

## OBSTETRIC MEMORANDA.

## FETAL MALFORMATION.

A HEALTHY woman, aged 24, was taken in labour with her first child, at her full term, on August 16th, 1874. As the head, which presented, became impacted on the pubes, the forceps were used. The foetus when born showed the following peculiarities of development. The left elbow, as was also the left knee, was somewhat ankylosed. The thorax appeared natural, but the abdomen and its contents were greatly different. No abdominal walls were visible, but the viscera were only enveloped by a thin membrane, which in front and above was continuous with the skin of the thorax, a line of demarcation being well marked, and posteriorly was attached at some places to the bones, and at others was



continuous with the skin there. This membrane was without doubt ruptured during the act of parturition; the umbilicus, os innominatum of the right side, sacrum, and anus were all absent, as were the whole of the urinary tract and the pancreas. Only part of the genital organs were present, but they were not sufficiently well marked to determine the sex. The rectum terminated in the cord, which passed through the membrane about the usual position of the umbilicus; the left foot was deformed, talipes equino-varus being noticed. The foetus, though without doubt alive at the commencement of the labour, was still-born; it weighed, six hours after birth, four pounds nine and a half ounces. The drawing gives a good idea of the appearance presented by this unnaturally developed foetus. The mother states that she received a fright whilst pregnant.

W. H. SHEEHY, L.R.C.P., Claremont Square.

## DOUBLE ARM-PRESENTATION.

I AM afraid that cases of double arm-presentation are not so rare as Mr. Karkeek supposes. I can report a case which occurred in my own practice about two months ago, and which ended fatally, but still worth reporting.

On the evening of December 16th last, I was sent for by two other medical gentlemen, who were in attendance on Mrs. M., as her case was an exceedingly peculiar one. When I arrived, I found both hands protruding beyond the vulva. Both gentlemen had tried to turn, but neither could introduce his hand far enough to catch a foot, owing to the jamming up of the pelvic cavity, nor could the arms of the child be put back. The pains had been very severe for eight or ten hours, and the arms were driven down this length before the regular medical attendant saw the case. Within the last hour, the woman's pulse had become very rapid, and she had the appearance of sinking. Without attempting to turn, I administered chloroform, and then tried it, but it

was quite impossible to introduce the hand, and still impossible to put back the arms. There was no alternative now but amputate one of the arms, which we did. After this was done, it was with the greatest difficulty I managed to turn. The woman died in about fifteen minutes after delivery. No *post mortem* examination was made, but I am of opinion that rupture of the uterus had taken place, which accounted for the sudden cessation of the pains, the high pulse, and the sinking appearance of the woman. I have turned in nearly all sorts of presentations, but this one presented difficulties which no one can think of until he has actually had a case. It is a pity that none of our obstetric writers say anything about this sort of presentation, as I feel certain that it frequently occurs.

There can be no doubt that if the case be seen early, there will not be so much difficulty in turning; or if one arm be quite down, and the other only partially so, then the usual method of bringing down the opposite leg to that arm which is advanced will cause the turning to be much more easily accomplished. But when both arms are driven beyond the vulva there is not only the difficulty of introducing the hand and causing the child to rotate on its axis, but the nates of the child rise and the feet are turned up behind the nates; so that, upon securing a foot, it is necessary to sweep it well backwards, for, if it be pulled straight down, the whole child becomes hopelessly jammed in the pelvis, and this was the difficulty with which I had to deal.

A. MILROY, L.F.P.S., Eglinton Iron Works.

## THERAPEUTIC MEMORANDA.

## JABORANDI.

ON January 26th, I had a specimen of jaborandi given to me by Mr. Holloway of Castle Street, consisting only of the leaves of a plant. An average-sized leaf picked out of the specimen had the following characteristics. It was about 1½ inch long and half an inch broad, of an ovato-oblong form, petiolate, with an oblique base, an obtuse emarginated apex and entire margin. The under surface of the leaf was hirsute, the hairs being small, few in number, and not easily recognised without a lens; but they were more numerous along each side of the midrib. The venation was reticulate; the primary veins coming off from the midrib at an average angle of 53 degs. on the side which had the larger half of the base, and at 56 degs. on the opposite side. These terminated within the margin by joining one another by means of intermarginal branches. When held up to the light, the leaves were seen to be numerous dotted with small puncta, which were generally scattered over the surface, and appeared of a light yellow colour. The leaves have a faint odour when cold, which becomes stronger on warming.

On the evening of February 2nd, I made an infusion of thirty grains of the leaves; but, being prevented from taking it then, I took it at 12.15 A.M. the following night, swallowing both dregs and infusion. Previously, I had taken my temperature and observed my pulse and respirations. I then sat down in an arm-chair with the paper, to divert my attention from the experiment. The following table gives the variation of temperature (centigrade scale).

	Temp. in right axilla.	Temp. in left axilla.	Average temp.	Pulse.	Resp.
12.15 A.M. ...	35.3	35.1	35.2	60	16
12.30 A.M. ...	36.	36.	36.	66	16
12.45 A.M. ...	36.	35.4	35.7	66	14
1 A.M. ....	35.4	35.3	35.35	68	15
1.15 A.M. ....	35.35	35.27	35.31	74	15
1.30 A.M. ....	35.3	35.	35.15	74	15
1.45 A.M. ....	35.35	35.2	35.275	75	16
2 A.M. ....	35.35	35.3	35.325	76	14
2.15 A.M. ....	35.4	35.3	35.35	74	16

The pulse and respiration were taken every quarter of an hour for two hours. During the second quarter of an hour, I began to feel my saliva being secreted more freely than natural. This continued to increase in quantity for an hour and a half, but had reached its maximum before 2.30, by which time I had expectorated four ounces, being the total amount excreted. The drug with me had no diaphoretic action, and not the slightest effect upon my sight or pupils; probably because I had not taken sufficient. It will be noticed from the table that my pulse rose gradually up to two o'clock, at which time the amount of saliva secreted seemed to be diminishing. The temperature was taken by means of two Casella's registering thermometers, Nos. 17,401 and 17,402; the last mentioned registering .05 of a degree higher than the other. It was this I used for the right axilla. One thermometer was placed in each axilla, and, after every observation, the index was shaken down, and in five minutes returned to the axilla, so that it re-

maintained ten minutes in position each time. From 12.15 to 9 A.M., I secreted twenty-one ounces of urine, of specific gravity 1020, of acid reaction, with no albumen. The drug appears to have no diuretic action.—ROBERT CORY, M.B., Carlisle.

#### MACKAY'S OMPHALIC MUSTARD PLASTERS.

I AM glad to read in the JOURNAL of January 23rd, under the heading of New Inventions, a description of Dr. Mackay's omphalic mustard leaflets. After using them frequently, I can testify to their efficacy as a most useful and elegant means for counterirritation. They can be applied with ease and accuracy, and they are free from the discomfort which generally attends the use of mustard poultices or plasters. Each leaflet is about four inches square, and contains from twenty to twenty-four discs or spots of mustard of the size of a large wafer, and they are placed so as to allow a considerable interspace between the discs. By this arrangement, two-thirds of the whole leaf are covered by the irritant, leaving the remaining third free. When used, the leaf is to be first dipped into water. The surplus water may be removed by shaking. It is then to be placed firmly and evenly upon the surface of the skin. In a few minutes, it produces a warm and not disagreeable feeling, and the skin beneath the spots becomes reddened. If allowed to remain for thirty or forty minutes, the whole surface beneath the plaster becomes affected, producing the benefit of an ordinary mustard application, but with the smallest possible injury to the skin. When the leaf is removed, the skin between the spots rapidly resumes its normal condition and appearance, whilst the impression from the discs will remain for some days. Any number of the spots may be applied, according to the effect desired; and they can be repeated upon the same surface at shorter intervals than is possible when using any other form of mustard irritant. In neuralgia, one or two spots of the mustard, placed over a painful spot along the course of the nerve, will frequently relieve the pain, with but little or no discomfort.

Upon the same principle, Dr. Mackay has produced leaflets composed of Spanish fly. The discs of the vesicant upon each leaf are smaller and more numerous than those of the mustard on the mustard-leaves; the idea being in each to imitate as much as possible the operations of nature, when relieved by the eruption of a number of papules or vesicles.

W. HEATH STRANGE, M.D.

### SURGICAL MEMORANDA.

#### THE NEW OPTOMETER.

IF Mr. Jeaffreson will again read the description of the optometer in the JOURNAL of January 16th, he will there find that in "the beginning of 1873" I had proposed an instrument corresponding to the "Refraction Ophthalmoscope", described in his *Aids to Ophthalmic Diagnosis*, published in July, 1874, and which seems to me more completely and better fitted for the purposes for which both instruments were designed, in that while the powers obtained are more numerous, the obtaining of them by means of the rack moving the two discs is much easier. A description of the instrument will be found in a pamphlet, entitled *A Contribution to Ophthalmoscopy*, published by me in February 1873, and in the Catalogue of the British Medical Association of the same year, No. 410, p. 119. By means of this instrument, the ophthalmoscopist, or anyone accustomed to the use of optical instruments, can determine his own degree of myopia or hypermetropia, or that of an educated and careful observer. But, as in the determining of patients in private or in hospital practice, we have not generally to deal with such, and, as this instrument, by no yet known method, will enable us to correct an astigmatic ametropia, so as to allow of the determination of the refraction by the usual control tests, I cannot see how Mr. Jeaffreson can call the instrument described by him in 1874, and by myself in 1873, the same instrument as one in which, by the combination of + and - spherical and cylindrical lenses, arrangements are made for the determination of simple, compound, or mixed astigmatism, in addition to the simple myopia and hypermetropia corrected by the instruments abovementioned.

The objections which Mr. Jeaffreson found to his instrument from its size and the necessity of having recourse to the table of calculations, were foreseen and obviated in the new instrument proposed, by having the glasses of the usual testing size, and by the product of any combination being found opposite the combination.

The table of calculations had been formed by me on much the same plan as Mr. Jeaffreson's, but occupying half the space. It will be noted that the one-half of the calculations in Mr. Jeaffreson's table is a repetition of the other, which a slightly different arrangement of the figures would have rendered unnecessary.

W. LAIDLAW PURVES, Hanover Street.

## REPORTS

OF

### MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS OF GREAT BRITAIN.

#### GUY'S HOSPITAL.

ANEURISM OF INTRAPERICARDIAL PART OF AORTA: EMBOLISM OF FEMORAL ARTERY: GANGRENE OF FOOT AND LEG: AMPUTATION OF THIGH: DEATH: NECROPSY.

(Under the care of Mr. BIRKETT.)

FREDERICK S., aged 33, an engine-driver, was admitted into the Hospital on June 15th, 1873. He gave a good family history. His own ailments had been limited to a sore on the penis contracted fourteen years previously, and followed by a bubo; to a "bad sore-throat" five years ago; and to indigestion. His usual daily allowance of beer had been four pints; and he had occasionally been intoxicated. Eight days before admission (June 7th), he had become suddenly faint, and fallen insensible; but had soon recovered. An hour afterwards, however, great pain had commenced in the right leg, and the patient could not stand upon it. The pain continued; and, on June 10th, the toes had begun to turn black. The blackness had slowly extended up the limb; and, on June 14th, there was some swelling of the right arm.

On admission, the right foot and adjoining part of the leg were gangrenous. Behind, and at the sides, the gangrene extended over the lower two-thirds of the limb; in front, it reached halfway up only. The skin on the dorsum of the foot was of a dark red colour; on the sole, it was nearly black, and the superficial veins were full of blood; on the leg, the skin was livid, and presented blebs containing a sanguineous fluid. The gangrenous part was quite insensible to the touch; but the skin of the limb immediately above it was inflamed, and exceedingly tender and painful. There was occasional pain in the foot. The dead part was not moist, and no odour arose from it. The man felt very weak; had no appetite; and the pain prevented sleep at night. The tongue was coated with a brown fur; the bowels were confined; the urine contained no albumen; the liver was enlarged. The sounds of the heart were feeble and intermittent; there was no *bruit*. The apex-beat was not perceptible. There was an unusual extent of dulness behind the sternum. Pulse, 120; respirations, 20; temperature, 99.5 deg. He was ordered

Liq. morph. hydrochl. ℞x; acidi hydrochlor. dil. ℥x; decoct. cinch. flav. ʒj, every six hours. Beer, two pints daily.

June 17th. He had not slept during the night; he complained of a pricking sensation in the sole of the foot. Pulse, 120; temperature, 99 deg.

June 18th. The patient had slept after a subcutaneous injection of morphia administered the previous evening. He had lost the power of extending his right hand; and could only partially use the fingers of that side. There was a little pain in the same wrist. Pulse, 120; temperature, 99.4 deg.

June 19th. He had slept again after an injection of morphia, and had regained the power of extending his right hand. The gangrene had not advanced up the leg; and the inflamed skin above the line of demarcation was rather less painful. Pulse, 120; temperature, 99 deg.

June 20th. Although morphia had been injected the previous evening, the man had passed a restless night. The leg was beginning to smell badly. Pulse, 120; temperature, 99 deg.

June 21st. He had again slept badly after an injection of morphia. Pain in the leg had increased. Pulse, 120; temperature, 101.4 deg. He was ordered pil. opii gr. i, to be taken twice a day; and to continue the mixture ordered on the 16th.

June 23rd. He had passed a better night. The bowels had not been opened for four days. The tongue was dry and brown. Pulse, 120; temperature, 101.8 deg. He had headache, and severe pain in the leg. There had been some swelling of the right side of the head and neck. He did not talk quite rationally. The gangrene was more complete, but had not extended higher up the limb. The superficial veins of the thigh looked turgid.

4 P.M. Mr. Birkett determined to amputate the limb. Upon chloroform being administered, the patient took it badly, and had several attacks of threatened apnoea. The femoral artery was compressed by a weight. Mr. Birkett made lateral semicircular flaps in the lower third of the thigh. Torsion was used on the femoral artery and several smaller vessels; the flaps were united by six interrupted sutures; the stump was then wrapped in carbolised gauze, and placed on a splint.