

18th of February, with the exception of having suffered from slight dysphagia and cough for the two previous days, but to these she paid no attention. At four o'clock the following morning she was awoke by sudden and great difficulty of breathing, which compelled her to assume the erect posture; there was a short hacking cough, with rigors and thirst.

She had never been similarly attacked. These symptoms increased somewhat during the day, when I was requested to see her at ten o'clock P.M. Her symptoms then were, orthopnea; the respiration being very quick and laborious, with a dry cough, and an occasional croup-like inspiration; great anxiety of countenance; heat of skin; intense thirst; and rapid pulse. Pressure over the larynx caused pain; there were also present a feeling of constriction round the throat, and a very distressing sense of suffocation, similar (she said) to that of being partially smothered under hay, of which she could speak from recent experience. An internal examination of the throat assured me that it was healthy, and auscultation and percussion revealed a normal state of the thoracic viscera, with the exception of some harshness of the respiratory murmur, in consequence of the partly obstructed state of the rima glottidis. Twenty-four leeches were immediately applied to the region of the larynx; half a grain of tartarized antimony in solution was given every hour; and three grains of the chloride of mercury, combined with half a grain of opium, every third hour.

On the morning of the 20th, at nine A.M., I found her lying down in bed, and very much relieved in every particular. The leeches had bled very freely: the antimony, for the first two or three doses, caused vomiting, but was afterwards retained, and she had expectorated a small quantity of extremely viscid mucus. I ordered the leeches to be re-applied, the bleeding to be encouraged by hot fomentations, and the medicines continued. In the evening she was going on favourably; gums slightly tender, from the calomel. Remedies as before.

On the morning of the 21st she was much worse; all her previous symptoms had returned during the night. Her difficulty of breathing was very great; there was some vertigo; her extremities were becoming cold; her pulse thready; and she expressed her firm conviction that if not shortly relieved from her distress, she should soon die. I quite coincided in my patient's opinion, and thinking it unjustifiable to spend more time in the trial of remedies, as soon as possible I performed the operation of tracheotomy, by making an incision, of about half an inch in length, down to the trachea, just one inch above the sternum, and then passing in the tracheotomy trocar and canula. There was a little hæmorrhage from the integuments, but it soon ceased, (before the trachea was opened,) and a small quantity of frothy blood, which issued at first from the opening in the trachea, almost instantly stopped. The relief afforded by the operation was most marked; after recovering from its immediate effects, her breathing became perfectly calm and easy; her anxiety and distress of countenance, with the dread of suffocation, vanished; the pulse increased in power and volume, and she expressed herself as feeling "in heaven." From this moment she continued to improve, without an unfavourable symptom.

On the 24th the tube was removed from the trachea; the opening, however, remained pervious for a period of from seven to ten days from the time it was made; it then gradually closed entirely. The gums became affected by the mercury, and were kept tender. If, during three or four days after the operation, the free ingress of air to the lungs was prevented, by my finger being placed unobservedly over the tube or opening, the patient immediately became aware of what was being done, and complained of difficulty of breathing; but day by day the respiration improved when the opening was temporarily closed, until it finally became quite natural. Mrs. M.—— quite recovered.

This, like many other cases of a similar kind, shows how very soon laryngitis subsides when the passage of air over the inflamed surface is obviated, and free breathing is permitted by an opening below; and how desirable it is to afford that relief early, and before the general powers have suffered greatly by the continuance of distress.

April 5th, 1845.

CHANGE OF PRESENTATION DURING LABOUR.

By C. M. MILLER, Esq. Claremont Terrace, Stoke Newington-road.

I LOOK upon the following case as particularly instructive to the student and young practitioner, in teaching them not to place too great a reliance upon the first presenting part of the fœtus. On the 28th of November I was called, at three o'clock P.M., to Mrs. M.——, in labour with her first child: she had been ill during the whole night, but the pains had increased in severity during the last two hours, coming on every ten minutes; no discharge at all.

As I was obliged to see a patient at a distance, I thought it advisable to institute an examination, and found the os uteri about the size of a shilling, and dilatable; head presenting, and distinctly felt also through the parietes of the cervix; membranes entire. It being a first labour, and viewed by me as perfectly natural, I was under no apprehension, but visited my distant patient, and returned to Mrs. M.—— at five o'clock; hoping now to find her considerably advanced. I made another examination, but found the os very little more dilated. The pains recurred every quarter of an hour; head still presenting. Such being the case, I again left her, with the promise to return at twelve, which I did, but found very little improvement in the size of the os. The pains had ceased entirely for the last hour; I could still feel the head.

I now left her for the night, giving orders to the nurse to send for me in case of the pains returning with any degree of force or frequency, or the liquor amnii escaping. I was not, however, sent for until nine o'clock on the morning of the 29th, the pains having come on at eight, and considerably increased in severity during the last half hour. I instituted another examination, and found, to my astonishment, not the head presenting, but the right elbow protruding nearly to the vulva, the head bent to the right side of the mother, and the child's ribs easily felt.

Of course my future proceedings were clear enough; I introduced my hand, and with some little difficulty turned the child, and safely delivered the mother. The child was dead. With the exception of exhaustion, the mother has gone on very favourably hitherto. Now had this been the hand instead of the elbow, I should not have been surprised, as cases of this member coming down by the side of or before the head are not unfrequent; but here was a positive change of position taking place during the hours of cessation of pain.

Having thus described the case, I leave it to your numerous readers, some of whom may have met with a similar instance.

January, 1845.

DEATH FROM HEPATIC ABSCESS BURSTING INTO THE PERICARDIUM.

By R. ALLAN, Esq. Staff Surgeon, Port Louis, Mauritius.

CUMIA, aged thirty-five, native of Bombay, had been in Mauritius one year, working as a field-labourer, when he came into the Immigration Dépôt, on the 21st of December, 1844, for the purpose of entering into a new engagement, having walked seven or eight miles on that day. He remained in apparent good health until six o'clock on the morning of the 26th, when he began to complain of pain at the pit of the stomach, and died at half-past ten A.M.

Section cadaveris twenty-one hours after death.—About two pints of reddish pus and serum within the pericardium, the entire of which membrane was slightly inflamed. On laying the pericardium freely open, thick yellowish-green pus was seen oozing from an aperture large enough to admit the finger, which led through the diaphragm into an abscess in the smaller lobe of the liver, capable of containing a pint of fluid.

It is probable that the pus of the hepatic abscess had been oozing into the sac of the pericardium during some hours before death, causing inflammation, and then annihilating the heart's action by pressure.

Messrs. Rogers and Powell, surgeons, were present with me at the dissection, and we have forwarded the parts to the Military Museum at Chatham.

Port Louis, Mauritius, Feb. 4th, 1845.

PARTIAL ADHESION OF PLACENTA OVER OS UTERI, WITH FOOT AND UMBILICAL CORD PRESENTING.

By JAMES FRENCH, Esq. Surgeon, Nantwich.

ON Wednesday, April 16th, 1845, I was summoned to attend Mrs. P.——, aged thirty-six, strong and healthy. She had previously given birth to three children, and had always natural and quick labour. She considered herself to be between the eighth and ninth month of pregnancy. When I saw her, at three P.M., she had slight pains, accompanied with hæmorrhage, which she told me she had occasionally had for six weeks previously. I at once considered it to be a case of placental presentation. On examination, I found the os uteri dilated to the size of a crown-piece, with a portion of the placenta projecting over about one-third of it, and adhering to the left side. From the continued hæmorrhage I ruptured the membranes, and found the umbilical cord and left foot presenting. The hæmorrhage ceased, as did the pains, and she fell asleep.

At seven P.M. she had several stronger pains, and on a second examination I found the left foot, with the umbilical cord twisted

round it, projecting from the os externum. There was great hæmorrhage. I immediately endeavoured to bring down the right foot, but was unsuccessful. She now had a very strong expulsive pain, and to my surprise and gratification the placenta was expelled, followed immediately by the head and body of a male child, which appeared to have been dead a day or two. No hæmorrhage succeeded, the uterus contracting, and since then the patient has done well.

April 26th, 1845.

REVIEWS.

Urinary Deposits; their Diagnosis, Pathology, and Therapeutical Indications. By GOLDING BIRD, A.M., M.D. London: Churchill. 1844.

HAD this work been presented to us, divided into two separate publications—and its matter may be properly distributed under two heads—we should have given our almost unqualified approbation to the one, whilst to the other we should have conceded a very moderate and limited amount of praise, and at the same time have greatly abated its pretensions by showing it to be open to severe strictures. Dr. Golding Bird belongs to that order of minds to which we would apply, with a specific restriction, the epithet *clever*. A diligent accumulator of facts, he possesses a quick and ready perception of their visible and immediate relations, he marks their obvious external characters, and constructs with them very pretty mnemonic arrangements. The study of urinary deposits, *per se*, is an excellent subject for the exercise of these talents. To select and arrange with neatness and perspicuity the tests by which the chemical constituents of the urine may be detected and discriminated, to distinguish and represent in woodcuts the crystallized forms of the various urinary deposits, as they appear under the microscope, are occupations exactly adapted to his tastes and talents. Consequently, all this is very well done in the volume before us. But when the problem is to interpret their significations, in reference to the physiological and pathological laws of the animal economy, to reason accurately, from the constitution of the urine in disease, respecting the condition of internal organs, and the nature of the derangements to which the chemico-vital functions are subject, a higher order of mental qualification is necessary than that which Dr. Golding Bird has hitherto shown. Whether he will himself acquiesce in our estimate of his talents we may shrewdly judge, when we find him adventurously discussing these profounder topics with Prout and Liebig, calling in question the facts and even the qualifications of the latter upon points of chemical theory, and lamenting that the great German chemist should be wanting in opportunities of coming to right conclusions in his inquiries!

As a specimen of that division of the work to which we willingly award our commendation, we may quote the following directions for a superficial

EXAMINATION OF THE URINE BY THE BED-SIDE.

“Urine without any visible deposit.”

“A piece of litmus paper should be immersed in the urine, which, if acid, will change the blue colour of the paper to red. Should no change occur, a piece of reddened litmus paper must be dipped in, and if the secretion be alkaline, its blue colour will be restored; but if no change occur, the urine is neutral.

“Some of the urine should then be gently heated in a polished metallic spoon over a candle, or, what is preferable, in a test-tube over a spirit-lamp, and if a white deposit occurs, albumen or earthy phosphates are present; the former, if a drop of nitric acid does not re-dissolve the deposit; the latter, if it does.

“If the urine be very highly coloured, and undergoes no change by boiling, the colouring matters of bile, blood, or purpurine, are present. To determine which, pour a thin layer of urine on the back of a white plate, and allow a few drops of nitric acid to fall in the centre; an immediate and rapidly ending play of colours, from green to red, will occur if bile, but no such change if purpurine alone exists. Should the highly-coloured

urine alter in colour or transparency by heat, the presence of blood must be suspected.

“If the addition of nitric acid to deep-red urine, unaffected by heat, produces a brown deposit, an excess of uric acid exists. If the urine be pale, immerse the gravimeter, and if the specific gravity be below 1.012, an excess of water exists in the urine, but if above 1.025, the presence of sugar, or excess of urea, is indicated. To determine which, place a few drops in a watch-glass, add an equal quantity of nitric acid, and allow the glass to float on some cold water; crystallization of nitrate of urea will occur in two or three minutes, if the latter exists in excess. Should this change not occur, the urine must be examined specially for sugar, which, it must be remembered, may exist in small quantities, without raising the specific gravity of the fluid.

“Should the urine be alkaline, add a drop of nitric acid; if a white deposit occurs, albumen is present; if brisk effervescence follows the addition of the acid, the urea has been converted into carbonate of ammonia.

“Urine depositing a visible sediment.”

“If the deposit is flocculent, easily diffused on agitation, and scanty, not disappearing on the addition of nitric acid, it is chiefly made up of healthy mucus, epithelium, or, in women, an admixture of leucorrhœal discharge.

“If the deposit is ropy and apparently viscid, add a drop of nitric acid; if it wholly or partly dissolves, it is composed of phosphates; if but slightly affected, of mucus. If the deposit falls like a creamy layer to the bottom of the vessel, the supernatant urine being coagulable by heat, it consists of pus.

“If the deposit is white, it consists of urate of ammonia, phosphates, or cystine; the first disappears on heating the urine; the second, on the addition of a drop of diluted nitric acid; whilst the third dissolves in ammonia, and the urine generally evolves an odour of sweet-brier.

“If the deposit be coloured, it consists of red particles of blood, uric acid, or urate of ammonia, stained with purpurine. If the first, the urine becomes opaque by heat; if the second, the deposit is in visible crystals; if the third, the deposit is amorphous, and dissolves on heating the fluid.

“Oxalate of lime is often present, diffused through urine, without forming a visible deposit; if this be suspected, a drop of the urine examined microscopically will detect the characteristic crystals.

“Much of the little time required for the investigation thus sketched out, may be saved by remembering the following facts:—

“If the deposit be white, and the urine acid, it in the great majority of cases consists of urate of ammonia; but should it not disappear by heat, it is phosphatic.

“If a deposit be of any colour inclining to yellow, drab, pink, or red, it is almost sure to be urate of ammonia, unless visibly crystalline, in which case it consists of uric acid.

“The only apparatus and reagents required for these investigations at the bed-side are—

“A gravimeter, made small enough to float in an ounce of fluid.

“Red and blue litmus paper.*

“A test-tube and watch-glass.

“Nitric acid.

“All these are readily arranged in a little case, and can thus be always at the convenience of the practitioner. For the microscopic examination of the urine, a vertical instrument on a firm tripod stand, and large ring-stage, provided with a good half-inch achromatic object glass, is alone required.”†

In thus attributing to Dr. Bird the merit of giving a faithful exposition of the present state of chemical information respecting the urine, it is necessary to mention, that our knowledge of the normal constitution of that secretion is still very far from complete. The beautiful theories of Dr. Prout, in which he traces every element of the aliments through the processes of digestion and assimilation into the blood and tissues, and thence their degradation into the matters contained in the urine, has received a fatal blow by the recent discoveries of Liebig and Pettenkofer, which demonstrate that most erroneous views have been entertained respecting its normal constitution. On all hands it is agreed, that the organic matters in the urine, whatever may be

* * The most convenient test-paper is that prepared by Griffin at Glasgow, in the form of little books, like bankers' cheque-books. They can be procured of Mr. Ward, operative chemist, Bishopsgate-street.

† A cheap microscope of this kind has been constructed by Mr. Pritchard, optician, of Fleet-street.”