ingly. It would be taking a very narrow view of the question to say that, because the disease is *pneumonia*, we must therefore treat it by blood-letting, or we must *not* treat it by blood-letting, or it is better to let it alone, for it will get well of itself. We can have no such definite rule of practice as this in our profession; we must be guided in our treatment by well grounded general principles; and the great art we have to learn is to be able to modify those principles in detail to suit the varying exigences of those pathological conditions included in the general name of the disease.

If we are called early to a case of pneumonia, when the attack is sudden and severe, the patient young, plethoric, and not the subject of any constitutional disease, we should best relieve the patient, and save him the ulterior changes belonging to the disease, by early and decided blood-letting.

In asthenic cases, *uncomplicated by other disease*, I have often seen great relief afforded in the early stage by local blood-letting, aided by diaphoretics; taking care at the same time to give either tonics or stimulants, or both, should the *general* condition of the patient seem to require it.

In asthenic cases occurring in persons *labouring under strumous and cachetic states of system*, even local bleeding may be dangerous, and will be seldom if ever required; for, instead of being in excess and highly coagulable, the blood is poor and watery; and although it readily exudes, the consequent filling up of the air cells is less dangerous, and expectoration more easily takes place; we may safely take more time about the case, the patient will not be so early threatened with apnœa, and our surest remedies will be those which give tone to the general system, aided by counterirritation and medicines of diaphoretic and diuretic properties. In these cases, as well as in those which occur in fevers, there is less need of mercury to effect the absorption of the effused matter; for, containing less plastic material, it is more freely expectorated during the attack, and more easily absorbed afterwards, provided we have been able not only to relieve congestion but to give increased tone and nervous power to the whole body.

Where pneumonia has arisen secondarily in the course of typhus and other fevers of a low type, I have always found it the most successful practice to trust, as far as medicines are concerned, to the appropriate treatment of the fever generally; and to limit the special treatment of the local disease to fomentations and counterirritation by turpentine, blisters, or other stimulants.

The subject is far too large a one to be satisfactorily dealt with in a short paper on such an occasion as the present, where so little time can be spared for discussion; but I feel sure the hints I have given may be safely trusted in practice as a foundation for further observation and research.

CASES OF PERFORATING ULCER OF STOMACH AND OF INTESTINE: WITH REMARKS.

By Wm. Hinds, M.D., Professor of Botany at Queen's College, Birmingham; Lecturer on Botanical Science at the Birmingham Midland Institute.

[*Read at the Midland Medical Association.*]

[*Concluded from p. 93.*]

My next case in some respects presents a most marked contrast to the one related. Instead of being a vigorous, healthy, and robust male, the patient was a feeble and delicate girl. In this case, too, the perforation was found not in the intestine, but in the anterior face of the stomach.

Case II. Sarah A. B., aged 18, had suffered for some considerable time from pains in the stomach, and was in the habit, with a view to obtain relief from the pains, of taking a teaspoonful of black pepper. She was somewhat chlorotic in appearance; and the catamenia had been absent about eleven months. After tea on Friday, October 27th, 1848, she was attacked with vomiting, pain of the stomach, and great depression. Subsequently, the same evening, she had several other attacks of vomiting. The vomiting recurred on the following morning; and, in addition, there were severe abdominal pains. Seen about midday, she was dressed and sitting at the table downstairs. Her tongue was slightly coated with brownish fur, and there was some feverishness complained of, and pains in the bowels, which were evidently tender; but, as she was dressed, a very accurate examination was not obtained. The pulse was feeble and small. The bowels had not been moved since the previous day. She had taken in the morning some brandy and two teaspoonfuls of pepper. A three-grain calomel pill, combined with a grain of opium, was at once ordered, with a simple diaphoretic mixture; a sinapism was applied to the abdomen. Having gone to bed soon after the visit, she became gradually worse, and died at six the same evening.

Post Mortem Examination thirty-seven hours after death. She was short in stature, well formed; but the mammary glands were not much developed. The abdomen was much distended and tympanitic at the upper part. When it was cut into, much serous and watery liquid escaped; and about two quarts in all were removed from the peritoneal cavity. Some vascularity was observed upon the small intestines, and very small portions of lymph were seen in some parts. In the anterior face of the stomach, about an inch and a half below the cardia, a circular orifice was discovered, communicating with the interior. The size of the hole was about that of a large pea. Around the orifice, on the peritoneal surface, distinct appearances of inflammation existed; but there was no adhesion to adjacent parts. The whole parietes of the stomach were hypertrophied; and, indeed, appeared to be at least twice their normal thickness. The mucous surface was almost uniformly pale; and the excavation at the seat of the peritoneal laceration did not exhibit any vascularity, or differ in appearance from the adjacent parts. The uterus was of the ordinary virgin calibre. The ovaries, externally congested in patches, contained several largely developed Graafian vesicles, and some appearance of a false corpus luteum. The other organs were healthy.

Remarks. No doubt, the question as to the *cause* or *causes*, and that as to *remedies*, if such there be, in these grave lesions, are the two points of inquiry which possess the highest interest, both to us as practitioners, and also to our patients; but there are besides several accessory considerations which well deserve some attention. On some of these points, I propose to make a few remarks; premising that I may do little more in some of these than merely specify the difficulties which present themselves.

We may ask, in the first place, what is the *origin* of a chronic perforating ulcer? One element in this inquiry would be, as to whether such a lesion would be favoured by delicacy of conformation or a low state of vital power. In many such cases, as in Case II, there is this condition present.

But any free general conclusion in this direction must be seriously vitiated by the evident *result* of the chronic disease upon the stomach and its functions. A stomach with an irritable ulcer cannot be considered able to maintain its healthy operations; but if not, the failure strikes at the root of nutrition, and, as a consequence, of health. Now, even this conclusion may be considered in one sense to be falsified; for a most able author and authority declares that "almost all the patients have been young women, plump, and in good condition, who, up to the moment of the fatal seizure, either seemed to

enjoy perfect health, or, at most, had complained of slight and vague feelings of dyspepsia." (Watson.)

I do not, however, consider the views advanced entirely falsified; for the very statement as to the class of patients would seem to show that delicacy of tissue which may be assumed to exist in these patients tends to favour rather than to check the progress of the disease. We have, moreover, on the authority of Dr. Copland, the fact that the non-active or non-vascular chronic ulcer is sometimes associated with an anæmic or cachectic state of system.

A still more favouring influence would, nevertheless, most likely be found to accrue from the so-called *remedies* for the gastralgia—vulgarly termed *spasm*—with which these cases are associated during their progress. A frequent *remedy* for this pain in Case II was a spoonful of black pepper.

In the case, however, of *intestinal* ulcer, neither may there be delicacy of conformation, on the one hand, nor any serious impairment of nutrition on the other. I believe, however, we shall be right in concluding that stimulating and irritating substances used as food, or as remedies, would have a tendency to aggravate the disease and to promote a fatal termination. In Case I, the gentleman was extremely fond of and much addicted to highly seasoned food—food of the sage and onions type; and we may reasonably conclude that the continual irritation which such matters would exercise upon the ulcer, would prevent any successful reparation in the worst cases.

How do these chronic inflammations or ulcerations first commence? Are they papular or pustular, or the result of mere abrasion of the entire mucous membrane, mere attrition, or chemical irritation by certain portions of food? Can we illustrate their origin and progress by reference to the various papular or pustular eruptions or chronic inflammations of the skin? I am unable to illustrate by facts any of these important inquiries.

Again, can we suppose the ulcer to commence in the glandulæ agminatæ of the ileum? But even if we could be sure of such a fact, we are just as far off the real cause, unless in many cases we could trace the disease to constitutional taint; as, for example, scrofulous disease. Now, Dr. Watson believes this to be very rare; for he states that he never saw but *one* case of extension of scrofulous ulceration to these glands with perforation, and that in a case of phthisis.

Then we have the gray or slate coloured spots much dwelt upon by French writers, as being sure and unequivocal signs of chronic inflammation. But here, again, recurs the query—What is the origin of these spots, and what relation do they bear to the ingesta?

It is a most noteworthy fact, in reference to these cases, that the ulcers have often the appearance of being punched out, as it were—the holes bearing more or less the character of a clean cut, and the surrounding parts being little or not at all involved.

Now, I think this fact may fairly lead us to infer the great danger there is, that when once the tissues immediately subjacent to the mucous membrane shall have become involved or implicated, the excavation may go on to a fatal issue in the rupture of the exterior coating of the peritoneum. We know, or have good reason to believe, that the mucous membrane not only performs functions of its own, but preserves the fibrous and muscular coats of the bowel subjacent. We cannot, however, say that even when these coats subjacent are involved, a cure is impracticable, though the prospect is not encouraging, if we can fairly institute any real comparison between the mucous membrane and the enamel of the teeth. In the progress of caries, the dentine of teeth has scarcely any power of reparation after losing its outer envelope. The comparison may or may not strictly apply. It is a mere matter of opinion.

In ulcer of the stomach, as I have already intimated in Case II, there is an obstruction in the uterine function. The catamenia in my own case had been absent many months. If there be any intimate relation between these, I confess I am quite unable to trace it. I can only understand that any cause which tends to interfere with nutrition, properly so considered, must lower the health, and may thus detract from the vigour of the sexual apparatus.

I have only one word to say as to *treatment*. The first thing which strikes us is the great difficulty of *diagnosis* in these cases. A relapsing and otherwise unaccounted for and persistent diarrhœa, with blood in the motions, may be *symptoms* of chronic ulcer, but they are not *signs*, not by any means pathognomonic of the affection. The mere dyspeptic symptoms are of course of no value taken alone. The æsthetic series—slight occasional pains and tenderness, are equally delusory.

If, however, in any given case a fair presumption existed of the presence of chronic ulcer of either stomach or intestine, I confess I should rely much more upon a bland diet, strictly unirritating and unmixed, than upon any drugs. The mind naturally recurs to various astringents—as zinc, alum, the sulphates of copper and iron, and nitrate of silver and of bismuth, together with certain supplemental tonics; but, I confess, I should not use any of these substances with that confidence which we all like to feel when treating a grave and often fatal disease. I am of opinion that a milk diet carried out for a long period would, if not cure a chronic ulcer, at least allow nature and the constitution fair play in the process; while the most promising of our drugs might, I think, be attended with injury rather than with benefit, unless we could watch and trace their effects from time to time in the progress of the case.

Transactions of Branches.

SOUTH MIDLAND BRANCH.

ON THE MANAGEMENT OF THE PLACENTA.

By P. McLOSKY, M.D., Rothwell, Northamptonshire.

[*Read Oct. 17th*, 1861.]

THE subject I have chosen for a few remarks is one very familiar to every general practitioner; viz., the management of the placenta. I shall confine my remarks to cases after the birth of the child, at the expiration of the natural term of gestation.

The management of the placenta constitutes the third stage of labour, and it cannot be said that it is always a simple and easy business; for, if we consider that over ten per cent. of the total deaths in childbirth occur from flooding alone, and that this depends generally upon the relaxation or irregular contraction of the uterus, we shall clearly see the importance of so conducting the expulsion of the secundines, as to insure that state of regular and permanent contraction, in which alone there is safety. The most frequent, as well as the most fatal cases of flooding, occur before the expulsion of the placenta; and they occur after labours perfectly easy and natural, as well as after very tedious and exhausting ones; they occur in the robust and healthy as well as in the anæmic and debilitated; so that in no given case can we say we are perfectly secure from this appalling accident—an accident so truly alarming and imminent as to demand the promptest judgment, the coolest presence of mind, and nicest tact, of the obstetric practitioner; it is the real difficulty of natural labour. It is an old saying, that "meddlesome midwifery is bad"—that, however, should be taken *cum grano salis;* as an intelligent accoucheur is never unnecessarily meddle-