CASE II.—Henry R., aged 32, potter, had suffered from debility, palpitation, and pains in the chest for several years. The symptoms came on after he had been employed in some heavy work. He had been troubled with cough for several months. Expectoration was muco-purulent, occasionally streaked with blood. He had lost flesh lately; no night-sweats. He never had rheumatic nor scarlet fever, nor any severe illness. The patient was pale and ill-nourished. The impulse of the heart was felt to the right of the sternum in the fourth and fifth interspaces. On percussion, the cardiac dulness was found to extend transversely from the left border of the sternum to about an inch within the right nipple-line at the level of the third interspace (see diagram). Over this area the heart-sounds were heard, sharp and

Henry R.—Area of Cardiac and Hepatic Dulness.

valvular; both sounded exactly alike. At the base, the first sound was faintly heard, the second was also rather feeble. Pulse 120, feeble. There was no dulness over the lungs; the respiratory sounds were harsh on both sides. Temperature normal. Nothing abnormal was detected in other parts of the body.

RECURRING FIBROID OF THE SKIN.

By H. T. BATCHELOR, M.R.C.S., L.R.C.P., L.S.A.,
Queenstown, Cape Colony.

THE following notes will be of interest if read by the light of a recent publication by Mr. Jonathan Hutchinson. Mr. Hutchinson there states, that, he has "never seen the recurring fibroid of the skin, on the upper extremities, on the head, nor, with one doubtful exception, on the upper part of the trunk." Supposing my diagnosis to be correct, the case I am about to relate will be one of recurring fibroid of the skin of the neck.

The patient, an elderly, spare man, with iron-grey hair, and dry skin, requested me to remove a small tumour from behind the ear. He told me it had been cut out by another medical practitioner twice within four months. The tumour was not large, not much bigger than a hazel nut, and my note of the operation runs, "removal of tumour from behind the ear, and two wart-like growths below it." The operation was done without an anæsthetic, and it appeared to me to be the simplest thing possible, to cut it out, in such a way that it would not return. The growth was distinctly in the skin; it could be taken up between the fingers of one hand as easily as a marble could be picked up, and it was felt to have no deep attachments. The removal was effected March 31st, 1885.

This man came back to me on June 2nd, 1885, when I again cut it out. He returned, November 8th, 1885, when it was removed for the last time by me. I have two of these growths in spirit. Each time the man presented himself the growth was larger. The measurements of the last are one inch and a quarter by length and breadth, irregularly round, and five-eighths of an inch in thickness. The last time I exposed the muscular structure of the sterno-mastoid in getting below it, and its situation corresponded with the apex of the mastoid process, and it invaded the posterior surface of the lobe of the ear. It began as a pimple, which the patient was in the habit of picking. He lived very much exposed to the heat of the sun, and wind and dust, in following his occupation. When last I saw him he was dressing it with an ointment, which had been recommended to him, as good for

cancers, and its surface was ulcerated, fungating and bleeding. After removal, it generally healed up quickly, and began again in the scar. The last time it began to grow from the centre of the wound, as a sprout, before healing was complete.

It caused little or no pain, and there was no enlargement of glands. It will be remarked then, that a small tumour situated in the skin, freely movable, was five times removed by two different surgeons during the space of eighteen months; and that, at first, it was about the size of a marble, and at the last time only measured one and a quarter inches in diameter; the position of the tumour being on the neck, just behind and below the ear.

After these ineffectual efforts on my part, I began to grow faint-hearted, and concluded that nothing short of amputation of the head would meet the case. The man himself also displayed an unwillingness to be "cut about" or "hacked about" any more, and as I did not feel justified in suggesting the major operation, the case stands thus:—he has his tumour and I cannot rid him of it.

ON THE MANAGEMENT OF INCOMPLETE ABORTION.

Read at the conjoint meeting of the East and West Sussex Districts of the South-Eastern Branch.

By ARTHUR W. EDIS, M.D.Lond., F.R.C.P.,

Obstetric Physician to the Middlesex Hospital; Physician to the Chelsea Hospital for Women, etc.

THE subject of incomplete abortion, or imperfect expulsion of the whole of the ovum, cannot fail to prove of interest to all who have to deal with the emergencies of general practice. The risk to the patient, whether from primary hæmorrhage or from septicæmia, is often very great; a fatal issue is by no means unfrequent, and even where this does not result, the general health may become seriously affected from the prolonged hæmorrhage, septic absorption, or uterine disorder ensuing in consequence. Apart from this, the anxiety experienced by the practitioner—the risk of his reputation suffering, even should he escape prosecution for malpraxis—renders the subject one of unusual importance, and, therefore, well worthy of consideration.

The consequences of incomplete abortion are far more serious than at first might be imagined. Many a young life has been prematurely cut short, the hopes of maternity blighted, or prolonged uterine trouble induced, in consequence of an early miscarriage, within a few months of the commencement of married life, not having been properly managed.

It will be beyond the scope of the present communication to allude even to the causation, symptoms, diagnosis, prophylaxis, or treatment of abortion generally. My remarks will be confined solely to the management of incomplete abortion, where the ovum has ruptured, the embryo been expelled only in part—the placenta, either entire or in fragments, being retained in utero, and giving rise to hæmorrhage or septicæmia in consequence.

The principle of early and complete evacuation of the contents of the uterus, where the vitality of the ovum has been destroyed, and abortion is inevitable, although generally accepted by everyone competent to give an opinion, is yet too often neglected in actual practice, and leads to the most calamitous results. The following cases will illustrate this.

M. T., aged 27, single. When first seen in consultation with her medical man, who had only been called in a few days previously, I found her lying in bed, on her back, with the knees drawn up, the abdomen tympanitic, very tender on the least pressure. The pulse was 144, very feeble; temperature 103.2° Fahr. The tongue was thickly coated, red at the edges, and inclined to be dry. She was delirious at times, but could be roused to answer questions. There was persistent fetid diarrhœa, constant sickness, and much pain complained of all over the abdomen. On vaginal examination, a sanious sanguineous discharge was found exuding from the os uteri, which was somewhat patulous. The uterus was enlarged, fairly mobile, retroverted. Thus far, no history had been obtained explaining her symptoms. Seeing that the patient was in a most critical condition, evidently suffering from septic peritonitis, I elicited from her paramour that she had had a miscarriage, procured some ten days previously by a midwife. She had missed two periods, and came up to town for the purpose of being set right. Two days afterwards, she had severe pain and profuse hæmorrhage, but I could get no well-marked history of any substance having passed. She became very feverish, and was compelled to keep in bed. It was not until nearly a week after this that a medical man was called in, and then he was told nothing beyond that she was losing blood.

The patient was too ill to bear much interference. The uterine

cavity was thoroughly irrigated with iodised water, quinine and opium administered, and every effort made to rally the patient; but she sank and died within twelve hours of my seeing her.

There can be no question that retained products of conception, decomposing within the uterus, had given rise to septic peritonitis. Had these been removed, and the case properly treated from the outset, the issue would, in all probability, have been different. One can but regret that skilled assistance had not been rendered until the patient's condition precluded any active treatment from being adopted.

In nulliparæ, where, after cessation of the catamenia for one or more periods, and the ordinary signs and symptoms of pregnancy exist, pain and hæmorrhage occur, showing abortion to be inevitable, our object should be to favour the expulsion of the ovum with as little delay as possible. The insertion of a carbolised sponge-tent into the cervix uteri, for a few hours, will not only serve to check the hæmorrhage, if this be at all profuse, but also to dilate the cervix, and so facilitate the expulsion of the ovum entire. It is in these cases, owing to the undeveloped or undilatable condition of the cervix, more especially where ergot has been too freely administered, that the ovisac becomes ruptured, the embryo expelled, and the chorionic villi or placenta retained.

More plugging the vagina with the intention of arresting hæmorrhage from the uterus is both unscientific as well as unsatisfactory, and should never be resorted to unless in severe emergencies, where either the practitioner has not the instruments at hand, or does not possess the requisite manipulative skill for passing a sponge-tent into the cervix uteri.

In such cases, small pieces of sponge wrung out of iodised or carbolised water, or other antiseptic solution, are preferable to the ordinary cotton-wool or strips of linen usually employed, in that the former tend to expand, and so fill up the vagina when moistened, whereas the latter shrink, and allow the hæmorrhage to continue. A vaginal tampon, in any case, should never be left in for more than a few hours without being removed.

In the event of a sponge-tent having been inserted into the cervix uteri, and the hæmorrhage arrested for the time being, the question will arise, How long shall this be left in before making efforts to empty the uterus? This will depend somewhat upon the time of the day or night when the practitioner has passed the tent, the amount of hæmorrhage which has already occurred, and other considerations. Owing to the extreme nervousness of the patient, her intolerance of any digital interference, the limited capacity of the vagina, or inability to depress the uterus by conjoined manipulation, owing to the patient holding herself so rigidly, the administration of an anæsthetic will generally be found requisite. This should invariably be entrusted to some competent assistant, and not left to the discretion of some unqualified friend or nurse. The operator is thus free to direct his attention solely to the evacuation of the uterus, which must be done systematically and thoroughly, not partially and imperfectly, as this increases the risk of hæmorrhage and septicæmia. The time selected, therefore, may be regulated somewhat by the practitioner's convenience; if the tent be inserted late at night, opium may be given to allay pain and secure rest, and the operation fixed for the following morning.

A sponge-tent should never be left in above twelve hours, and when removed, iodised or carbolised water should be freely injected into the vagina before attempting any further manipulation. If the cervix be already sufficiently patulous to admit the finger, or hæmorrhage is not an urgent symptom, the insertion into the cervix uteri of a sponge-tent is uncalled for.

Having first seen that the bladder is empty, the patient should be placed close to the edge of the bed, in the dorsal or left lateral decubitus, as may seem most convenient to the individual practitioner. With one hand pressed over the lower abdomen, the fundus uteri is then depressed, so as to enable the forefinger of the other hand to pass entirely into the uterus, when, if possible, the whole of the remaining ovum is swept out of the uterus. If this cannot be accomplished, the portion of placenta within reach must first be detached and removed; the uterus then generally contracts sufficiently to bring the remainder of the placenta within reach, when the finger is again employed, to sweep it out, or scrape it off from the uterine wall.

Firm pressure should be employed from above, and the finger should not be withdrawn until the uterus is felt to contract, so as to avoid the formation of clots in the interior.

It is well to inject hot iodised water at 110° or 120° Fahr. through a metal tube or elastic catheter into the uterine cavity, to wash out any placental debris, and also to check further hæmorrhage, should this be troublesome. A binder should then be applied to the abdo-

men, as after ordinary labour, ergot administered, and the usual precautions taken to promote convalescence.

In practice, it will, however, often be found difficult, if not impossible, to determine whether the whole of the placenta has been expelled, and it is in these cases that danger arises, whether from recurrence of hæmorrhage, or from symptoms of septic absorption. If any doubt exist, it is better to explore carefully the cavity of the uterus. Denman long ago pointed out the fact that, where any portion of the placenta remains *in utero*, the cervix does not contract thoroughly, but remains more or less patulous. If symptoms of septicæmia have already declared themselves, it may be unwise to insert a sponge-tent. If any difficulty be experienced in passing the finger sufficiently far up into the uterus to allow of placental debris being removed, the ovum forceps will here prove of much service. Having inserted them well into the uterus, the handles are separated gently, and any projecting portion of placenta seized and removed, the operation being repeated in a different direction until the whole of the contents have been secured. Where the uterus remains unusually bulky, hæmorrhage recurs on the patient rising, or persists unduly long after the supposed miscarriage, or where the lochia are distinctly offensive in character, we may be pretty certain that the uterus is not yet empty. In place of contenting ourselves with the administration of ergot, our plain duty is to explore the cavity of the uterus. Instances have been recorded where portions of placenta have been extracted many months, and even years, after the miscarriage happened, no effort having been made to remove the cause, the symptom alone being treated.

The narration of a case of this nature may prove of interest as exemplifying practically the treatment indicated.

M. C., aged 40, had been married three years, up to which time she enjoyed most excellent health. She had a miscarriage six months after marriage, at the end of the second month from which she recovered perfectly. Six months later a second miscarriage took place, and since then she had never been thoroughly well. The periods, at first, were rather prolonged, but not irregular. About Christmas, 1884, serious hæmorrhage took place, and since that date hæmorrhage had been more or less constant, absent for a week or two, then suddenly beginning again. In November, 1885, she stated that she was subject to bursts of hæmorrhage every two or three days, with watery discharge in the intervals. There was no pain at any time of any moment.

On examination, the uterus was found to be bulky, fairly normal in position, mobile, the uterine sound passing upwards and forwards three inches. The cervical canal was somewhat granular, and there was much glairy mucous discharge, but not offensive. The cervix uteri was dilated by means of laminaria tents. Ether was administered, and the interior of the uterus explored. Several portions of hypertrophied mucous membrane were scraped off with the curette, together with some small nodular masses. Linimentum iodi was freely applied to the uterine cavity, which was then syringed out, and ergot administered every four hours. There was no return of hæmorrhage after this until about a fortnight subsequently, when the regular catamenial period came on, and lasted six days. The patient left for the country a month after her admission. Two months later, the husband wrote to me, saying, "There has not been the slightest hæmorrhage of any kind so far, nor has there been any return of the period." There can be little doubt, I think, that the removal of some placental debris, together with some hypertrophied mucous membrane, constituting the so-called fungous endometritis, served effectually to arrest hæmorrhage, and thus cure the patient.

In some cases, where the placenta is very adherent, and cannot readily be removed by the fingers or forceps, the blunt curette may be employed to scrape the surface, so as to remove all debris. This method is more often indicated in those cases where a portion of the placenta has been retained for many weeks or months after the incomplete miscarriage has taken place, and where a species of fungous or villous endometritis has been set up.

Syringing out the cavity of the uterus with hot iodised or carbolised water, at 110° to 120° Fahr., so as to remove all debris, where removal has been difficult, or where hæmorrhage is free, often proves of much service in lessening the risk of septicæmia. This may be repeated morning and evening for some few days, if deemed requisite. Swabbing out the cavity of the uterus with liq. ferri perchlor. or linimentum iodi, where the discharge has been very offensive, or the placenta very decomposed, is indicated in some cases, but should not be resorted to as a routine practice.

It is of great importance to keep the patient quiet in bed for at least a week or ten days, apply a binder firmly to the abdomen, as after ordinary labour, and resort to vaginal injections. If the lochia be-

come in the least unpleasant or offensive, intra-uterine injections should be employed. Ergot and cinchona may be administered, with advantage, in most cases.

The administration of ergot is not an unmixed blessing. Where uterine action has already set in, ergot intensifies this action unquestionably; but if only a portion of the ovum be expelled, ergot tends to produce such an amount of contraction of the cervix uteri as to preclude further attempts at removal of the remainder. We may have to wait several hours until the influence of the ergot has passed off, before being able to insert the fingers or forceps to complete the delivery of the placenta. If hæmorrhage be severe, ergot is, of course, indicated, and must be given; but, when the hæmorrhage has ceased, it may be well to refrain from further administration of the drug until complete removal of the placenta has been effected, when its employment may again be persisted in. Where we have reason to believe that the whole of the placenta has not been expelled, and the hæmorrhage continues, or recurs on the least exertion, and ergot fails in enabling the uterus to throw off the retained portion, its employment should be discontinued, and proper means adopted to extract the remainder of the placenta.

I have seen instances where ergot had been given freely and continuously for several successive weeks or months, without the desired effect being produced. This illustrates the abuse, not the rational use, of the drug, and cannot be too strongly condemned.

It is with the hope of directing special attention to the absolute necessity of removing all placental debris, in these cases of incomplete abortion, that I have thought it worth while to occupy your time and attention on this occasion, and if I have succeeded in this, my object will have been fulfilled.

BATH AND AIX-LES-BAINS.

By E. J. TILT, M.D.,

Past President of the Obstetrical Society of London.

RETURNING the other day, with a patient, from Aix-les-Bains, I came across a leading article on Balneology, in a recent number of our JOURNAL, and my attention was arrested by the following passage.

"England possesses several springs of undoubted value, but, for some reason or other, they are less highly esteemed than water from foreign sources."

It struck me that, with regard to Bath, the reason was the bad system of management that has hitherto prevailed there. Bath has not the beautiful climate of Aix-les-Bains, its high temperature, and permanent sunshine. The waters of Aix-les-Bains are more efficiently mineralised, very much more abundant, and of a higher temperature than those of Bath, and their natural high pressure facilitates douching. Nevertheless, of the two thousand English who went to Aix-les-Bains last season for gout, rheumatism, and neuralgia, one thousand might have been as well cured at Bath, if the same system was followed there as at Aix-les-Bains. After deriving benefit from Bath waters some twelve years ago, I did my best ("Why We Go to Foreign Watering Places," *Lancet*, October 24th, 1874) to urge the medical men to change the wretched system of administration that had been handed down to them, but without being successful. I hear, however, with pleasure, that at last there is a great improvement in the working of the Bath waters, that Aix-les-Bains is being imitated as far as possible; so I again venture to make a few remarks on both these remarkable watering places.

From time immemorial the summer has been the season for treatment at Aix-les-Bains, and although the temperature be high, and reliably so, still patients are ever reminded by medical men and attendants to avoid catching cold after the douches.

One of the most experienced practitioners at Aix, Dr. Macé, told me that when the weather turns chilly, he did not like to begin the use of hot vapour douches—douches Bertholet. Such being the case, what can be thought of, I hope I may say, the old plan of telling patients suffering from chronic gout, rheumatism, and neuralgia, to come to Bath in the autumn, when the cold, wet, and windy weather has set in? It should be now extensively and persistently advertised, by the proper authorities, that the Bath season for treatment begins in June, and continues during the months of July, August, and September.

Dr. Tunstall, who wrote a good book about Bath, incidentally mentions that the baths and douches did much more good to the inmates of the hospitals who went to bed immediately after taking baths or douches, than to the rich patients who dressed and went home as they liked. If, in the warm climate of Aix, patients are

carefully wrapped up in blankets and quickly taken home, and put to bed to sweat for an hour or so, with the aid of some warm drink, it is absolutely necessary to do the same in the uncertain climate of Bath; with gouty, rheumatic and neuralgic patients after they have been shampooed and douched at the baths. Aix-les-Bains belongs to the State; the buildings have been well planned, and on a handsome scale. The Bath waters belong to the corporation, have been managed by a committee of retired tradesmen, so the buildings are scattered, and their construction defective. About 1868 the corporation might have built a suitable establishment, but they preferred to let the land to a joint-stock hotel company, in one wing of which hotel, the corporation built a suite of baths at a cost of £12,000.

What I will call the bathing unit at Aix, consists of a large square lofty room fitted up with the requisite furniture for douching, etc. This room is entered on one side by two small closets, called dressing-rooms, placed side by side. A patient leaves his clothes in one dressing-room, and while he is being manipulated for twenty minutes, another is undressing in the adjoining room, and is ready to enter the bath-room as soon as it is vacant. The saving of time effected by this arrangement will be seen at once.

The Bath bathing unit, judging by the baths constructed by the corporation in the hotel I have spoken of, consists of a fine bathing-room, a large dressing-room, and a water-closet—a water-closet for every patient, as if the Bath water was more purgative than that of Carlsbad. Possibly, something can be done to rectify the defective construction of the buildings.

I was at Bath during the whole of August and part of September, 1874, for an indolent knee swelling, so I was at the Queen's baths every day for six weeks. There were not many bathers, but I certainly saw a dozen very bad cases of chronic gout and rheumatism, men that could with difficulty be got into the building. There was, however, no medical man to look after them; indeed, I never saw the face of a medical man at the Queen's baths during my six weeks' attendance.

At Aix-les-Bains, the medical men live at the Etablissement from 8 to 11 A.M. They see their patients as they come, move about in the passages to ascertain how they are getting on, so as to continue or modify the treatment. The Bath medical men should imitate this mode of practice, if they want to rival the success of Aix-les-Bains; doing their best that the bulk of the bathing may be done between the hours of 7 and 1 o'clock.

I have had to say so much in praise of Aix, that I trust its medical men will not mind my stating that they do not pay sufficient attention to the diet of their patients. There is this difficulty about the dieting of patients at a watering place: that they are in a minority, compared to relatives and friends that accompany them, and who require the best of living as they are in perfect health. It is customary at Aix to board at one of the many excellent hotels. The breakfast is tea or coffee, with bread and butter, and is governed by the time of the bath, which it should precede; lunch is at 12 o'clock, and dinner at 6 o'clock, and of the usual table d'hôte type.

With regard to the lunch, I will describe what I used to sit down to at the Hotel Château Durieux, a most comfortable hotel, with a first-rate cook. First came omelette, or eggs done up in some other way, then fish, boiled, fried, and sometimes a salmon *mayonnaise*. There followed two stews of mutton, veal, or chicken, with rich sauces and, lastly, broiled steak or cutlets. Cheese and strawberries concluded the repast. A gouty friend, who was stopping at the Europe, asked me whether this was the kind of food for a man who was undergoing an elaborate treatment for gout.

Some dozen acquaintances under different Aix medical men, for gout or rheumatism, assured me they had not been told what to choose out of the different dishes I have enumerated; and, at my hotel, I was amazed to see patients who described themselves as having been martyrs to gout, eat heartily of almost everything, both at lunch and at dinner. The previous shampooing and douching accounts for good appetite and better digestion; but I am convinced that this promiscuous high feeding greatly diminishes the amount of good that might follow the full treatment of chronic gout, rheumatism, and neuralgia at Aix-les-Bains.

To like to get the most for our money is a national characteristic; and, as the wine is included in the board, few order better wine. We used to sit down about 80 to meals at the Hotel Château Durieux, and only two or three ordered other wine. This is decidedly to the advantage of the patients I have had in view, provided they do not take too much of the wine, and take it mixed with water or Vals water; but I have seen patients, who for years had been suffering from gout, take more than a bottle a day of this second-rate decidedly acid *vin ordinaire*, day after day. Those who think of sending patients to Aix-les-Bains should carefully advise them as to diet and wine.