sure on its vessels by gravitation, thus facilitating increased bleeding; and at the same time, a certain amount of dilatation of the vessels themselves, with frequently exudation into the tissues they supply. And thus we find thickened walls, increased in thickness also by the action necessary to expel contents abnormally retained. This fluid pressure cannot exist without the nervous structure being pressed upon, and thus tenderness and uneasiness are felt, which no doubt are increased by the causes of irritation to the mucous surface already alluded to. When miscarriage has occurred in a retroflected uterus, then these effects are very much increased; and continue for a long time, so long that, as Dr. Barnes has remarked, the original causation is forgotten. But this position also renders the expulsion of the ovum more imperfect and prolonged, especially where there is, as is frequently the case, a firm adhesion between the villi and the uterine wall; and this is well shown by my own experience, for in nearly every case where I have been called in consultation for difficult abortion, with violent hæmorrhages, the uterus has been found retroflected. Other effects succeed to retroflexion, such as external infiltration of serum, or even blood, besides the reflex neurotic symptoms; but at the present I am alluding to the actual clinical state of the uterus itself, the result of its retroflexion especially, accompanied by hæmorrhages. And the question which arises from the consideration of these facts is: Whether the large and tender state of the uterus is dependent upon the retroflexion, or a coincidence with and accident to the state? If the organ have become so in consequence of its malposition, then the line of treatment seems clear, namely, to restore it. But, say some: If you interfere with the uterus in this condition, you will cause an increase of the inflammation and make matters worse.

But, suppose it can be shown clinically that the uterus *can* bear the handling necessary for its restoration to position, that it is not made worse, but, on the contrary, gradually loses all its bulk and tenderness, then the objection just mentioned is without ground. But in truth the term "inflammation", as applied to the sensitive irritable state, is a misnomer: not but that much care should not be exercised in the restoration, lest we unnecessarily increase its irritability by our manipulation. To assist in the solution of this problem, I have ventured to add briefly the results of my own clinical experience, and this is as follows.

1. In no instance where I have restored the uterus, and kept it *in situ* by a vaginal pessary, have I found any inflammatory symptoms follow.

2. In no case have I found other than improvement, the uterus gradually becoming smaller, less sensitive, and the discharges from it less, till it gradually resumed its normal state, so far as was compatible with a certain amount of permanent thickening, the result of the former engorgement.

3. In the case of hæmorrhage, and this especially the sequel of abortions, the restoration of the uterus to its normal position has always been attended by a diminution of the loss rapidly, and in a few months the cessation, except when other causes for hæmorrhage, as fibroids, abrasions, etc., coexisted. An exception also must be mentioned, namely, that the first period after restoration is more free not infrequently, although the second shows clear signs of abatement. This is probably owing to the ease with which the fluid can escape from the uterus now in normal position, while the causes of the hæmorrhage in the uterus are not yet much lessened.

I may add that, in restoring the uterus enlarged and tender, I do not employ the sound, at least very rarely. By gently lifting up the fundus out of Douglas's pouch (in which it is somewhat firmly retained by the recto-uterine ligaments, as shown by Dr. John Williams) by the finger introduced by vagina or rectum, and hooking down the os, assisted by the supine posture, and then introducing a Hodge's pessary, I have generally succeeded in bringing the fundus into its natural position.

If abrasions be present at the first, I generally reduce the uterus and wait a little time; if the abrasions be not cured, I apply the usual remedies. However, we may, in the less irritable organs, apply them earlier, the pessary remaining *in situ* or removed each time. Frequently, however, the abrasions and catarrh pass off as the general improvement takes place.

If the facts which I have noted agree with the experience of others, which I think to a large extent they do, then it may be laid down, as a rule of practice, that notwithstanding the tender and bulky state of the uterus we may, when we find it retroflected, especially associated with metrorrhagia, without fear restore it at once to position, and employ a Hodge's pessary to retain it there. If the restoration be difficult to complete at once, the uterus still inclining somewhat backwards, it will, so far as I have noted, fall into its place shortly by the action of the pessary, assisted by the various movements of the body. If the patient complain of uneasiness, it is very easy to neutralise all pressure

by the adoption of the horizontal posture, assisted by the prone position. If this be carried out for a few days, I have found that the uterus tolerates the instrument well, for in a short time the sensitiveness is lessened by the restored position as before mentioned. Of course, sometimes the uterus is adherent in its retroflected state; care must, therefore, be taken lest we carry on our attempts at restoration too vigorously. Gentle tentative trials should, of course, be made at commencement.

I need hardly point out that care must also be taken in our diagnosis, lest we mistake retro-uterine hæmatocele for the bulky tender retroflected fundus. I may give one case, as illustrative of the advantage of at once restoring the uterus to its normal place in severe hæmorrhage.

A. B., married, mother of six children, was admitted under me into Guy's Hospital, April 4th of this year, in consequence of very severe uterine hæmorrhage, which led her medical man to suspect malignant disease. She was very exhausted and blanched. The history of the case was as follows. She menstruated regularly up till last November. After this, she saw nothing for nine weeks, when severe hæmorrhage set in, but it was shortly checked. She kept her bed for three weeks, but upon getting up the bleeding at once returned, and continued daily up to the time of admission, being very profuse whenever she exerted herself, altogether having had nine or ten severe hæmorrhages. I found the cervix patulous, more anterior than normal, with a swelling behind. This proved to be the body of the uterus, retroflected, somewhat more bulky than normal. I essayed to restore the uterus to its proper position; but the bleeding which took place, on the use of the sound, was so profuse that I had to desist, and plug the os with a sponge-tent. After ten minutes, this was removed and the bleeding was found to be arrested. I then introduced a Hodge's pessary, which, assisted by digital pressure on the fundus *per vaginam*, restored the organ. A dose of ergot was then given. The bleeding at once ceased, with the exception of a slight flow for three days, followed by a little watery discharge. She gradually regained strength and colour, and finally menstruated normally on May 13th, about five weeks after her admission. To the present time, she has continued regular. She had only one drawback from rapid recovery, a slight local inflammation of two of the veins in her legs.

CASE OF INDURATED MEDIASTINO-PERICARDITIS.

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BAUER, in his article upon Diseases of the Pericardium in Von Ziemssen's *Cyclopædia of Medicine*, relates some interesting cases of indurated mediastino-pericarditis: I propose to give an abbreviated account of a case which has been under my care.

Ellen B., aged 20, a delicate-looking girl of blonde complexion, and below the middle height, by occupation a shirt-maker, was admitted as a patient under my care at the Eastern Dispensary on August 21st, 1873. A year previously, she had been under treatment at the dispensary for pleurisy of her right side; there was no effusion. For the past three months, she had been losing flesh, and had ceased to menstruate. On August 16th, she gave up work on account of pain in her chest. She looked very ill; the expression of her countenance was anxious; the skin feverish; pulse quick; tongue dry, with the edges and tip very red; the dorsum covered by a yellowish white fur. She had anorexia and thirst. The bowels were loose; the urine was of specific gravity 1020; no albumen. There was no sign of any pulmonary mischief. The heart's apex could be felt between the fifth and sixth ribs, half an inch inside the nipple-line. The vertical percussion-dulness began at the fourth left cartilage; on the right side, it extended over the fourth, fifth, and sixth cartilages; transversely on a level with the fourth rib, it commenced nearly an inch to the right of the sternum and ended just within the left nipple-line. On auscultation, loud grating friction could be heard all over the præcordial region. The hepatic and splenic dulness were normal.

From this date, all the usual symptoms of enteric fever gradually declared themselves; raw-beef tongue; bowels loose, four or five evacuations daily; abdomen tub-shaped; tenderness and gurgling in the ileo-cæcal region; pink spots disappearing under pressure on the abdomen and chest; sudamina; increased area of dulness over the spleen, which eventually projected two inches and a half from the left costal margin, and was markedly tender when handled. This occurred when there were signs of effusion into the left pleural cavity. In addition to

this left pleural effusion, there was every evidence of pericardial effusion, undulatory impulse, triangular-shaped dullness, the blunt apex of the triangle reaching as high as the second left interspace; the heart's sounds were muffled; there was cessation of friction; the respirations were hurried; the cough hacking; there was no expectoration. She had also an ulcer with a yellowish white floor on her right tonsil, and there was some enlargement and tenderness of the cervical glands at the bifurcation of her right carotid artery. Her temperature attained its maximum on August 24th, when it reached 104.4 deg. Fahr. Her pulse was small and feeble, ranging between 120 and 130. She wandered in her sleep, and her pupils were dilated. By September 17th, the signs of effusion into her pericardium and left pleural cavity were fast disappearing; grating friction could be heard in the left axillary and infrascapular regions, and loud rumbling friction all over the præcordial region. Her general symptoms improved from this time: the bowels were no longer loose; the tongue cleaned and became moist, and she was able to sit up in bed. On November 6th, the temperature was 100.4 deg. Fahr.; it varied from 99 deg. to 100 deg. Fahr. up to her death. She now got pleurisy of the right side.

During the early part of December, oedema of the ankles set in; this extended up her legs, and by the end of the month, there were signs of some fluid in her abdomen. At this period, I found, on examining her chest, the following condition. The heart's apex was nowhere to be seen or felt; the præcordial dullness was pyramidal, commencing above at the second left interspace; it extended on the right side downwards and outwards to within an inch of the right nipple; transversely, it reached from this point to the left nipple. There was no alteration of the area of dullness during a full inspiration. The heart's sounds were of regular rhythm, uncomplicated but extremely feeble; there was no increase in their strength as the stethoscope was carried up the sternum. Her jugular veins, more especially the right, were turgid and pulsated slightly; on pressing one's finger up the vein and making the patient hold her breath, there was no filling of the vein from below; but, on relaxing the pressure and telling her to take a deep inspiration, it became immediately distended. Her pulse was between 120 and 130, remarkably feeble in character; a full inspiration almost completely extinguished it. Her respirations were short and hurried; there was still some dullness in the right mammary and lower part of the axillary and infrascapular regions, with weak respiration and here and there crepitation. The lower border of the liver could be felt two finger-breadths below the right costal margin in the vertical nipple-line. The spleen, as far as could be ascertained by percussion, had resumed its normal size and position.

By January 26th, the ascites had greatly increased in amount; there was no oedema of the head, neck, or chest; the urine became albuminous. On February 27th, paracentesis of the abdomen was performed by Dr. Cameron, the resident medical officer to the dispensary, and eleven quarts of greenish yellow highly albuminous fluid were drawn off. On February 28th, the temperature was 100 deg. Fahr.; pulse 104. She had some tenderness at the seat of puncture. Her appetite was good; she passed more urine, which was no longer albuminous. The fluid rapidly reaccumulated in her abdomen; but she declined any further operation for its relief. On March 23rd, she died.

The appearances found after death were as follows. The pericardium, which was enormously thickened, was firmly attached by tough connective tissue to both lungs, the diaphragm, anterior chest-wall, and lower dorsal vertebræ; it was so closely adherent to the heart as to completely obliterate all trace of pericardial cavity. The heart was a little enlarged; the left cavities and valves were normal; the right ventricle was somewhat dilated, and the tricuspid orifice more patulous than usual; the muscular substance of the heart was palish in colour, but it was not examined microscopically. There was apparently no diminution in the lumen of any of the large vessels. Both lungs, besides being tightly attached to the pericardium, were more or less adherent by their lower lobes to the chest-walls; there was some fluid in the right pleural cavity. Both lower lobes of the lungs were somewhat congested and oedematous. I could find no trace of tubercle anywhere. The peritoneal cavity contained several quarts of greenish yellow serum. The omentum was studded with miliary tubercle; the liver was enlarged, and presented a nutmeg appearance upon section; the spleen was of natural size; its capsule was thickened. The kidneys were healthy. The other organs were not examined.

This case, both in its clinical features and in the appearances disclosed on dissection, tallies exactly with the description given by Bauer. In all these cases, the physical signs have been increased area of cardiac dullness, indistinct apex-beat, muffled heart-sounds, a small feeble pulse, weakened, and, in some cases, completely extinguished by a full inspiration—the "paradoxical pulse". I may remark that diminution, amounting in some cases to complete extinction, of the radial pulse

was pointed out by Dr. C. J. B. Williams, in the *London Journal of Medicine* for April 1850, as present in advanced stages of pericarditis and adhesion of the pericardium. Lastly, and what may be considered perhaps the pathognomonic sign of all, there was swelling of the cervical veins during a full inspiration.

CASE OF HYDATID TUMOUR OF THE LEFT KIDNEY SUCCESSFULLY TREATED BY ASPIRATION.*

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CASES of hydatid tumour of the kidneys are of such rare occurrence, and their diagnosis and treatment are often attended with so much difficulty, that the following case appears worthy of being brought before the Medical Section of this Association.

Henry Whitbread, aged 8, living at Gamlingay, in Cambridgeshire, was admitted into Addenbrooke's Hospital, on July 5th, 1876, under my care. He was a sharp intelligent looking boy, and rather thin. His only complaint was of an enlarged abdomen. A large tense elastic swelling occupied almost the whole of the left half of the abdomen, which was absolutely dull on percussion. No distinct edges could be felt to the tumour, which was not, however, perfectly smooth and regular, since two slight localised swellings were found on its anterior surface. Superiorly, the percussion-dullness reached to within one inch and a half of the nipple in the nipple-line, and, tracing it to the right, it became separated from the liver-dullness (right lobe) by a band of well marked resonance. It then passed down, about one inch and a half to two inches to the right of the mesial line, and lost itself below in the dullness of the (full) bladder. On tracing it to the left, the dullness reached as high as the seventh rib in the axillary line, but at this level it did not quite extend to the spine. The whole of the left hypochondrium was filled with the tumour, and there was complete dullness down to Poupart's ligament. The percussion was tympanitic over the rest of the abdomen not occupied by the tumour. At the upper part of the tumour, the "repercussion thrill" could be obtained.

The heart's apex beat immediately beneath the nipple, just under the fourth rib. The heart- and lung-sounds and the urine were normal. The liver was also normal. On July 6th, I introduced the needle of an aspirator into the tumour, and drew off forty-four ounces of hydatid fluid. No hooklets were found in the fluid. After the operation, the boy vomited several times, his pulse became quick (140 to 150), and the following day he had an eruption of urticaria, which lasted till July 8th. The temperature on July 7th was 102.4 deg. Fahr., but at no time did it exceed this point. On July 10th, the boy was progressing favourably; there was no tenderness over the tumour, but the urine was found to contain albumen, due to the presence of pus.

July 13th. The descending colon was found to be displaced towards the right side, and to run obliquely from the neighbourhood of the xiphoid cartilage to the left iliac fossa.

July 15th. The urine still contained pus. The abdomen was enlarging again. When the boy was made to sit up in bed, he complained of pain in the loins, and four of the lumbar spines were found to be prominent, and the skin over them reddened. They were very painful on pressure. The pain in the back continuing, it was decided to aspirate the tumour again on July 16th, and this was done by Dr. Humphry under the influence of chloroform. Thirty-one ounces and a half of a greenish opalescent fluid were withdrawn, which, in the latter stage of the operation, was flaky and apparently purulent. After standing, the fluid deposited two ounces of pus. Under the microscope, pus-cells and the heads of numerous echinococci armed with hooklets were detected. He vomited again several times after the operation, but no urticaria followed the second puncture, as is invariably the case so far as my experience goes. There was a slight fall of temperature after the second aspiration, which was permanent, the temperature only on one occasion exceeding 100 deg. Fahr.

On July 25th and 26th, small cysts with hooklets were found in the urinary sediment. From this time, the patient became gradually better. The pain in the loins and tenderness over the vertebræ became less and less, and the urine deposited less pus. The descending colon also assumed its normal position. On several occasions, echinococci were found in the pus, and also a few hyaline casts. The boy was made an

* Read in the Section of Medicine at the Annual Meeting of the British Medical Association in Manchester, August 1877.