

culty, indeed an insurmountable one on the hypothesis of aortic disease, of insufficiency, would consist in accounting for the closure-sound of the semilunar valves in the vessels of the left side of the neck; unless we were to hazard the very speculative conjecture that, from the displacement of the heart, the great vessels might be so compressed as to allow the sound of the pulmonic sigmoids to be conducted so far. Are the murmurs mitral—that is, obstructive and regurgitant? There is an entire absence of the general symptoms of such affection: the impulse-beat of the heart, though forcible, is steady; and the pulse is entirely free from that instability so characteristic of such disease. Can a double lesion coexist, and the conjoined signs modify each other? It is the existence of doubts and difficulties incident to cases like this that must plead my excuse for digressing somewhat from the main subject-matter of my paper to discuss, as briefly as possible, some points connected with the pathology of cardiac murmurs and sounds. It has generally been maintained that comparatively loud murmurs, systolic or diastolic, heard at the apex of the heart, belonged almost exclusively to the affections of the mitral orifice; but I believe that the apex may be at times a common focus of aortic and mitral murmurs. Marey has experimentally demonstrated, what had long been clinically known, that a systolic murmur of intensity may be heard at the apex in constrictive disease of the aortic mouth, propagated by the back current; and I would furthermore add, from personal experience, that when insufficiency occurs in young persons where the aorta is still resilient, a strong diastolic murmur may be heard at and below the apex—indeed, I believe that often the stronger the diastolic murmur in this situation, the greater the reason to suspect aortic insufficiency. That a diastolic murmur occasionally attends constrictive disease of the mitral orifice is well known, and at times with an amount of intensity and thrill which is difficult to explain, remembering that it occurs during a period of cardiac repose, and, consequently, during the passive flow of the blood-current. It appears to be conditioned upon the amount and tension of the blood in the auricle, the tonicity of its walls, and the shape and condition of the obstructing outlet. So that murmur—*qua* murmur—at the apex cannot enable us to achieve precise diagnosis; for, as mitral diastolic murmur may be here strong or weak, so may aortic regurgitant murmur be strong or weak likewise. To effect the desired precision, we must auscult the aorta; observe the amount of collapse of the superficial arteries; seek, when practicable, the intermittent murmur of Duroziez in the femoral artery; study the tracing, and note the regular though special pulse in uncomplicated cases; and also mark the usually unimpaired state of the general health. For in aortic as in moderate mitral insufficiency, if the compensation is simply physiological, and the patient able to observe proper hygienic rules, an average state of health may be maintained for years.

(To be concluded.)

### ON AN IMPROVED ELASTIC PESSARY.

By JOHN CLAY,

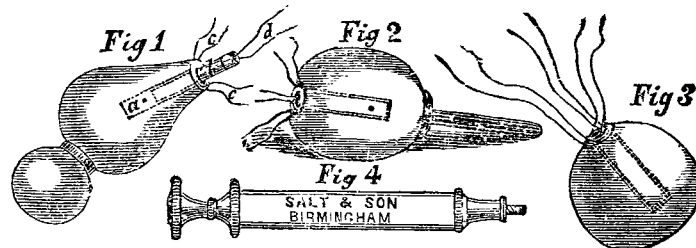
PROFESSOR OF MIDWIFERY, QUEEN'S COLLEGE, BIRMINGHAM.

WHEN an elastic pessary is introduced into the vagina and remains *in situ* for some time, the tube attached to the pessary for the purpose of inflating it often becomes so annoying to the patient that a prolonged use of the instrument cannot be tolerated.

To remove this difficulty, I have succeeded in devising an instrument which can be adapted to any form of elastic pessary for the purpose of inflating it, and for removing the air when it is desired to withdraw the pessary from the vagina. The annexed woodcut shows the instrument fitted to the ordinary globular and intra-uterine pessaries, and to the double pessary, for flexions of the uterus described in THE LANCET of Sept. 25th, 1869, p. 434.

\* Marey asserts that they can and do; and that the pulse of simple insufficiency is far more irregular than that of contraction. I venture to doubt the correctness of the latter assertion.

The principal feature of the instrument is a new form of valve shown in detail (Fig. 1). Its mechanism consists of a double tube (*a, b*), forming a cylinder and piston. The pessary is introduced into the vagina in its flaccid form, and is then inflated by the force-pump (Fig. 4), which is connected with the valve by screwing at the part *b* (Fig. 1).



The piston-rod (*b*) is then pushed in flush, and the force-pump unscrewed. When the pessary is required to be removed, it is held firmly by two catgut strings of convenient length (*cc*), at the same time that the piston is drawn forward by the string (*d*). The air will then escape, and the pessary collapse, when it may readily be withdrawn from the vagina.

The working-out of the suggestion seemed at one time to be a mechanical impossibility; but, owing to the skill and attention of Messrs. Salt and Son, of this town, an instrument has been perfected as simple in its construction as it is efficient in its application.

I purpose on a future occasion to give fuller details of the application of these pessaries to different forms of uterine ailments.

Birmingham, Dec. 1869.

## A Mirror OF THE PRACTICE OF MEDICINE AND SURGERY IN THE HOSPITALS OF LONDON.

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.

### LONDON HOSPITAL.

A CASE OF EMPYEMA TREATED BY PARACENTESIS, AND  
SUBSEQUENTLY BY BLISTERING; CURE.

(Under the care of Dr. ANDREW CLARK.)

THE success which attended the treatment renders the following case well worthy of record. We are indebted to Mr. Grubb, the resident medical officer, for notes.

The patient was a weakly boy eight years of age, who, six months before admission, had had an attack of scarlatina, which was followed by dropsy lasting for six weeks. One week before admission the boy again suffered from dropsy. When first seen by Dr. Clark he presented the following symptoms: Anasarca; great dyspnoea; a short, dry cough, without expectoration; a flushed face; and an inability to lie on the left side. The heart was displaced to the left; no cardiac bruits. The lung-sounds on the right side were very feeble, and all the signs were present of considerable effusion into the corresponding pleura. The urine was very scanty, smoky, and contained much albumen; specific gravity 1015. The pulse was 106, and the respirations 36 in the minute; temperature about 102°. There was a slight amount of ascites.

The patient was first treated by tincture of the perchloride of iron, spirit of nitric ether, digitalis, and bitartrate of potash; and for a time was put on a daily allowance of three ounces of gin. The breathing at first was relieved by this treatment, and an increased quantity of urine was passed; but at the end of the first week after the patient's admission into the hospital there was great dyspnoea and restlessness. On the