September 28th, 1872, mentions a number of diseases which arise from water so contaminated. Among others, he names goitre, cretification of the arteries and valves of the heart, rheumatic arthritis, and calcareous deposits in various organs. In this district, anæmia is soon produced, when young females, especially from the South of England, come to reside here. This is a most frequent occurrence among the domestic servants of the neighbourhood. The majority of the young girls, living in the small farm-houses scattered over the moors and in the sequestered valleys, are highly anæmic in appearance, and are often under treatment for that condition.

Pregnancy has a powerful effect on goitre. Many bronchocèles appear during the first pregnancy, or are noticed immediately after the first labour; the popular notion being that the swelling is due to the exertion of bearing down during the expulsion of the child in delivery. An eminent continental observer has shown that, in pregnancy, there is enlargement of the thyroid gland; there are fewer red blood-corpuscles, and there is a watery state of the blood; the tone of the system is reduced, as in those who show a goitre from bad hygienic conditions or surroundings. The thyroid is a vascular organ; and those causes which reduce the tone of the system reduce the tone of the vaso-motor nervous system and dilate the vessels: thus the circulation is rendered slower. This allows exudation of white cells to take place into its tissue, and produces degeneration of the thyroid gland. Many goitres disappear after the climacteric period.

The results of these observations may be summed up as follows.

1. The water-supply in limestone districts has a powerful influence in deteriorating the blood, causing dyspepsia, anæmia, and a want of contractile power in the blood-vessels, as shown by the development of goitre and tendency to hæmorrhages, more especially flooding in childhood.
2. Goitre and the hæmorrhagic tendency are aggravated, and sometimes even produced, by certain conditions: *e.g.*, overcrowding, bad ventilation, and damp dwellings.
3. Pregnancy assists in the development of goitre and the hæmorrhagic tendency.
4. The predisposition to goitre and "flooding" is affected by consanguinity and heredity.
5. The best treatment for both conditions is change of locality, and the prolonged administration of some preparation of iron.

CASE OF RETENTION OF MENSTRUAL FLUID IN THE FALLOPIAN TUBE: A REPLY TO DR. HARLEY.

By LAWSON TAIT, F.R.C.S.

I AM quite satisfied to accept Dr. Harley's criticisms in the spirit in which they are offered; but I greatly regret that he did not more fully investigate the subject before he made them. For what he is pleased to call his "speling", I trust he has better arguments.

First of all, he asserts that no menstrual fluid (proper) is secreted by the Fallopian tubes. Dr. Harley jumps to this conclusion, because he found no menstrual fluid in the tubes of a woman who was not menstruating, but only on the point of doing so. I have, on the contrary, more than once seen menstrual fluid in the tubes of women who have died during menstruation, though I am by no means certain that this is a constant phenomenon, as I can recall two instances where it was looked for and not found. On page 1 of the Sydenham Society's translation of Bernutz and Goupil's *Diseases of Women*, the following sentence may be found; and, so far as I have seen, Dr. Harley stands alone in his opposition to the view it expresses concerning the share the Fallopian tubes have in menstruation: "Soon the cavity of the tubes is dilated by a bloody mucus, which mixes in the uterus with the blood exhaled by its cavity, now lined by an imperfect decidua, and then escapes by the open cervix."

Besides this, we sometimes see menstrual fluid poured from the divided end of a Fallopian tube after ovariectomy. A few months ago, I was obliged to operate on a woman during menstruation, and, for reasons irrelevant here, I did not include the tube in the clamp. For several days after the operation, menstrual blood flowed from the tube in considerable quantity. Dr. Harley's division of menstrual fluid into "proper" and (by inference) "improper", I do not profess to understand. I am quite content with the evidence I have met with, that the Fallopian tubes, in at least some instances, contribute towards what is usually recognised as the menstrual fluid.

That my patient is not the subject of bifid uterus I am quite certain; and for this I have the evidence of my two hands, between which

I had the organ, after I had performed abdominal section. Even if the uterus had been bifid, the case would have been quite within the category in which I placed it, as I am sure Dr. Harley's knowledge of comparative anatomy will enable him to see. The point made by my critic, to the effect that it could not have been the Fallopian tube, because the wall of the cyst contained an abundance of unstriated muscular fibre, must be really amusing to any one familiar with Dr. Arthur Farre's observations. We all know that muscular cavities, when distended by such a condition as I suppose to have taken place in this Fallopian tube, have their walls hypertrophied, and that, when emptied, their walls contract vigorously; and, therefore, it was not surprising that the cyst contracted after being emptied. That I could not find a canal leading into the uterus was probably due to the closure of the aperture, as I suggested in my paper. If it had been a double uterus, I should have expected the cavity to run down for some distance alongside the other undilated half. But it did not. The cyst had an intimate relation to the cornu of a perfectly normal uterus; and this it was which chiefly led me to recognise at once that I was dealing with a dilated Fallopian tube.

I said, at the conclusion of my short and perhaps inadequate account of the case, that the recovery of the patient left a good deal to speculation; but certainly, what is so left does not include any of the points raised by Dr. Harley, and this he may easily satisfy himself upon by consulting the literature of the subject. Thus I may direct his attention to a case published by no less an authority than Dr. Meadows, in the eighth volume of the *Obstetrical Society's Transactions*, in which the conditions seem to have closely resembled those in the case I published, with this difference only, that both tubes were affected instead of one; and that, by the death of the patient, an opportunity was afforded of ascertaining what the exact pathological conditions were. Here they are described: "It was found that both Fallopian tubes were enlarged, not regularly or uniformly, but so as to form a kind of cyst. On the right side, there were two such enlargements, on the other, one. There was no evidence of any communication between these dilatations and the fimbriated opening. On the left side, there was not even an opening into the uterus, the ostium uterinum being completely occluded. They were all filled with a dark, thick grumous fluid, of a prune-juice colour. It is evident that, in this case, we have an example of what MM. Bernutz and Goupil contend for, viz., menstrual retention within the Fallopian tube. The one fact which is clearly revealed is, that the Fallopian tubes do, as well as the uterus, take part in the menstrual secretion; and hence, when any obstruction occurs to the passage of that secretion into the uterine cavity, and so externally, we get the resulting symptoms of menstrual retention."

Other cases of an exactly, or nearly, similar kind are on record; but I am quite satisfied to rank with such observers as Bernutz, Goupil, and Meadows, even at the risk of Dr. Harley's criticism, by which I have in no way been induced to modify the title under which I published my case, or to alter in the least my views regarding it.

THERAPEUTIC MEMORANDA.

MILK AS A VEHICLE FOR QUININE.

It is not, I believe, generally known that milk is an elegant and convenient solvent for quinine, and that it disguises to a great extent its bitterness. If one grain of sulphate of quinine be dissolved in an ounce of milk, we shall find that the bitterness of the draught is hardly perceptible; with two grains there is rather more bitterness, but it is not at all marked. A dose of five grains may be taken in two ounces of milk without an unpleasantly bitter taste; and if the same quantity be put into a tumblerful of milk, the bitterness is all but lost. This method of administering quinine must in some cases be preferable to the ordinary way of dissolving it in acid or spirit, especially where the bitter taste is objected to (as in the case of children), or where the required dose is large; and it will, doubtless, be found to possess other advantages.

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GLYCERINE IN INTERNAL HÆMORRHOIDS.

AFTER reading Dr. David Young's paper in the January number of the *Practitioner*, which is referred to in the *BRITISH MEDICAL JOURNAL* of June 1st, I was anxious to make a trial of glycerine for this troublesome complaint. I have now used it three or four times, and each time its administration was followed by marked relief. Especially was the relief most observed in a young man aged twenty-one, suffering from advanced phthisis. This patient's life was rendered miserable for