hours after death, the body was found to be fat, and there was a small bruise under the left eye. The belly was somewhat prominent, but not hard. There was blood, both fluid and clotted, in the abdomen. The spleen had a long perpendicular rent on the inner side, extending from the hilus to the inferior border, where the rupture was the deepest. The organ was diseased; was of the consistence of thick cream; had a very delicate capsule, and weighed in its empty condition one pound and a half. No bruise could be found in the abdominal or chest-walls, nor on the skin of the chest or belly. A slight bruise was found beneath the skin of the left temple, but no corresponding mark on the skin itself.

I expressed an opinion, not forgetting Case No. 1, and taking all the evidence into consideration, that the spleen, in this instance, was ruptured by a sudden movement. The man was charged with a simple assault, and sentenced by the district magistrate to one month's imprisonment.

The second of these two cases is very similar, both in the circumstances under which it occurred and in the view taken of it by the legal authorities, to the celebrated Indian case which occasioned a collision between the executive government and the judges, and a reference to the Secretary of State.

Those interested in the subject of rupture of the spleen will find a large number of references in Dr. Norman Chevers's work on *Medical Jurisprudence in India*. He observes in a footnote: "Dr. J. W. Wilson suggests, with great reason, the probability that, however softened and congested it may be, the spleen never ruptures spontaneously, except under the action of muscular pressure, while the patient is turning or moving suddenly." Dr. Skeritt does not assign any reason for the anæmic condition which gave rise to the epistaxis and the passive hæmorrhage in the interior of the spleen, causing the bursting of its fibro-elastic tunic. The description of the case does not, perhaps, preclude the supposition that malarial poisoning may have been the cause. But the case would not on this account, I believe, be less unique. *Congestive apoplexy* (to use the phraseology employed in the official nomenclature of disease) of the spleen is common in chronic malarial poisoning, and predisposes a fragile spleen with a delicate capsule to rupture from slight causes. Dr. Skeritt's case, however, is the first instance of *sanguineous apoplexy*, either of a healthy or an unhealthy spleen, that has come to my notice. In the two cases related above, the cause of the rupture was probably the sudden concentration of the weight of the organ at the hilus or point of suspension, and the consequent giving way of the stretched and attenuated capsule. It is conceivable that such an accident might happen even in bed.

INTESTINAL OBSTRUCTION.

By EDWYN ANDREW, M.D., Shrewsbury.

IN the very able address of Mr. Jonathan Hutchinson on Obstruction of the Bowels, at the Bath meeting of the Association, he refers at some length to my case of malignant stricture of the colon.

From the brief time allowed to speakers, a mere outline of the case only was possible; but, judging from the purport of Mr. Hutchinson's remarks, this was evidently misleading, and requires further explanation. The patient, who generally treated himself, had been under my care occasionally during the previous two years for other affections (carbuncle, eczema, etc.), but had never referred to his bowels until the 1st of July last. On this date, he complained of pain and fulness over the cæcum, slight sickness, and diarrhoea, which he attributed to eating salmon. He said, on being questioned, that he had had one or two attacks before during the last three years, which were always relieved by a little aperient medicine; and that generally his bowels were quite regular, with solid motions.

On examination, there was found slight fulness over the cæcum, but little or no pain on pressure, no distension of the abdomen, and no abnormal symptoms, except coating of the tongue and loss of appetite. He was prescribed saline, with a little liquor bismuthi, prussic acid, and tincture of belladonna, and, should the pain return, to take pills of morphia and belladonna; to apply a fomentation with belladonna over the cæcum, and to be most careful in avoiding any indigestible food.

During the month of July, I saw him but seldom, as he said he was so much improved that he passed solid stools, which he did not permit me to see, in spite of my urgent request; but there was still slight cæcal pain and loss of appetite.

On July 28th, he called at my house with more cæcal pain, and vomited during his stay about three pints of almost fecal matter. He was sent to bed, and ordered to take pills of opium and bella-

donna, and effervescent saline, with hot fomentations. Several large gruel enemata, the first containing turpentine and croton-oil, were administered; soda-water, ice and milk, and, if exhausted, some spirits or wine, were ordered to be taken.

Under this treatment, although there was no action of the bowels, the pain and sickness gradually abated; but the abdomen slowly became distended from below upwards. The patient remained quite conscious, and cheerful and chatty to the last. The pulse was generally regular, and about 84; temperature normal; and good quantity of urine. Fæcal vomiting returned on the last day, and death was apparently the result of exhaustion. The diagnosis made was a stricture or impaction in the cæcum.

The *post mortem* examination was made a few hours after death, while the body was quite warm. The stricture was found just above the cæcum, a little higher than I had anticipated. The rest of the colon was quite empty, and the small intestines greatly distended, but not even congested, except near the cæcum, and containing a dirty fæcal-looking fluid (without any hardened masses), similar to what the patient had vomited, which fluid could not be forced on, even with much pressure, into the ascending colon on the other side of the stricture. The other structures of the abdomen appeared quite healthy.

Mr. Hutchinson, from an examination of the gut after slight decomposition had taken place, considered that the stricture was not very tight during life; that a hard mass of fæces had probably obstructed it; and that laxatives, by liquefying the fæces, would be better treatment than opiates.

With all deference, I cannot coincide in this opinion; for, as stated above, the contraction was sufficiently great a few hours after death to prevent fluid from passing, with considerable pressure. The ascending colon was entirely empty, and, on washing out the gut, no masses, at least of any size, were observed.

Opium also seemed to me here specially indicated to allay spasm of the muscular fibre of the bowel, and to give rest to that portion of the bowel where there was threatening perforation. My only doubt is whether I should have pushed it to a greater extent than to render the patient temporarily comfortable, and refused the effervescent saline, which he particularly begged for, and which may have tended to the fatal vomiting.

To sum up, whilst cordially acknowledging the very great value of the memoranda of treatment laid down by Mr. Hutchinson (in the JOURNAL of August 1st), still, speaking as a general practitioner, with one's disadvantages compared with a consulting hospital surgeon, and taking into consideration the surroundings and prejudices of patients, and the time at one's disposal, the treatment, I think, in the generality of cases, may be much more simplified. My own plan has been to make a probable diagnosis of the seat of obstruction, whether in the large or small intestine, from the history, sudden or gradual production, amount of pain, absence or frequency of vomiting, amount of urine, increase of pulse or temperature, and abdominal physical signs;—in acute cases, to avoid entirely aperients, and to endeavour to obtain physiological rest by pills of opium combined with belladonna; the more pain, the greater proportion of opium; the less, the more belladonna; and these continued, no matter the amount, until the constitutional effects are produced;—in chronic cases, to try first aperients, such as a pill of calomel, opium, and ipecacuanha at night, followed by a large dose of castor-oil early in the morning; this failing, two drops of croton-oil; these drops not producing relief are generally a test, by causing uneasiness and often vomiting, and show that further aperients must be discarded, and recourse had to opium and belladonna. In both cases, I use occasionally large enemata with O'Beirne's tube, if possible; if vomiting, frequent small nutritive enemata are given; if not, ice and milk by mouth; and the abdomen is gently kneaded with an oiled hand along the course of the colon.

The conjunction of opium and belladonna seems to me most happy. The latter seems to prevent the constipating effect of the former, and gives, in a large proportion of cases, rest and final strength to the bowel to expel its contents, even without aperients, when the condition of the bowel is such that it can be relieved without operation.

These drugs have generally been given in the form of coated pills by mouth, occasionally by hypodermic injection, the only objection to which is inconvenience and frequently intense vomiting; rarely by rectum, as it is often objected to by country patients, and, in my experience, this mode is less effective.

The susceptibility of patients with regard to belladonna so varies, and the extract is of such uncertain strength, that the dose required can only be judged of by the effects produced; and this explains the large doses of one practitioner compared with the small doses of another. In some cases, when under the influence of opium and belladonna,

constipation remains some time without any other bad symptom, the addition of a small quantity of watery extract of aloes to the above drugs; in others, small doses of sulphate of magnesia frequently repeated, have proved most effective, either being at once stopped on the return of any acute symptom.

By these means, most of my cases of obstruction have had a favourable termination. In those which have unhappily terminated fatally, the *post mortem* examinations have shown that abdominal taxis under ether (which I have never employed, although probably of the greatest use in exceptional cases) would have been useless, and that no further relief would have been possible, except by opening either the colon or the small bowel by operation.

In another paper, I hope to be able to give an analysis of a number of cases, also a new mode by which, I believe, obstruction of the colon may be more accurately diagnosed.

DROPSY OF THE AMNION SIMULATING OVARIAN TUMOUR.

By H. W. BODDY, M.B.Lond.,

Assistant-Physician to the Clinical Hospital for Women and Children, Manchester.

ON April 27th, Mrs. E. requested my attendance, complaining of what she thought was dropsy. She was a sallow and rather emaciated woman. She had already borne four children, and was advanced six months in her fifth pregnancy. She was in her usual health, and had gone on as in former pregnancies until about a month ago, when her abdomen began to enlarge rapidly. She was confined to bed. She said that within two or three days she had felt the movements of the child. On inspection, the abdomen appeared much and uniformly distended. On percussion, fluctuation was unusually distinct, showing the presence of fluid in large quantity. The umbilical and hypogastric regions were unduly prominent; both iliac regions were resonant to percussion, and there was dulness along the centre line of the abdomen. The heart was normal in its sounds. The urine was scanty, with much deposit of urates, but not albuminous. On vaginal examination, the os uteri was with difficulty reached by the finger; it was closed, and of usual size. The whole of the abdomen was occupied by the tumour; and the patient complained much of the dyspnoea and pain caused by the excessive abdominal distension.

My diagnosis at this stage was that of a large unilocular ovarian cyst, complicating pregnancy. A purgative and a diuretic mixture were given to increase the flow of urine.

At my next visit, the woman was out of bed, and able to go about, saying she felt much better,—evidently the result of the purgative and diuretic. Two days after this, however, she was again confined to bed, complaining greatly of the abdominal distension and pain. Next day, the patient complained of something like, though differing from, labour pains. I again made a vaginal examination. The os was slightly dilated, and the membranes protruding. With the finger of one hand within the vagina, fluctuation was distinctly felt when the abdomen was percussed with the other hand. The case then became clear as one of excessive dropsy of the amnion. I then punctured the membranes, and a very large quantity of fluid gradually drained away. Two days after this, labour set in; it was very lingering, lasting for a day and a half. The pains gradually became weaker and less frequent. I therefore applied the long forceps to the head, and completed delivery without much difficulty. The head was enormously hydrocephalic. The body and limbs were small, much as would be expected in a six months' foetus.

The lingering character of the labour was to be accounted for—1. By the difficulty of forcing an enlarged though soft head through the passages; 2. By there being so small a bulk of body and limbs for the uterus to contract upon; and 3. By the over-distension, as well as want of development, of the uterine muscular fibres, diminishing the propulsive power.

It appears to me that the diagnosis of dropsy of the amnion, though it occurs somewhat frequently, is not sufficiently insisted on, and, in fact, is hardly mentioned in our best text-books on midwifery and diseases of women. Very little, indeed hardly any, mention is made of it in either Barnes's, Playfair's, or Leishman's manuals. It cannot be an excessively rare disorder, as I myself know of four cases that have occurred.

The diagnosis of this disease is not very easy; for Dr. Kidd lately read a paper before the Dublin Obstetrical Society, in which he said he had tapped a case of amniotic dropsy through the abdominal walls, believing it to be an ovarian tumour, without bad result, for the patient recovered after the birth of dead twins, and has since had a normal

pregnancy. Still it would be desirable not to run the risk, by this operation, of possible extravasation of blood or other fluid into the peritoneum, and consequent peritonitis.

With ordinary care, the mistake of confounding this disease with ascites could not be made. A multilocular or solid ovarian tumour would also be distinguished from an over-distended uterus by the irregularities in its form. The greatest difficulty would be to distinguish this disorder from an ovarian monocus associated with pregnancy. The rapid growth of the tumour, and its always central position, would be means of distinguishing hydramnios; also, on vaginal examination, as Dr. Kidd says, the position of the uterus would help us, for in amniotic dropsy the os uteri is high up, while in ovarian tumour it is forced lower by the superincumbent mass.

Since writing out the previous case, I have seen, in the JOURNAL of September 7th, an account of another case of dropsy of the amnion by Dr. Hunt of Wolverhampton. It differs in several respects from mine, but the suggestion thrown out as to the cause of hydramnios seems a very probable one. The suggestion is that it is due to obstructed circulation through the umbilical cord and placenta.

As a rule, dropsy results from impeded circulation, and more especially impeded venous circulation; as, for instance, ascites results from obstruction, either to the portal vein itself or to its radicles within the liver. In an exactly analogous manner, disease of the umbilical cord, or of the placenta itself, would cause a transudation of serum through the amniotic covering of the cord and placenta, and so hydramnios would result. In my case, both placenta and cord were too soft and decomposed to give any information. There may have been some latent syphilis, as the husband had been twenty years a soldier, but there were no signs of it either in him or his wife. The four previous children are all quite healthy.

The phenomenon of hydrocephalus in the foetus was doubtless causally connected with the amniotic dropsy, resulting from venous congestion of the foetal arachnoid membrane.

ON CASES OF CEREBRAL TUMOUR AND OTHER FORMS OF BRAIN-DISEASE, WITH SPECIAL REFERENCE TO THE DOCTRINE OF LOCALISATION.*

By T. R. GLYNN, M.B.Lond., M.R.C.P.,

Physician to the Royal Infirmary, Liverpool.

THE cases to which I am about to direct your attention are, with one exception, cases of cerebral tumour which have recently come under my care, and in which I have had opportunities of making careful *post mortem* examinations.

The characters of the clinical phenomena which patients with cerebral tumours exhibit depend, in large measure, on the nature of the tumour; the rapidity of its growth; the existence or not of inflammatory action, or hæmorrhage, about it; the implication or not of membranes or of nerve-trunks; and also, and perhaps in larger measure, on the site occupied by the tumour, on its relation to convolutions and ganglia.

The extraordinary progress recently made in our knowledge of the structure and functions of the brain renders the study of the symptoms attending affections of different parts of it very interesting.

The first case to which I shall allude is not one of cerebral tumour, but of *embolic obstruction of the left posterior cerebral artery*. I refer to it, because it seems to me to afford authoritative evidence as to the nature of the functions of the posterior lobes of the brain.

CASE I.—John H., aged 36, was admitted into the Royal Infirmary on February 13th, 1877, suffering from advanced phthisis. He was an intelligent man, but weak and emaciated. He progressed favourably till March 1st, when I learned that his manner had become suddenly strangely altered, and his mind affected. I was told that he had got out of bed during the night, it is presumed to go to the urinal; while walking, he staggered and his right hand became clenched; a nurse went to him, and, with her assistance, he walked back to bed. He was fidgety and restless all night after this.

I found him lying on his back; his expression perfectly vacant, his eyes open, and directed as if looking at something on the opposite side of the ward. When spoken to, he did not turn his head or eyes in the direction of the speaker; a light passed before his eyes was not noticed; the pupils were normal in size; they contracted slowly when a light was held close to them. The left pupil was smaller than the right. When asked if he saw a lighted candle we held near him, he looked

* Read before the Medical Society of Liverpool.