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 I used a large needle, but, although the chest wall was so oedematous, the fluid withdrawn was clear serum.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.

decidedly the weaker. There was visible arterial pulsation across the neck just above the sternum. The pupils were equal and sensitive. She was certified to be suffering from aortic valvular disease. The epileptic attacks, which averaged five a week, were complicated by syncopal symptoms; and she was, therefore, carefully watched, as sudden death was apprehended.

On January 21st, 1878—as on several previous occasions—the medical officers were sent for, as the patient was suffering from a fit of longer than usual duration, and death from syncope appeared imminent. She rallied from this attack; but on the following morning, while standing speaking to a nurse, she fell dead.

The body was examined twenty-four hours after death. The heart weighed twelve ounces. There was a white patch of the size of a shilling on the right ventricle, and another of the same size in front just above the apex. All the cardiac cavities were full of blood. The muscular substance was pale, very soft, and easily torn by digital pressure. Both ventricles were dilated, and the left was also considerably hypertrophied. The aortic valves were competent. The aortic opening was seven-eighths of an inch in diameter; the mitral opening one inch and an eighth; the pulmonary one inch and a quarter; the tricuspid one inch and a half. There were patches of atheroma on the inner surface of the aorta; the free edges of the valve were thickened; and there were calcareous spicula in the attached edges. The aortic valve consisted of only two segments; the anterior being the larger and covering the origin of both coronary arteries; the segments were thickened and somewhat sacculated. The two posterior segments of the pulmonary valve were joined together by their contiguous free edges as far as each corpus Arantii; therefore, the pulmonary valve, as well as the aortic, consisted practically of only two segments. The ductus arteriosus was patent, the opening being one-eighth of an inch in diameter. The innominate and the left carotid arteries arose from the aorta by a common trunk; the carotid crossing the neck at the level of the upper edge of the sternum.

CASE OF HIGH TEMPERATURE AFTER PARTURITION: TREATED WITH WARBURG'S TINCTURE.

By J. BURNLEY WALKER, M.D., Golcar, Huddersfield.

It has occurred to me that the following brief notes may not only serve as a fitting sequel to the interesting case published by Dr. Playfair, at page 687 of volume ii of last year's JOURNAL, but may also be a guide to the treatment of a class of cases which unhappily are but too common in general practice, and, from the attendant circumstances, probably cause more anxiety to the family practitioner than any other.

Mrs. A. B., aged 42, a spare delicate woman, was confined of her sixth child on January 9th, 1878. The labour was in every respect a natural one, and not attended with more than ordinary difficulty. On the second day after delivery, she complained of a creeping sensation, commencing at the feet and travelling to the face, accompanied by intense throbbing headache, which was followed by burning, flushed face, and extreme thirst. On palpating the abdomen, there was a little tenderness to the left of the uterus. The lochia were offensive, and lactation had ceased. This state of things existed (accompanied with insomnia) for several days; the temperature fluctuated from 101 deg. to 104 deg., with no distinct regularity, except that the afternoon temperature was always the highest. The pulse ranged from 110 to 120. The tongue was dry, fissured, and "leathery".

Without detailing particulars from day to day, I may say that, on January 26th, at 11 A.M., I found her much worse. Temperature 104.8 deg.; pulse 120. The patient was obliged to lie on her back, and could with difficulty speak. The breathing was hurried and shallow. There were continual "creepings" (no distinct rigor). There was no pneumonia. On examination, the uterus was found to be fixed as by adhesions, and on the left side there was considerable tenderness to the touch. I ordered her fifteen grains of salicylate of soda every two hours, and one ounce of brandy every three hours, in addition to milk, eggs, and beef-tea. By the time three doses of the salicylate had been taken, the temperature had fallen to 98.6 deg. and the pulse to 88. The breathing was much slower; there were no creepings; the thirst had gone; and the tongue was moist, while there was profuse diaphoresis.

The cure, however, had produced more discomfort than the disease; there was deafness, with distressing noises in the head, which the patient described as intolerable.

On my visit next morning, I found the temperature had risen to

104.8 deg. and the pulse to 132. There was increased tenderness on palpating the abdomen, with some tympanites; the breathing was again hurried and oppressed. The patient's condition was now so critical that I suggested a consultation, and at noon Dr. Clarke of Huddersfield saw the case with me. At his suggestion, I prescribed half an ounce of Warburg's tincture; no food having been taken for an hour previous to its administration. Failing this remedy to reduce the temperature, we determined upon resorting to cold affusion. However, the administration of the tincture was immediately followed by profuse perspiration and refreshing sleep. At 8 P.M., the temperature had sunk to 98.6 deg. and the pulse to 100. The frequency of the respiration had correspondingly diminished. The patient expressed herself very much relieved; she could now lie on her side and sleep for two or more hours at once. I ordered three drachms of the tincture to be given during the night, and one ounce of brandy every hour, as the consequent exhaustion was so marked. Since this, the case has had no untoward symptom. The pulse and temperature remain normal, while the abdominal tenderness has entirely disappeared.

This case needs no comment. The immediate improvement was so marked that, I have no doubt, this patient's life was saved by the timely administration of "Warburg". The case has this additional interest: that cold affusion was not employed, as in Dr. Playfair's; hence more reliance may be placed on the value of the drug, which, since the publication of its formula by Dr. Broadbent, should now no longer rank in the list of quack medicines, but should be added to the armamentarium of every practitioner.

CLINICAL MEMORANDA.

CROUP: DIPHTHERIA.

ON re-reading Dr. Johnson's letter (*Lancet*, February 16th) by the light of his last, in the BRITISH MEDICAL JOURNAL of June 1st, I can readily see how I should have so misapprehended Dr. Johnson's intention; but still, as his views are at present not my views, and as he did not say, but only "meant to say that the membranous exudation which characterises diphtheria, when not the result of direct contagion from a previous sufferer, is caused by a drain-poison", he will the more readily pardon my unintentional misconstruction. Since, however, my misapprehension has elicited from Dr. Johnson so clear and explicit a definition of the point at issue, I regret it the less. And, as the final settlement of this important practical question is the end and object of us all, I hope Dr. Johnson will forgive me, if, notwithstanding his last letter, I still have the hardihood to contend that "a false membrane which has resulted from infection by a drain-poison" may not be diphtheria. It is possible, as stated by Dr. Johnson, "that, in the absence of direct contagion, the occurrence of membranous pharyngitis or laryngitis affords conclusive evidence of infection by sewage-poison conveyed through either air or water"; but I am quite unable to admit that the single pathological symptom "false membrane" always means diphtheria.

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VARICELLA OCCURRING IN AN INFANT TWENTY-FOUR HOURS AFTER BIRTH.

ON March 17th, 1878, I attended Mrs. M. in her seventh accouchement. On visiting her the next morning, the nurse drew my attention to the child, "who had a rash coming out"; its body was quite clear from any eruption at birth. I found a well-formed vesicle on one wrist, also several red papulæ on the face and forehead. The following day, another crop of vesicles and papules appeared, and the illness ran the usual course of a case of chicken-pox, lasting about ten days, the infant passing through the ordeal nicely. The mother was free from any vesicular rash, and had had no symptoms of illness whatever; but the other children, six in number, were suffering from chicken-pox in its various stages. Now, I believe the incubation in varicella is from three to four days, with a premonitory fever lasting from twenty-four to seventy-four hours, when the rash appears; how, then, are we to account for a child in so few hours from its birth contracting this disease? Either it must have been peculiarly susceptible to the above contagion, and the usual period of incubation and primary fever was wanting, or else the infection was conveyed through the parent to the foetus *in utero*. I must add that the child had not been taken from, neither had the other children been admitted into, the lying-in room. This case will do away with the theory, held by some of the older physicians, that varicella only occurs in the vaccinated.

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