colour had been passed. I now gave him quinine sulphate (3 gr.) every four hours, and left instructions to preserve any motion. Had I had the facility I should have tried the blood reaction.

On September 30th the morning temperature was 103°, pulse 110; the evening temperature 104°. The bowels had not acted. There was no abdominal tenderness; there was some gurgling in the right iliac fossa and slight tympany. No typhoid rash was to be observed.

On October 1st the temperature was 103.5°, and the pulse 110. Three motions of typical pea-soup character had been passed. All this time he complained of nothing but weakness.

I reported the case as enteric, and he was removed to the fever hospital. He was evidently in the second week of the disease.

Here was a beautiful example of the uselessness of the public treating symptoms with patent medicines, even granting there be virtue in the latter.

A fortnight later a young man 20 years of age came to see me in a very depressed state, thinking he had fever. He presented a similar rash to the above. His temperature and pulse were normal; urine, specific gravity 1025, showed no albumen. His tongue was flabby and pale, and he complained of backache. At first he said he had taken no medicine, but on asking him to think again his sister, who was with him, said, "Yes, doctor; his sister gave him two pills." On asking what pills, "Doan's" was the reply. I ordered seidlitz powder and gave a hepatic stimulant; he was soon himself again.

London, N. G. W. R. SKENE, M.B., Ch.B.Edin.

ADRENALIN IN PULMONARY HAEMOPTYSIS.

THE note by Dr. A. C. Bird on this subject is particularly interesting to me, as I have quite recently had a parallel case to his.

My patient, a young clergyman, was sent to this district about two years ago, suffering from pulmonary phthisis. In September of last year he had a rather severe attack of haemoptysis, which, however, readily subsided under the ordinary treatment—absolute rest in bed, application of ice, etc. On December 6th he had a second attack—a very severe one—and in spite of ergot and opium (both internally and hypodermically), sulphuric acid, hazeline, terebene, ice locally and in the mouth, and absolute rest of body and voice, the copious coughing up of blood continued until the patient's pulse began to show signs of collapse.

On December 19th I prescribed a teaspoonful of 1 in 5,000 solution of suprarenalin (Armour) three times daily, and from the giving of the first dose the condition of the expectoration changed, the bright red gave place to a "foxy" colour, and after the third dose of suprarenalin all trace of blood in the sputum had gone and has not reappeared as yet.

I have still more recently used suprarenalin in a second case of haemoptysis with equally rapid result, and also in a case of fairly severe *post-partum* haemorrhage again, so far as one can tell, with excellent effect.

Rothbury. ARTHUR S. HEDLEY, M.B.

BLEEDING IN PNEUMONIA.

THE report of the following case may interest those who have read Dr. Lees's paper and Dr. Barr's comments thereon.

O. P., a boy aged 14 years, who had had bronchitis in childhood; had left-sided empyema two years ago. This was drained and part of rib resected. The scar and physical signs of thickened pleura remain. His present illness began with typical signs and symptoms of acute pneumonia at the right base. On the third day the temperature reached 107° F. for a short time. On the fifth day the temperature was 105°, the pulse feeble (about 180), respirations 65; there was marked cyanosis and much distress from feeling of suffocation. Four leeches were applied over the region of the right auricle, and withdrew some 2 oz. of blood; for two hours longer the bites were encouraged to bleed freely, so that I am sure not less than 4 oz. in all were abstracted. At the end of the two hours the patient was comfortable, the cyanosis was gone, the temperature was 103°, the pulse 125, and the respirations 60. For two more days the temperature continued between 103° and 105°, but the pulse never exceeded 130, nor was cyanosis again marked. The case terminated favourably by lysis.

During the last twenty years I have occasionally bled in certain cases of pneumonia (twice in one alcoholic patient), but I have never before seen such marked evidence of the value of this procedure.

Southampton. S. HUGHES, M.B., etc.

THE TREATMENT OF MYIASIS.

WITH reference to the very interesting "Notes on Myiasis" by Captain P. S. Lelean, F.R.C.S.Eng., R.A.M.C., in the BRITISH MEDICAL JOURNAL of January 30th, may I point out that larvae can be at once got rid of by the following method? The tip of an ordinary probe is lightly smeared with vaseline and pressed on to a little calomel so as to take up about 1 gr. of the drug. It is then passed into the cavity containing the larvae and gently moved round it. The calomel kills the larvae in a few minutes. They can then be removed by gentle pressure, or, better still, by syringing the cavity which contains them with a little warm boracic lotion.

The other drugs, such as turpentine, which have been recommended for destroying maggots, are uncertain, irritating, and very painful. On the other hand, calomel acts rapidly, certainly, and without causing the slightest pain or discomfort. It also seems to destroy or neutralize the excretory products of the larvae, which are often sufficiently irritating to excite considerable local inflammation and high fever.

Calomel is also fatal to most of the lower forms of life, and I have used it successfully to get rid of a leech which had accidentally entered the nasal fossa.

G. H. YOUNGE, F.R.C.S.I.,
Lieutenant-Colonel R.A.M.C. (retired pay).

REPORTS
ON
MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF THE BRITISH EMPIRE.

SOUTH WIMBLEDON AND MERTON COTTAGE HOSPITAL.

SPONTANEOUS RUPTURE OF THE UTERUS: LAPAROTOMY: RECOVERY.

(By MARTIN RANDALL, M.D.Lond., F.R.C.S.)

CASES of spontaneous rupture of the uterus occurring early in labour are so uncommon that this one may be thought worthy of record:

History.—E. S., aged 36, at full term in her tenth pregnancy. Her previous confinements, save the first, second, and ninth, have all been normal. In the first she was confined of twins prematurely at five months. The second was a transverse presentation, and the ninth child was born deformed, at eight months, and lived eight days. She is a healthy woman, but works hard and is somewhat ill-nourished. On October 19th, 1903, she went to bed as usual and slept. She woke at 2 a.m. on October 20th, and found she was losing a little blood. An hour later pains came on. She voluntarily states that they were only six or eight in number, and that she experienced something different from what she had suffered in her previous confinements. The pains ceased altogether. She was not sick, and no history of shock or collapse could be obtained. She was seen by a midwife, who told her to send again. There was no history of a fall, blow, or strain.

State on Examination.—She was seen in the morning of October 20th by Dr. Arthur Edgelow, who asked me to see her with him later in the day. She still had slight loss. She was sitting with her buttocks on the edge of the bed and her feet resting on the floor. She complained that she could not lie down, because the attempt to do so took her breath away. She also complained of cramp in her back and sides, passing down the thighs, and made worse on movement. There were no uterine pains. Colour was good, facial aspect anxious. Respiration short and gasping, as in pneumonia. Pulse 120, regular, of fair quality. Temperature normal. After much persuasion she was induced to lie on her side, with shoulders and thorax propped up by pillows. Her movements were like those of a person suffering severely from lumbago. On vaginal examination a ring-like space was felt, in which lay part of the placenta. No part of the fetus was palpable. A loss of 2 or 3 oz. of dark blood followed the examination. Dr. Edgelow then gave chloroform, and after external cleansing I introduced my hand with a view to clearing the uterus. It entered the abdominal cavity through a tear in the posterior and left part of the uterus, and thus the nature of the case became clear.

Operation.—She was removed as soon as possible to the Cottage Hospital, the abdomen cleansed, and the vagina douched. Dr. Brice Poole administered chloroform, and Drs. Edgelow and Gerrard kindly assisted at the operation, at 9 p.m. Under chloroform the child could be felt lying transversely above the uterus, with its head on the left. On opening the abdomen the first thing seen was a bulging, yellowish, bladder-like object. This was the intact amnion. The child was seized by the buttock, which presented, and removed, head last, care being taken to exclude the liquor amnii from the abdomen as far as possible. The amnion did not appear to be unusually tough or thick. The child, a fully-developed male, of quite average size, was dead.

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The cord having been clamped was followed to the placenta, which was found plugging the rent in the uterus. It was removed, the chorion peeled off the uterine wall, and the uterus drawn out of the abdomen. There was little bleeding. The rent was just behind and parallel to the insertion of the left broad ligament. It was jagged and extended from the fundus into the vaginal fornix. It was closed by interrupted silk-worm gut sutures inserted as in a Caesarean section and a fine continuous silk peritoneal suture. This could not be applied over the last two stitches closing the vaginal fornix. The insertion of the sutures caused very free bleeding. A drainage tube was passed down on the left of the uterus, after clearing away clots and blood, of which the peritoneum had contained very little. The wound was then closed, save for the drainage tube space, and dressed in the usual way. The operation was well borne.

Progress.—Progress was good for the first six days, the tube being removed on the fifth. The temperature then began to rise to 101° at night, and tenderness developed in the left iliac fossa. On the fourteenth day a deep lump could be felt just above the outer part of Poupart's ligament. No sign of effusion in the pelvis could be detected per vaginam. On the sixteenth day an incision was made through the abdominal wall immediately above the outer half of Poupart's ligament, and a collection of pus evacuated from under the iliac fascia. One or two small stitch abscesses formed in the abdominal wound. After this progress was steady, but slow, and the wounds were soundly healed by December 25th. She had just completed a normal menstrual period. I regret that the placenta was not minutely examined.

REMARKS.—The special features of interest are, the early period of labour at which rupture occurred, the absence of serious shock and haemorrhage, and, most noteworthy of all, the fact that the amnion was not ruptured. The mode of treatment to be adopted was obvious. The history of the onset of loss, followed by "six or eight" pains was most definite, and there can be little doubt that the rupture occurred at this time—about 4 a.m. on October 20th. The operation was performed about seventeen hours later, and during this period there were no uterine pains. Cases occurring thus early in labour are exceedingly rare. A very good example is recorded by Dr. Milne Murray.[1] In his case rupture apparently took place between four and five hours after labour began. Operation revealed a tear almost identical with the one found in my case, but the amnion was ruptured. Convalescence was complicated by the formation of a pelvic abscess which discharged per vaginam. Dr. Murray refers to records of three somewhat similar cases, and gives references to them. The complaint that she could not lie down was very puzzling. The first idea was that she had pneumonia, which the breathing suggested, and when this was excluded, that she had lumbago. The symptom was fully explained by the position of the fetus, which evidently embarrassed the thoracic organs less in the erect than in the recumbent position. The absence of severe shock I attribute to the small amount of haemorrhage, probably due to the placenta plugging the rent, and to the fact that the amnion was intact. That the placenta may thus act in arresting haemorrhage is proved by a case recorded by Dr. Dakin,[2] in which after delivery of the child per vias naturales, the uterus was found ruptured, with the placenta in the tear. Its removal was followed by such severe haemorrhage that the patient died in about ten minutes. As regards the condition of the amnion, it has been said that the uterus cannot rupture without the membranes being ruptured. Dr. Murdoch Cameron, in a most interesting case that he records,[3] points out that this is a fallacy. In Jewett's *Obstetrics* reference is made to two cases of ruptured uterus in which the membranes were intact. One died and one recovered. In such instances the uterus must be actually burst. It is not torn by undue pressure on a certain spot but gives way at its line of least resistance, just as an over-distended bladder or cycle tire yields where weakest. Whether in this case there was a transverse presentation or a placenta praevia is uncertain. Nothing in the previous history pointed to the latter, but I cannot too much regret having omitted to examine the after-birth from this point of view. The suppuration that occurred was annoying but not surprising to one who saw the room where she was when first seen, and the ablutions which were requisite and necessarily somewhat hurried before operation. There was never any indication of peritonitis, and the abscess which was opened appeared to be in the cellular tissue under the iliac fascia. Finally, it is open to question whether the uterus should have been removed. This procedure adds greatly to the shock of the operation, but this would have been as favourable a case for its adoption as could be obtained. The general opinion now appears to be that the uterus should not be amputated if simpler and less severe methods of dealing with the tear are practicable.[4] But it might have been a better mode of treatment to leave the lowest inch of the tear, which was in the vaginal fornix, unsutured; to have used a gauze drain passed into Douglas's pouch through this opening, and to have completely closed the abdominal incision.

REFERENCES.

[1] *Journal of Obstetrics and Gynaecology of the British Empire*, 1902, vol. i, p. 142. [2] *Trans. Obstet. Soc. Lond.*, vol. xl, p. 30. [3] BRITISH MEDICAL JOURNAL, October 14th, 1899, p. 972. [4] Proceedings, Obstet. Soc. Lond., BRITISH MEDICAL JOURNAL, January 13th, 1900, p. 78.

MANCHESTER UNION HOSPITAL.

A CASE OF PANCREATIC CYST: LAPAROTOMY AND DRAINAGE.

(Reported by ARTHUR H. BURGESS, F.R.C.S.Eng., M.B., M.Sc.Vict., Visiting Surgeon.)

J. W., aged 45 years, was admitted to the hospital on May 20th, 1903, complaining of severe diarrhoea of about ten days' duration. He appeared extremely emaciated, and stated that he had been getting steadily thinner for the previous six months. On examination of the abdomen a smooth, elastic swelling was discovered, deeply placed in the epigastric region, exhibiting no tenderness to pressure, uninfluenced by the respiratory movements, and not capable of being moved in a lateral direction. Indistinct fluctuation was obtainable, percussion yielded a dull tympanitic resonance, auscultation revealed no *bruit*, nor was the swelling pulsatile. On inflating the colon with air the tumour was noticed to be well above the transverse colon, and on distending the stomach with carbonic acid gas that viscus lay across the front of the swelling, completely obscuring it. There was no excess of fat or undigested muscle fibre in the stools, and on one occasion only was the presence of a small quantity of a Fehling-reducing substance noted in the urine. A diagnosis of probable pancreatic cyst being made, laparotomy was performed on June 25th, 1903, through a median incision in the epigastrium, to which at a later stage was added a transverse cut partly throught the right rectus. On tearing through the layers of the small omentum a tense, thin walled cyst was exposed, firmly connected with the head of the pancreas, the remains of which were spread out over its lower portion, the tail of the organ not being involved. The cyst was aspirated, and 27 oz. of fluid withdrawn. Owing to the thinness of its wall and its close incorporation with structures around, enucleation of the cyst was out of the question and from the depth of its situation it was impossible to bring it up to the abdominal wound. A glass tube was therefore introduced through an enlargement of the trocar aperture, the margins of which were tied closely round the tube with a stout silk ligature, the tube itself being surrounded with sterilized gauze. The rest of the incision was sutured.

The fluid withdrawn was of a reddish-brown colour, glisten-with crystals of cholesterine, specific gravity 1036, alkaline, contained albumen but not sugar, and gave the guaiacum reaction for blood pigment. By some error, the fluid was unfortunately thrown away before it could be specially investigated for the presence of ferments.

After the operation the general state of the patient markedly improved and a rapid increase in weight was noted. The glass tube was removed on the sixth day, the discharge, never very profuse, gradually diminished, and the fistula finally closed on November 4th, 1903. The man is now in excellent condition.

MEDICAL WILLS.—The estate of the late Dr. Samuel Woodcock, J.P., has been valued by his executors at £8,662 gross, and £4,476 net.—The will of the late Dr. Theophilus W. Trend of Southampton has been proved at £18,382 15s. 5d.—Colonel Sir George Thompson, K.C.B., I.M.S., who served in Afghanistan in 1878, and with the Chitral Relief Force in 1895, has left £3,329 18s. 10d.

MORTALITY AMONG AMERICAN PRACTITIONERS.—From statistics compiled by the *Journal of the American Medical Association* it appears that the number of medical practitioners who died in the United States and Canada during 1903, was 1,648. This is probably within 5 per cent. of the total mortality in the medical profession in North America, the number of which is estimated at about 120,000. The time the deceased doctors had been in practice varied from one to seventy-five years. The greatest number of deaths occurred in the twenty-fifth year of practice, in which 51 were recorded. Of the entire number 209 had practised more than fifty years, and two had been in practice seventy-five years at the time of death.

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