the colon in its transverse portion was adherent to the stomach. On further inspection it was found that at a spot rather nearer to the splenic than to the hepatic flexure, at the spot, indeed, where this adhesion existed, there was considerable condensation of tissue, so that the two hollow viscera here were quite inseparable from one another. On laying open their cavities respectively, deep ulceration was found to have taken place at the corresponding spot in the interior of the colon, whereby a somewhat funnel-shaped passage had been tunnelled, as it were, through the condensed tissue, the apex reaching the interior of the stomach, and appearing distinctly on its mucous surface as a somewhat valvular opening of about the size of a goosequill, and situated between two and three inches from the pyloric orifice. The latter was rather contracted, admitting only the point of the index finger, and there was some fibroid thickening of the pyloric ring. There was no ulceration elsewhere in the stomach, but in the depending parts of it intense vascular injection with patches of bistre pigmentation. Moreover, there was no ulceration in other parts of the colon, nor any alteration of its lumen or other morbid change. Liquid faecal matter, much coloured with bile, was found here and there in the small intestine. There were no enlarged mesenteric glands, and no secondary deposits on the surface of the liver; but at this stage the examination of the body had to be brought to a close. Sections of the condensed tissue, microscopically examined, revealed the presence of a neoplasm, which exhibited the histological characters of cylindrical epithelioma.

REMARKS.—The rarity of the lesion present in the foregoing case is amply attested by the scant notice of it to be found in the ordinary textbooks of medicine; in some of which, indeed, there is no notice of it at all. More than thirty years ago the late Dr. Murchison, after ransacking English, American, and Continental medical journals, and all anatomical museums within reach, succeeded in collecting thirty-three cases of gastro-colic fistula. In searching medical records since, an isolated case is to be met with now and then. Two or three cases may be found in the *Pathological Transactions* (and only two or three in the now forty volumes). Albeit, Murchison's Memoir, based upon his collection, and published in the *Edinburgh Medical Journal*, July and August, 1857, must be recognised as still the best source of information on the subject.

Finding, then, as we do on reference to the same, that of these thirty-three cases, the great majority, namely, twenty-eight, arose from disease commencing in the stomach, and only two from disease commencing in the colon; only one, indeed, from cancerous disease of the colon; we see that in the case before us we have not merely a rare lesion, but a rare form of that lesion.

The prominent clinical feature of the case was the faecal vomiting. The overwhelming frequency with which this symptom is dependent upon intestinal obstruction raises a very strong presumption in any given case that this condition is present as the cause of it. Once satisfied, however, to the contrary, the diagnosis in the main is arrived at. Fistulous communication between the colon and the upper part of the small intestine is so surpassingly rare that it can hardly be taken into account; while if diffuse peritonitis ever gives rise to faecal vomiting, as maintained by some writers, intestinal obstruction, as shown by Mr. Treves, must be the proximate cause of it.

But, the existence of gastro-colic fistula assumed, it was not so apparent where and what was the disease which had led up to it. The acute gastric disturbances the patient had formerly suffered from, and the firm resisting feeling with some tenderness observed in his epigastrium, taken in connection with the relative frequency, as shown above, of the gastric origin of the lesion, rather suggested the presence of some latent, and possibly malignant, ulceration of the stomach; while the two acute abdominal attacks which he stated he had experienced, followed by hæmorrhage from the bowel, however significant when regarded in the light of the *post-mortem* disclosures, seemed of too transient a character, and too remote from the advent of the fistula, to draw attention to the colon as the seat of disease. That for six months preceding his fatal illness, that is to say, up to within three weeks of his death, the patient should assert that he never enjoyed better health in his life is not a little remarkable.

It is interesting to note that while faecal vomiting is so characteristic of gastro-colic fistula, when intestinal obstruction can be excluded, this same lesion may exist without it. As Murchison pointed out, in cases of gastric cancer, which are just those in which the lesion is most apt to occur, if the pylorus is much obstructed no faeces are formed. The food taken into the

stomach passes by the "short cut" into the colon, and is voided *per anum* in a crude and more or less undigested form, giving rise, indeed, to the condition described under the name of "lientery." Normal faeces not being formed, of course there is no faecal vomiting. In this case, however, not only was the faecal character of the vomit unmistakable, but the stool when voided was of quite natural appearance, and no crude or undigested matters had at any time been noticed in it. Indeed, the opening from the stomach side, it will have been observed, was somewhat valvular, admitting pretty free passage into the interior of the organ, but not so readily a passage out of it. There was no evidence of any of the matters used for rectal feeding reaching the stomach.

As to treatment, the question of surgical relief was discussed, and Mr. F. K. Green, F.R.C.S., was consulted; but the general condition of the patient was deemed to contraindicate operation. In a somewhat similar case recorded by Mr. Walter Edmunds in the *St. Thomas's Hospital Reports* for 1883, colotomy on the right side was performed with a view to intercept the contents of the colon before they arrived at the fistula, but the operation was attended with no very encouraging result.

HÆMORRHAGES OCCURRING DURING PREGNANCY.¹

By A. E. AUST-LAWRENCE, M.D.,

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THE object of this paper is to put before the profession those cases where a woman is pregnant yet loses blood *per vaginam* either at regular intervals or irregularly. My purpose will be best served by giving cases illustrative of the subject, which will help to elucidate some of the problems placed before us when we are consulted by women who are pregnant and yet are in doubt about it, owing to seeing blood discharges come from the vagina.

To begin with, we will assume that the woman is pregnant, that under perfectly normal conditions she ought not see any discharge of blood from the date of conception to the advent of labour, but we have to look at one form of hæmorrhage, which is, to a certain extent, natural, namely:—

Persistence of Menstruation.—It is not impossible that a woman may be pregnant and yet have a discharge of blood from the uterine cavity before the two deciduæ have come in contact, which will in no wise interfere with the progress of development. Whether this is to be regarded as a menstrual period after conception, and whether an ovum has escaped after the fecundation of a previously escaped one, I shall not enter upon. My subject is essentially a practical one, and I am willing to admit that one real period may take place after conception, but not more than one; the seeming menstrual acts which do take place can be explained by some of the various causes of hæmorrhage which I shall relate further on. I cannot enter upon the question of ovulation, either with or without uterine hæmorrhage. One point there can be no doubt about, and that is, that when once the uterus has acquired the habit of bleeding periodically we see this habit kept up in the various diseased conditions of the uterus long after ovulation must have ceased. We often find that greatly increased hæmorrhages, at certain definite intervals, do occur. Of course it is exceedingly puzzling for a woman who thinks she is pregnant to find that her periods recur, and it often makes her think she is not pregnant, and very often medical men are deceived, because they overlook facts which I shall give in detail in this paper. One can quite understand that, if conception occurs just prior to the advent of a menstrual period, that period will come on, but most likely modified in its duration and amount of discharge lost, and I also admit the possibility of one period subsequent to the impregnation; but, as a rule, these are not the cases that we are consulted about. In these cases the error that happens, as a rule, is only that of miscalculating the date of confinement, the amount of blood lost not being more than an ordinary period, and very often much less. We must dismiss, then, in my opinion, persistence of menstruation as a cause of bleeding in pregnant women, except in very rare cases, such as in double uteri and extrauterine gestations. The probability of one period may be admitted, but other causes, to be mentioned as we go on, will explain the majority of cases, only one must not lose

¹ Read before the Bath and Bristol Branch of the British Medical Association

sight of the fact I have already alluded to, namely, the tendency of all uterine hæmorrhages to be more or less periodic, and given a woman who loses a little blood more or less constantly from the uterus, she will lose a great deal more at what would, under ordinary circumstances, be a menstrual period.

The second cause of bleeding in pregnant women is one I have often noted, namely, from a granular and eroded os and cervix uteri not malignant. Here we have a pregnant woman who loses a little blood at irregular intervals, increased in amount at what would be the periods; or she constantly passes a dirty brown mucus in large or small quantities, varying with the hæmorrhages above mentioned. In these cases all we have to do is to examine the woman and recognise at once the cause. I have seen twelve cases of this form. The application of nitric acid to the granular surface soon cause the parts to assume their natural state. Astringent injections will sometimes cure these cases without any other treatment. In some cases the granular state we see is complicated with a similar condition high up the cervical canal, and possibly extends into the uterus; then nothing is of any good to stop the bleeding, which, if excessive, would soon run the patient down; all we can do in these cases is to induce abortion.

I regard this form of bleeding as being very common, and constantly overlooked because no proper examination is made. If the os and cervix be exposed with a duck-bill speculum, the granular surface is easily seen, with its highly developed papillæ, and if you rub these with a sound they will bleed; but in simple cases, where the disease does not extend up the canal into the uterus, you do not see any blood coming down the canal. The direct application of nitric acid cures these cases like magic; but if you see dark blood coming down the canal, you may rest assured that you have some intrauterine cause of hæmorrhage such as I shall describe further on.

One interesting case I saw lately. The woman was pregnant four months, and yet had repeated hæmorrhages. I found a small polypus growing from just inside the cervical canal. This was removed; the bleeding ceased, and the pregnancy went on its normal course.

The third kind of cases includes those where the bleeding comes from the cervix owing to its being the seat of malignant disease. I have seen several cases with a history like this: No evidence of any disease or anything unusual until pregnancy has taken place, when slight hæmorrhages have occurred at irregular intervals; sometimes, however, there has been profuse bleeding. An examination reveals the nature of the case. Under most circumstances the best treatment is at once to induce abortion. You check the bleeding to a great extent, and you lessen the woman's risk by not letting her go on to full term with an increasing disease of the cervix uteri.

Although I have seen six cases where the disease of the cervix was recognised prior to the delivery at full term—simply because the women came on account of the unnatural discharge of blood—yet I have seen a very much larger number where there has been no doubt but that the disease existed prior to delivery, from the history which I obtained; but the women only came under observation after confinement, most of them being supposed to suffer from some of the many post-puerperal conditions which induce menorrhagia. In all these cases the disease was already far advanced, and in all the fatal termination was most rapid.

It is not always easy to diagnose malignant disease soon after labour, as the following case shows: A woman came into the hospital under my care with pelvic pain and offensive discharge, a very large, hard, ragged cervix, and fixed in the pelvis, but it was not cancer. It was a case of septic cellulitis, fixing the big subinvolved uterus with its bulky lacerated cervix, the bleeding and offensive discharge being caused by a piece of retained decomposing placenta, itself the origin of all the trouble. The patient made a perfect recovery.

Certain forms of vaginal hæmorrhage must not be overlooked, as the following case shows: A woman was six months pregnant, and began to bleed profusely. The doctor in attendance thought it was a case of placenta prævia, and induced abortion. The bleeding went on; he then washed out the uterus with solution of perchloride of iron. The bleeding stopped for two days, then recurred very badly. I was then asked to see her with her doctor, and immediately on passing my finger into the vagina recognised an ulcerating malignant growth of the anterior vaginal wall, about an inch long and half an inch broad, beginning half an inch posterior to the meatus urinarius. Of course the expla-

nation why the bleeding ceased when the solution of iron was injected was simply this, that as the solution ran down from the uterus it went over the vaginal sore. It was a case of primary vaginal cancer, and proved rapidly fatal.

I have seen very troublesome bleeding in pregnant women from vascular growths at the meatus, also from rupture of some of the vaginal veins, most probably due, I believe, to coitus, although possibly in some cases to straining at stool. Of course, one may see cases where bleeding from the urinary tract may give rise to the idea of its being uterine; but an examination will clear up these cases, as well as those where the bleeding may come from the rectum.

Hæmorrhages from the stomach and lungs, complicating pregnancy, I have nothing to do with in this paper. The question does arise sometimes as to the propriety of inducing labour, in order to lessen vascular tension, and so lessen the bleeding.

We come now to consider the part the placenta may play in these hæmorrhages; and I take, first, those cases where the position of the placenta is normal, but its constitution is wrong. Either there is a deficiency of trabecular structure which does not give proper support to its vessels, or the vessels are weak from fatty degeneration. Whichever of these conditions exists, the result is the same; the placenta is very soft and pulpy, and from very slight causes blood oozes from its vessels, and either escapes into the amniotic cavity or, more frequently, passes down between the membranes and the wall of the uterus, and escapes externally. If in spite of rest and opium, and small doses of ergot, the bleeding persists, then clear out the uterus. I have seen a large number of these cases, and have never regretted acting too soon, but have regretted sometimes not acting soon enough. If the amount of blood which a woman is losing is telling on her health, you must check it, and there is only one way, and that is by clearing out the uterus. In these cases, with a speculum, you can see the blood coming directly from the cervical canal; it is most usually dark, and often the woman has pains like those that occur early in labour.

We now take another class, where the construction and position of the placenta are normal, and yet, from an accident, separation of the placenta has taken place, with the result of one of two things: (a) hæmorrhage, external; (b) hæmorrhage, internal. If the hæmorrhage is external, of course it is visible, and if there is much loss, and you cannot check it, do not try and be too refined in your diagnosis as to whether it is accidental hæmorrhage, placenta prævia, or the form of hæmorrhage I mentioned in the last class. Realise at once the position of the woman, and clear out her uterus; she has no safety as long as the placenta is separated, and bleeding is going on.

Again, take the second variety, where the bleeding is internal; these are the cases to try a medical man. The woman is bleeding into her uterine cavity either between the membranes or wall of the uterus, or into the amniotic cavity itself. There is no external evidence of hæmorrhage, yet every symptom the woman has points to the loss of blood. You exclude loss from every conceivable place—mouth, bladder, bowels, and vagina; you have positive history of sudden pain, and tension in the uterus, faints, etc. Your only chance of saving that woman is in clearing out her uterus; and if you do not see the patient early the probability is that in spite of all she will die. I shall never forget a case I had myself. The lady was a primipara, eight months gone, and was suddenly seized with great pain and faintness. I saw her soon after, and there, protruding from the vagina, was a large bag of the membranes, purple from contained blood. I ruptured the membranes and delivered rapidly, and saved her life, but was blamed for hurrying her labour. I need hardly tell you I did not take the blame quietly. Of course, the public do not understand these things, and we must act as our judgment dictates, although I am aware that sometimes we get less blame if we allow patients to die unaided than if they die in spite of our efforts to save them.

The last class is one best known to most medical men—namely, placenta prævia, and I do not intend to enter upon this subject any further than to use it to illustrate one form of hæmorrhage. My chief object has been to divert attention from this variety of hæmorrhage into other channels, for the usual idea is that if a woman bleeds before she is gone six months, she is going to abort, and if she bleeds after six months, she has placenta prævia.

I trust this short paper of mine will open up other possible sources of hæmorrhage. Exclude all the other varieties I have named, and the presumption is you have a case of placenta prævia to deal with; and there again the golden rule comes in, clear out

the uterus; and as in the majority of cases the os uteri is closed, I wish to draw your attention very briefly to these sponge tents I use, and also to the precautions which I adopt. I have no doubt but that most of you saw them last year, when I read a paper on the "Treatment of Incomplete Abortion." I bring them before you again because I find that tents are being blamed for evils which arise from their abuse, and from their not being used with proper antiseptic precautions. Of course, when the woman is near her full time you can often do all the work with the best tent in existence—namely, your index finger properly aided with a dilating india-rubber bag.

The precautions I use in clearing out the uterus are as follow: (1) wash out vagina with carbolic lotion, 1 part in 100, (2) pass into uterus a 20-grain iodoform bougie to keep the contents of uterus aseptic, (3) pass into uterus my antiseptic sponge tent, (4) plug vagina with iodoform wool to keep the tent in position; leave the woman alone for twelve or even twenty-four hours, then (1) remove vaginal plug, (2) remove tent, (3) wash out vagina with carbolic lotion, (4) pass into the uterus one or more fingers and clear out its contents, (5) wash out uterus and leave in it iodoform pessary of 20 grains.

The tents referred to in this paper were shown at the meeting of the Obstetrical Society in London in December, 1889. They are very carefully prepared from sponge which has been soaked some days in 1 in 2,000 of corrosive sublimate, and after they are made up they are coated with gelatine holding in solution corrosive sublimate 1 part in 1,000. The gelatine coating enables them to be passed very easily, as the point of the tent retains its firmness for some time. The tents have been made for me by Mr. Buxton, chemist, Queen's Road, Clifton.

MEMORANDA: MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

A NEW REMEDY FOR SEA-SICKNESS.¹

THE successful treatment of sea-sickness which surgeons afloat have so much to do with, and which generally they are unable effectively to alleviate, must prove my excuse for bringing before the profession the curative effect of kola (*Sterculia acuminata*) in this affection. In the few cases which I have lately had to deal with, I have found the internal administration of the seed of the kola a most successful remedy. Half to one drachm of the seed chewed slowly was followed, in about forty minutes, by complete cessation of the various symptoms of *mal de mer*; the depression, vomiting, and giddiness disappeared; the heart's action regulated and strengthened, and a confidence in heavy weather that my cases never before experienced during the many years they have served in the Royal Navy, and had tried the usual remedies prescribed by their advisers. At present, no means of preventing sea-sickness in those susceptible of it is known; and I venture to believe that in kola, or its alkaloid, we have one, and that a larger trial of this drug will tend to support my opinion. From its well-known sustaining and invigorating properties during fatigue, for which it is daily used by the natives on the West Coast of Africa and the Soudan, its action in sea-sickness seems to be the giving tone to the nervous system, proving a stimulant—acting generally and locally. As a good deal of attention is now directed to this drug, it would be advantageous if for future trials pharmaceutical chemists would give us a neater, more portable, and efficient preparation than the kola seed, which seems reliable only when freshly procured.

CHAS. W. HAMILTON, Surg. R.N.

A CASE OF IDIOPATHIC INFLAMMATION OF THE TONGUE.

On the morning of October 2nd, 1889, I was called to see M. L. The patient was an overgrown strumous-looking girl of 17. On waking about 5 o'clock she found her tongue swelled and protruding between her teeth. She had a similar attack nine years before, and had been under treatment then for twenty-seven weeks. She sat up in bed unable to speak intelligibly. The swelled tongue, forcing apart the dental arches, protruded an inch and a half. Over the swollen organ the saliva kept flowing

abundantly. She had little or no pain, and the inconvenience and unsightliness of her affliction gave her much uneasiness. Pulse was good, 92; respirations, nasal, 20 a minute; temperature, 99.8°. She had been as well as usual the night before. Menstruation had begun early (13 years), and was regular, the last period having taken place a week before. She had not used mercury nor other poisonous substance as a medicine or food, so far as she or her relatives knew. Her father was living, aged between 40 and 50; her mother died of consumption; her only brother was 15 years old, and never ailed anything; he, however, looked strumous. She usually had good health, but had occasionally suffered from swelling of the glands.

A smart purge was given, followed by 5-grain doses of potassium iodide three times a day. The mouth was kept clean by syringing, often with solutions of borax and alum sulphate.

At the end of ten days the swelling was not greater, but the teeth of the lower jaw were beginning to ulcerate into the tongue on its inferior surface. The submaxillary and sublingual glands were hard and swollen, and she complained of stiffness all round the neck. There was no rash. Pain and stiffness were relieved by poultices applied over the swollen glands, and linimentum iodi was then painted over them, and iodide of potassium continued internally.

On October 24th there was no reduction in the size of the tongue, and quinsy developed in the right tonsil. Temperature 102.5° F. Potassium iodide was stopped, and poulticing and fomentations soon relieved the tonsillitis.

I proposed to incise the tongue, but the relatives resolutely refused to allow me. I therefore, on October 26th, applied six leeches scattered over the surface of the swollen member, and the bites were encouraged to ooze about four hours. A week after she could withdraw the tongue a little, but it was still impossible to get it inside the teeth.

On November 5th I again applied the half-dozen leeches, which caused oozing for four or five hours after they fell off. Then iodide was resumed internally as before, and on November 27th the tongue was inside the teeth, but it was not until December 21st that she could bring the teeth together.

REMARKS.—The chief peculiarities of this case are, I believe, its rarity, the absence of severe symptoms, and the duration of the disease. From the improvement which followed leeching I should not hesitate to incise the tongue in another such case at the beginning, giving iodide to complete the cure. I much regret that she refused the photographer one negative while the tongue was protruded. A good photograph would have shown the disfigurement better than any amount of letterpress could describe.

Tarporley.

ALLEN McCULLOCH, M.B.

PROLONGED SOMNOLENCE AFTER INFLUENZA.

I HAVE had a case recently which must, I think, be considered an example of the disease *La Nona*, of which such wonderful reports have been given.

The patient, a child aged 1 year (not at the breast), had an unmistakable attack of the epidemic catarrh, with general myalgia well marked. The mother described it as "not being in pain, but uncomfortable all over." The attack was followed by a peculiar somnolence and great prostration, which lasted some ten days, during which the child had to be roused for food, of which it took very little; also it was roused for its bath, which in health it vigorously resisted, but now scarcely noticed.

The convalescence commenced suddenly. The child was put to bed at 6.30 P.M., and, being for some reason forgotten, it slept till 3 P.M. of the following day, when the mother roused it and gave it food. It went to sleep again directly, and slept for about half an hour, when it awoke spontaneously and seemed itself again, taking notice of everything as usual, and from that time made a good recovery.

During the somnolent period I was several times in doubt whether it would recover, the prostration being extreme. The mother had had a typical attack of the epidemic a month previously, but developed no somnolent symptoms.

Holland Park, W.

ALFRED E. BARRETT.

DIABETES AFTER INFLUENZA.

I SHOULD like to add to the interesting series of sequelæ to influenza, recorded in the JOURNAL, two cases of diabetes which appear to owe their origin to the morbid conditions brought about by this curious epidemic.

¹ Communicated by the Director-General of the Medical Department of the Navy.