CASE XI.—M., aged 28, has been married four years. Between eighteen months and two years before marriage, he had a primary sore and urethral discharge, which healed under treatment in three months. No constitutional symptoms followed.—F., aged 22, has suffered since marriage from general debility; but no distinct symptoms of syphilis have shown themselves.—The first child, at the age of four weeks, exhibited well marked syphilitic symptoms, nasal discharge and snuffling, superficial cracks round the nose and mouth, slight coppery tinge of the skin, and spots on the abdomen.

CASE OF PLEURITIC EFFUSION: PARACENTESIS THREE TIMES: DEATH: NECROPSY.*

By W. MAKEIG JONES, M.R.C.S. Eng.,
Late House-Surgeon to the Rotherham Hospital.

FOR permission to report the following case I am indebted to Mr. B. Walker, Surgeon to the Rotherham Hospital.

G. M., aged 30, male, unmarried, was a tall fine made man, and had served nine years in the Indian army. He had enjoyed good health till three months ago, when he had an attack of acute pleurisy. Not recovering from this, and being in poor circumstances, he came under my care as an out-patient, and was attended at his own home.

On May 27th, 1877, when I first saw him, he was lying on his back in bed, nearly exhausted, and almost cyanotic. His respirations were very frequent, and he had a constant short hacking cough. His finger nails were clubbed. His tongue was foul, and he gave a history of profuse night sweats for some time past. On examining his chest, the right side measured eighteen inches, and was superresonant on percussion. The cardiac impulse was to the right of the right nipple line. The left side measured twenty-one inches, was absolutely dull on percussion, and no breathing sounds could be heard. The chest-wall on the left was so swollen and oedematous, that it was impossible to feel the ribs. Knowing what was the matter with him, I had taken the aspirator with me, and at once proceeded to tap him somewhere about the angle of the scapula. I used a large needle, but, although the chest wall was so oedematous, the fluid withdrawn was clear serum. It measured thirty-five ounces. The upper portion of the lung expanded at once, and the heart's apex moved close to the right of the sternum. On the next day, a succussion-splash could easily be obtained, but this soon cleared off, and he nearly recovered and was able to walk about. In about a fortnight's time, however, it began to fill again; and, on June 19th, 1877, he was in much the same state as when I first saw him. I again tapped him, and this time drew off one hundred and forty ounces of clear serum. The cardiac impulse returned to its normal site, but the lung appeared to expand very slightly. He recovered in a few days, and used to walk out; but, on July 18th, 1877, I had again to tap him, drawing off forty ounces of clear dark serum. The cardiac impulse again returned to its normal site, but no breathing sounds whatever could be heard over the left lung. On visiting him the next day, he had gone out for a walk. On July 26th, 1877, he was seized with vomiting, and his urine was nearly suppressed. It was of a high specific gravity, acid, but contained no albumen. Symptoms of uræmia soon developed, he became comatose, and died on August 3rd, 1877.

A necropsy was made on August 4th, 1877, when both kidneys were found on section intensely congested, the smaller vessels in both portions standing out as dark lines; the other abdominal organs were healthy. On opening the chest, the heart was seen lying in the right side of the thorax with its apex under the right nipple line. The tricuspid and mitral valves were covered with recent lymph. The apex of the right lung was tuberculous. The left pleural cavity contained several pints of clear serum. There were a few long stringy adhesions in some parts. The costal pleura was slightly thickened where the puncture had been made, but was otherwise apparently healthy. The whole of the left lung was compressed into a carnified mass about the size of the palm of a hand. Its pleura was covered with about a quarter of an-inch thickness of tough leathery lymph, which must have prevented the lung from expanding. The head was not allowed to be opened.

REMARKS.—There are two points worthy of notice in this case. 1. Although the left side of the chest was cedematous, the fluid was not purulent. 2. If, after the first tapping, iodine had been injected or a drainage-tube inserted, the patient might have recovered. Either would have been useless after the subsequent tapping, as the lung was then incapable of expansion.

* Read before the Sheffield Medico-Chirurgical Society.

DISARTICULATION AT THE HIP.

By T. F. CHAVASSE, M.B. Edin.,
Assistant-Surgeon to the General Hospital, Birmingham.

THE BRITISH MEDICAL JOURNAL for April 27th contains the report of a discussion which has recently taken place, at the French Academy of Medicine, upon amputation at the hip-joint, the subject being introduced by a paper of M. Verneuil. In that communication, the eminent Parisian surgeon advocates driving back into the general circulation, by means of Esmarch's bandage, the blood contained in the limbs; and says that the operation itself should be performed by means of lateral flaps, a tedious dissection being undertaken as though removing a tumour, and all the blood-vessels ligatured before division. By these means, it is thought to procure a nearly bloodless operation, and, by facilitating the after-drainage of the wound, to render blood-poisoning less likely to occur.

What I conceive to be the best method of preventing hæmorrhage in this operation is compression of the aorta, not by the tourniquet, but by folded towels, or a pincushion, placed over the vessel, and a strong India-rubber band encircling the abdomen. Previously to this application, three or four turns with the elastic bandage should be made at the upper part of the sound thigh, to prevent egress of the contained blood until all is finished; thus constituting a sort of reservoir in the limb. On the affected side, if the operation be for malignant disease, it is better merely to elevate, and to allow the blood to gravitate, than to thoroughly empty the limb by the bandage. The blood contained should certainly not be driven out of both limbs, or, from the excessive engorgement of the internal viscera thus caused, the brain and lungs amongst the rest, unlooked for complications may arise for which the anæsthetic may be blamed.

By following M. Verneuil's particular method of operating, I must confess I cannot see any advantage to be gained. By a dexterous manipulator, the operation generally in vogue amongst English surgeons, viz., by transfixion, can be accomplished in from ten to thirty seconds, and a few minutes will suffice for securing all the important vessels. M. Verneuil's plan occupies at least half an hour, and so probably the danger from shock is increased. Mr. Spence, who, in this particular operation, has had more experience than falls to the lot of most surgeons, having performed twelve disarticulations at the hip with five successes, one of them being a primary for a machinery accident, remarks, in his *Lectures on Surgery*, vol. ii (second edition): "I have no hesitation in saying that, from my own experience, rapidity of execution in this operation is of great importance, as diminishing the risk from shock and loss of blood."

Ligaturing each vessel before it is cut, to prevent loss of blood, is unnecessary; for, in Mr. Spence's last case, at which I had the pleasure of assisting him, the operation was performed, as a last resource, upon a man with a very large malignant sarcoma of the femur; the veins of the limb were dilated to thrice their natural size. By compressing the aorta with a pincushion and India-rubber band, not more than two ounces of blood were lost altogether. The bleeding that did occur was nearly all from the large femoral vein, which had not been securely enough ligatured before the compress was removed.

Upon reference, I find that M. Verneuil advocated his operation at the Academy upon the strength of one successful case in which it had been performed. The plan of dressing that this surgeon recommends (*à la Lister modifié*) is not of the highest importance, as, by cutting the posterior flap carefully from without inwards, the edge of the wound need not, as Bell has shown, be so near the rectum but that the proper antiseptic precautions may be taken, putrefaction avoided, and free drainage effected.

ABNORMALITIES OF THE HEART IN AN EPILEPTIC PATIENT.*

By GEORGE J. HEARDER, M.D.,
Medical Superintendent of the Joint Counties Lunatic Asylum, Carmarthen.

E. G., AGED 44, was admitted January 27th, 1873, demented and subject to epilepsy. She had been deserted by her husband on account of her intemperate habits. Her height was fifty-seven inches; her weight one hundred and one pounds. The cardiac impulse was increased in force and area. A loud rough systolic murmur was audible, most distinctly in the line of the sternum, and was prolonged in the course of the great vessels. The radial pulses were very feeble, the left being

* Read before the South Wales and Monmouthshire Branch.