In December, at about the time when she had calculated to be confined, the breasts became full and hard and a little milk ran from the nipples. After this time there was retrogression of the mammæ.

On February 7th her size did not appear diagnostic of advanced pregnancy, I measured her body at the level of the navel and found it to be 34 inches in circumference.

Vaginal examination proved the os uteri to be undilated, and the uterus to be large and heavy. No *ballottement* could be obtained and with a different history the case might have been pronounced one of fibroid tumour. There was no discharge whatever nor had there been any since the slight show in April. Between February 7th and March 27th, when labour occurred, I saw her several times. She walked to my surgery a few days before her confinement and had no more serious symptoms than a little anæmia and *malaise*. The labour was rapid, the fœtus being expelled with two or three sharp and quickly recurring pains. Hardly any fluid and practically no blood was discharged. In examining for the placenta, the finger went into a fissure in a hardened mass, which had a rough and somewhat gritty touch. The placenta came away readily and was found to be hard and tough, not easily torn like an ordinary placenta, and both it and the membranes were pale, being almost devoid of blood. There was sign of its having recently been attached to the uterus by a surface of considerable size. The fœtus, a female, weighing 3 lbs., presented a shrunken and withered or mummified appearance. The epidermis was peeling. The head was covered with hair and the nails were just developed. The body was considerably distorted by pressure of the uterus upon it; the sternum, pointing laterally, formed a prominence under the left arm, and the lower part of the spine was in the condition of lateral curvature.

The woman made a fair recovery. Her temperature was never raised, but she was for some time somewhat anæmic. The lochia were represented by a very little discoloured watery discharge. There was no further secretion of milk. A decided menstruation occurred on April 27th, that being the 31st day after labour.

It would appear in this case that the fœtus died at the end of the seventh month, and was afterwards retained *in utero* for five months. The placenta remaining attached may have allowed of a limited circulation through the fœtal tissues, where probably some deposition of calcareous material took place.

In the few cases recorded in which the remains of a fœtus have been discovered in the uterus many years after the pregnancy, portions of the osseous system alone have remained, the soft parts having been absorbed or discharged. It evidently requires a considerable time, however, for the destruction of even the softer tissues of a fœtus when putrefaction does not occur with its comcomitant septicæmic symptoms in the woman, both of which were absent in this case.

A. ADAIR DIGHTON, L.R.C.P. & S. & L.M.Edin.

Cheltenham.

GLYCOSURIA AND THREADWORMS IN A CHILD.

I WAS called on March 28th to see a boy, aged 5, whose mother informed me had been losing flesh rapidly for a month. He had a little night cough and night terrors. He had lost his appetite, but was markedly thirsty, and would drink much water and suck as many oranges as he could get. At night time, when he awoke, this was specially noticeable. His mother said that the water he passed was less in quantity than usual. She thought he suffered from worms, as he grated his teeth at nights, and frequently picked his nose with his fingers during the daytime. She had given him several "worm cakes," but no worms had come away in his motions.

I found the patient emaciated; his face was thin, and the lines upon it were strongly and unnaturally marked. There was wasting of the intercostal muscles, his ribs being rendered unduly prominent. Physical examination of the chest revealed only signs of a mild attack of bronchitis. His temperature, as far as I can remember, was normal or nearly so —certainly not much above or below the normal line. His water, on examination, was found to be acid in reaction, of specific gravity 1031. It gave no trace of albumen, but a decided reduction of the copper salt was obtained on boiling a small quantity of the urine, after filtration, with some Fehling's solution. I do not think the reduction of the cupric salt was due to uric acid, as my testing was done as carefully as possible, and more than once to make certain. The next day I put the child on the diabetic's diet, with the exception of allowing him milk to drink, and prescribed a 3-grain dose of santonin the last thing at night, to be followed by an aperient the first thing next morning.

On April 3rd I again examined his water, and found it to be acid; specific gravity 1029; sugar was again present. I did not estimate the sugar present quantitatively but with a rude guess from the colour of the suboxide after reduction, there seemed to be probably about the same amount present as on the previous examination. Three santonin powders given at various intervals brought away a quantity of dead worms, after which the boy's nervous system seemed to settle down, his appetite returned, and he rapidly regained his former state of health. A later examination of the urine gave the following result—acid, specific gravity 1023; no sugar was present.

The points of interest in this case seem to me to be—Was the glycosuria due to, or was it merely coincident with, the presence of the thread worms in the intestine? Would the removal of the worms without the dieting have banished the glycosuria—in other words, was the glycosuria due to reflex nervous irritation? And, lastly, would the dieting without the removal of the worms have been sufficient to bring about the same result, that is, was it merely a case of physiological glycosuria? It seems possible that if diabetes can be produced by shock, which it undoubtedly can, a temporary glycosuria might be brought about by a temporary nervous irritation, whether central or reflex in origin, and consequently threadworms may be, under some circumstances, a definite cause of glycosuria in a child.

Youlgreave. T. WILSON PARRY, M.A., M.B.Cantab.

REPORTS

ON

MEDICAL & SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF GREAT BRITAIN, IRELAND, AND THE COLONIES.

THE MIDDLESEX HOSPITAL.

A CASE OF URTICARIAL ASTHMA, THE RESULT OF MUSSEL POISONING.

(BY GILBERT MARTYN, M.B., House-Physician to the Hospital.)

THE following case indicates clearly the relationship of urticarial eruption of the skin and mucous membrane which was so strongly advocated by Sir Andrew Clark as the main cause of asthma.

A woman, aged 43, came to the out-patient department here about 8.30 P.M. with the following history. She had eaten about a dozen mussels for her supper, and an hour afterwards began to feel a choking sensation and great difficulty of breathing. At the same time a "nettle rash" accompanied by great itching appeared on the body. Her friends stated that her breathing became so difficult that she went blue in the face and threatened to become asphyxiated. She was given a tumblerful of warm water, after sipping which she expectorated a little tenacious mucus and her breathing became slightly better.

She was then brought to the hospital. On arrival she was still cyanosed, her extremities cold, her breathing laboured, and an acute urticarial rash was present nearly all over her body, but most marked on the trunk. On listening with the stethoscope to the chest, the breathing was typically asthmatic with long wheezing expiration. The stomach and lower bowel having been effectively emptied and brandy and hot bottles having been used, the patient was much relieved, though the breathing still continued for some time of the above type. It is interesting to note that the woman had never been the subject of asthma before, nor markedly of bronchitis. She was in the habit of eating mussels, but had never before suffered ill-effects from so doing. Examination

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of the mouth and pharynx revealed nothing save some injection of the posterior wall and fauces. She did not while in the hospital expectorate any more mucus, otherwise it would have been interesting to demonstrate the presence of Curschmann's spirals. She was able to go home in about three hours' time, the pulse and respiration having greatly improved. I cannot find recorded instances of the concurrence of urticaria of skin and mucous membrane the result of a common cause, though cases in which the two alternate are, I believe, comparatively common.

REPORTS OF SOCIETIES.

LEEDS AND WEST-RIDING MEDICO-CHIRURGICAL SOCIETY.

E. WEST SYMES, M.D., in the Chair.

Friday, May 3rd.

CASES AND SPECIMENS.

CASES and pathological specimens were shown by Drs. SOLLY and MOUILLOT, HELLIER, MANTLE, BARRS, GRIFFITH, BRONNER, and CHURTON, and by Messrs. ROBSON, LITTLEWOOD, and ROBINSON.

DISCUSSION.

A discussion was held on the paper read by Dr. Barrs on the Prognosis of Cerebral Hæmorrhage, and published in the BRITISH MEDICAL JOURNAL of May 18th.

SYMPHYSIOTOMY.

Dr. BRAITHWAITE read an account of a successful case of symphysiotomy.

ANTITOXIN TREATMENT OF DIPHTHERIA.

Dr. MANTLE (Halifax) read a paper on the antitoxin treatment of diphtheria, with notes of two successful cases: (1) R. A., aged 4, had been suffering from diphtheria, apparently of a very mild form, for six days. There were small patches of exudation on both tonsils. There were enlarged glands but very little constitutional disturbance. The temperature and pulse were little altered, and there was no albuminuria. A fragment of membrane was sent to the British Institute of Preventive Medicine, when true diphtheria bacilli were cultivated. The symptoms improving, the injection of serum was delayed. The left nostril was involved on the seventh day, obstruction and sanious discharge from it being noticeable. The treatment adopted was germicidal applications locally, and perchloride of iron internally. Although the symptoms were apparently under control, on the eighth day a sudden constitutional change was manifest without any increase in local symptoms. The temperature ran up to 103 4°; the pulse became very rapid and the heart much embarrassed, with systolic murmurs at the apex and base. Antitoxin (10 c.cm.) was injected. In fifteen hours the nose was clear, and the throat also at the end of twenty-four hours, whilst the temperature steadily fell to 99° in this space of time. The second injection, which experience shows to be necessary at the end of twenty-four hours, was resented by the friends. The throat showed more membrane two days afterwards, and the temperature began to rise again. A second injection (5 c.cm.) was then allowed under chloroform, after which the child steadily improved, but with a permanent mitral systolic murmur. (2) A boy, aged 9, in the Halifax Infirmary for morbus coxæ showed diphtheritic patches on both tonsils. There was slight rise in temperature but no albuminuria. The breathing was more or less stridulous, insomuch that the house-surgeon was prepared to do tracheotomy. That night the patient was first injected with 5 c.cm. of Behring's antitoxin. A second injection of the same quantity was made next day. The following day, through the ward being closed, he was removed to the infectious hospital; the medical officer stated that the throat and larynx were quite clear soon after admission and that he made a good recovery. In both of these cases there was frozen drainage acting as the exciting cause. Dr. Mantle laid stress upon the necessity of adopting local as well as constitutional treatment. It being proved that the bacteria did not enter the tissues but were found chiefly on the surface of the lymph exuded on the mucous membrane, the local application of a germicide and preferably a solution of bichloride of mercury was of the greatest service. The fact that the bacilli produced toxins rapidly absorbed by the blood and tissues causing great constitutional disturbance rendered it necessary to adopt other means to neutralise these poisons. Experience had shown already that the injection of horse's serum which had been made to produce large quantities of antitoxins by repeated injection of diphtheritic toxins had the desired effect, and it would appear that we never before had such a complete control over the disease as by these methods of treatment.

REVIEWS.

THE DYSPEPSIA OF PHTHISIS: ITS VARIETIES AND TREATMENT. By W. SOLTAU FENWICK, M.D.Lond., B.S., M.R.C.P. London: H. K. Lewis. 1894. (Demy 8vo, pp. 216. 6s.)

THIS book contains an elaborate study of the various forms of the so-called dyspepsia associated with pulmonary tuberculosis. It treats of dyspepsia preceding phthisis, as well as the more recognised forms occurring during the initial and late periods of that disease. It includes also a chapter on the dyspepsia of strumous children which deserves attention.

Nothing can be more obvious than the efforts made in recent times to restrict the term dyspepsia, and to regard it as signifying the symptom-complex or syndroma due to varying underlying morbid processes. From this point of view, the first two chapters dealing with the pathology and morbid anatomy, both naked eye and microscopical, have a certain special interest. In the chapter on the gastro-enteritis of phthisis Dr. SOLTAU FENWICK bases his remarks on the investigation of some fifty cases. An interstitial gastritis with changes in the gastric glands was mostly found. A number of propositions concerning the etiology of this gastritis are here discussed. The author adopts the view that it is due to the toxins produced in the pulmonary cavities, and some researches of his own are given in support of this opinion, which can of course only apply to the dyspepsia of later phthisis. It hardly appears necessary to discuss any causal relation between gastric disease and phthisis; such relation can only be that of a predisposing cause to be considered along with many other factors, both local and general, which may help to prepare the way for the tubercle bacillus. Under a form of dyspepsia which precedes the development of phthisis the author recognises an atonic and an irritable variety. It would appear a fairly easy matter to mistake for it the dyspepsia of incipient phthisis with few manifestations.

The clinical picture of dyspepsia in strumous children in Chapter IV is based on an analysis of 32 cases. It would seem desirable that further researches should be made into this interesting subject before it can be decided whether a special form of dyspepsia really occurs at all exclusively in so-called strumous children, and whether it is in sufficient measure dependent on the so-called strumous diathesis to warrant a separate description. In the absence of any morbid anatomy the author is inclined to look upon it as a motor and sensory neurosis of the gastro-intestinal tract.

A valuable analysis of 500 cases of dyspepsia in early phthisis will be found in Chapter VI, and the last chapter, which also includes an analysis of cases, is an important and interesting contribution to the subject of perforation of the intestine. Perforation due to tuberculous ulceration is not nearly so uncommon an event in the author's experience as current teaching would lead one to suppose. In describing each variety of dyspepsia, the symptoms, etiology, prognosis, and treatment are fully dealt with. The author apparently sets little store on the information obtained by the investigation of the gastric chemistry. If results are discordant, there is the more reason for further research. It can hardly be denied that much additional knowledge of gastric disease has of recent years been obtained in this way.

This book certainly provides much useful reading, and

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