during the mechanism of labour, and appeared to contain broken down coagula and other matter. Exploration of the uterus with the finger traced the cyst-wall to the superior extremity of the occipital bone, and an evident communication with the cranium.

Mrs. A— was delivered of a stillborn male child about two hours after my arrival without any instrumental help, the fœtus in every other respect being well developed. Some little difficulty was experienced in the third stage of labour, the uterine contractions not being sufficient to complete the expulsion of the placenta without assistance. The patient made favourable progress, and appeared to be doing well until the morning of the 26th, when she had a severe rigor, followed by all the horrors of acute puerperal metritis: pain in the hypogastric region, difficulty of micturition, considerable elevation of temperature and pulse, diarrhoea, and tympanites. The lochial discharge, which before had been perfectly satisfactory, and the mammary secretion were arrested. The uterus could be well distinguished above the pubes, large, baggy, and painful to the touch. For fourteen days Mrs. A—'s condition gave me the greatest anxiety, but under the treatment adopted, the administration of small and frequently repeated doses of aconite and opium, applications of turpentine, followed by

large poultices to the abdomen, and constantly washing out the vaginal canal with Condyl's fluid and water, the disease was combated, and she has now made a successful recovery.

With the consent of Mrs. A—, I sent the fœtus, untouched, to the Royal College of Surgeons, and the following report of the tumour has been forwarded to me by the Pathological Curator, Mr. Frederic S. Eve:—"The cyst, an encephalocele, is formed by a protrusion of the meninges through an opening occupying the position of the occipital protuberance, and which corresponds to the interval between the four ossific centres of the occipital bone. The cyst also contains a small elongated mass of brain substance. The specimen will of course be preserved in the museum."

The case illustrates one of the many irregularities so frequently noticed in obstetric practice, and as such is worth recording. Had I been called to Mrs. A— at an earlier stage of the labour, before the full dilatation of the os, and with a history of hæmorrhage, there would have been no inconsiderable difficulty in making out the nature of the presentation. In this particular case, the encephalocele did not appear to obstruct the course of the labour, but rather to facilitate its progress. It is probable that rupture of the cyst during the parturient efforts occasioned the escape of some of the contents into the interior of the uterus, and gave rise to the subsequent metritis which caused me so much anxiety.

East Sheen, S.W.

## 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.

## ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.

### FOUR CASES OF PARALYSIS OF ACCOMMODATION AFTER DIPHThERIC SORE-THROAT; REMARKS.

(Under the care of Mr. JOHN TWEEDY.)

FOR the following notes we are indebted to Dr. David Harrower, clinical assistant.

CASE 1.—Edith D—, aged ten, came on Nov. 27th complaining of "loss of sight" and inability to read any but large print. Eight weeks before she had diphtheria of the throat, her mother stated, and about four weeks after this her sight began to fail. When first seen her vision was Jaeger 16, V =  $\frac{1}{2}$ , imperfectly. The pupils were semi-dilated, and there was no power of accommodation. She was treated with quinine internally, and a weak solution of eserine (half a grain to the ounce) was applied each night. On Nov. 30th she was much improved; pupils much smaller; vision Jaeger 4, easily  $\frac{1}{2}$ .—Dec. 7th: Reads Jaeger 1 and  $\frac{1}{2}$ , but with difficulty.—Dec. 14th: Reads Jaeger 1 and  $\frac{1}{2}$  easily. There is manifest hypermetropia of two dioptries (twenty inches English).

CASE 2.—Florence R—, aged ten, at Christmas had a "bad sore-throat," and about the beginning of the second week in January noticed that she could not see the letters distinctly. Sight grew gradually worse till she came on Jan. 22nd. She was then anæmic; the pupils were active to light; the vision was Jaeger 2 and  $\frac{1}{2}$ . On examination, the throat was pale, and on articulating Ah! the soft palate and uvula were drawn up to the left. Treated with quinine internally and a weak solution of eserine locally. Feb. 12th: Vision, Jaeger 1 and  $\frac{1}{2}$ ; patient looking much better. There was manifest hypermetropia of two dioptries.

CASE 3.—Florence S—, aged fifteen, draper's assistant, about two weeks before Christmas had a very bad "sore-throat with white patches on it." She recovered and went to her work again. Her sight began to fail about Jan. 7th. On Jan. 22nd, 1884, when first seen, she was rather anæmic-looking; the pupils were large, reacted to light, but not to accommodation; vision was Jaeger 16,  $\frac{1}{2}$ ; treated with quinine. Her vision improved slowly, and on Feb. 12th V =  $\frac{1}{2}$ , but still no more than Jaeger 16.—Feb. 19th: She had