some cases, and reading Lusk's recommendation (*Science and Art of Midwifery*, second edition, page 301), in which he refers to Jenk's paper in the *Transactions of the American Gynecological Society*, I gave the drug a trial, and have since used it repeatedly. In one case of so-called "habitual abortion" it failed to do good. This lady had one healthy child, then five abortions, or premature labours, at different periods; then a child born living at five months and a half, which died. She was then treated with chlorate of potash and iodide of mercury, with iron alternately, and was delivered at six months and fourteen days of a very feeble living child, now a fine healthy boy, 6 years old. Next time, when pregnant, she was ordered viburnum, but aborted at the third month. She was again pregnant, was treated with viburnum, and aborted at the second month. Possibly there was a specific element in this case, judging from the one successful pregnancy; but I have not been able to establish it.

Another patient aborted twice after marriage; when pregnant for the third time, she was treated with chlorate of potash, and delivered, at term, of a healthy child. She next aborted at the second month, in spite of viburnum. Abortion was again threatened about four months ago, but passed off after taking viburnum; and she is now fully six months pregnant. A third case had recurrent monthly uterine contractions from the second to the seventh month. Small clots and quantities of blood passed several times. In this case, bromides, in combination with nepoche, were found more effectual than viburnum. A fourth case derived benefit from viburnum, but markedly so when given in combination with nepoche and belladonna. I might adduce many more such cases in the same strain. On the whole, my impression is distinctly in favour of the drug; yet I cannot believe it to be in every case "a sure arrestor of uterine action."

With all courtesy, I must demur to the method in which Dr. Campbell's cases are recorded. Brevity excuses much, but accuracy is at times sacrificed thereby. In the first place, it is surely necessary to show that abortion was actually threatened ere we write of its arrest. Do uterine contractions never occur without separation of the decidua, or death of the fetus? Do not very many women suffer severely from pains at each monthly period, and, in many cases, carry to term without any drug? What is meant by the os dilating? Case 1, in which abortion occurred, is the only case, except 2, where the os is referred to; in Case 1, "it continued to dilate." Now, dilatation of the os, unless it be the internal os that is meant, is by no means uncommon without abortion following. Scanzoni has recorded a case, now classical, in which not only was ordinary treatment employed, but the introduction of a sound and intra-uterine injection failed to bring about "the inevitable abortion." I have mentioned cases with a somewhat similar history. (*Transactions of the Edinburgh Obstetrical Society*, vol. ix, p. 109.)

Nor do "breaking of the waters" or hemorrhages invariable end in abortion. The "flow of the waters" may be due to very active glandular secretions from the cervix; or even to the formation of, and rupture of amnio-chorial pouches, the "false bags of membranes." We often meet with the latter occurrence, one or two months before the termination of normal pregnancies. In early pregnancies I have also noted this, and observed that the pregnancy went smoothly on. Probably the fetal sac has need of more room, or there is hydramnion in such cases. Hemorrhages are too often regarded as causing miscarriage; if from the interior of the uterus, they are more likely (from disease of the membranes or death of the fetus) the consequence than the cause; if from the cervix, there is in early pregnancy no necessary disturbance of the uterine contents. Abortion may come on in these cases, as has been pointed out by Barnes (*Obstet. Med. and Surg.*, vol. ii, p. 232), in consequence of the law, "when hemorrhage sets in from any given point, there quickly follows an attraction of blood towards the point of escape."

Given a healthy uterus and a healthy fetus, it is extremely difficult to dislodge the latter, except at a monthly period. Some women abort on the slightest provocation, although seemingly healthy. Others, as I have known, may undergo the most extraordinary exertions, jump high gates, dance, or run without inconvenience. Thus, in estimating the value of any drug as an arrestor of uterine action, many side issues need consideration. At the same time, given, more especially in primipare, a gaping os with some part of the ovum protruding, attended by rhythmical uterine contractions and hemorrhage, then, if viburnum, or anything else, arrest the progress of abortion, it is well that the profession should know it. Even with hemorrhage and a patent os, if we cannot feel the ovum and the pains be irregular, while miscarriage is likely, it is by no means certain. I have seen, as must everyone with experience, many cases "settle" under most diverse treatment—sedatives, for example, opium or chloral; astringents, as gallic acid or acetate of lead, or, per-

haps better than these, hamamelis; vascular sedatives, as bromides, digitalis, antimony, or viburnum.

In typical abortion, the ovum is separated from the uterus, and hemorrhage follows; it may have caused the separation; the internal os is first dilated, then the cervix, and lastly the os externum. Now, can viburnum be depended on after such a process has begun? I think we must rather regard it as a preventive drug in "habitual" abortion, if given with a view to regulate uterine action, than as an arrestor of the immediate causes of abortion. In my own practice, I have experienced doubt when to prefer it to chlorate of potash; I have combined the drugs in some cases with good effect. In cases where we suspect constitutional affection, I prefer mercury and iron, given together, so that the former drug, while exercising its special influence, may not unduly affect the red blood-corpuscles. Iron has been looked on as an abortifacient; my experience contradicts this.

As an example of the benefits of other means than viburnum, I may mention that, ten years ago, I succeeded in bringing a pregnancy to a successful termination at full time after ten successive miscarriages.

DAMP AND DIPHTHERIA.

By H. NELSON HARDY, F.R.C.S. Ed.,
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A SERIES of cases of diphtheria which has occurred in connection with one of the Dulwich police-stations, seems to show that there are good grounds for the belief that there is some special connection between damp houses and the development of diphtheria; though other unsanitary conditions, no doubt, powerfully contribute to prepare a soil favourable to the spread of the disease.

The cases I am about to relate occurred, for the most part, in the persons of strong, able-bodied young men. There was no epidemic of the disease in the neighbourhood at the time; indeed, inquiries made of the sanitary authorities of the district showed that, with the exception of the police affected, the district was singularly free from the disease; and the one thing in common to all the patients was, that they were more or less intimately connected with a damp and unhealthy station, their duty obliging some of them to live in it, and all of them to be in it for a considerable portion of each day. The station is an old dwelling-house, consisting of two storeys, not originally built for a police-station, but converted into one some years ago, before sanitary considerations began to occupy so much attention as they do now, and the water-closets and drains had never, previously to this outbreak of diphtheria, been in a satisfactory state. Two families belonging to the force had occupied the rooms not used as police-offices; namely, an inspector and his wife and family, having two rooms on the ground-floor, and one on the first-floor; and a mounted constable and his wife and children, occupying the remainder of the upper rooms.

On December 24th, 1884, a constable, aged 19, who had been less than six months in the force, and had had no previous illness while in it, had a pretty severe attack of diphtheria, was convalescent on January 7th, 1885, and was then granted a month's sick leave, returning to duty on February 7th, 1885. On January 29th, 1885, the mounted constable, aged 30, already referred to as living in the upper rooms of the station, who had been twelve years in the force, and whose only illness had been an attack of diarrhoea, was attacked, had a prolonged and very severe illness, was not convalescent till the beginning of March, and was then granted a month's leave.

On February 20th, 1885, a constable, aged 25, who had been two years in the force without any previous illness, took diphtheria, had it slightly, was convalescent on March 2nd, and was then granted a month's leave of absence.

On April 13th, 1885, a constable, aged 32, who had been six years in the force, and had no illness of importance during that time, but whose duties rendered it necessary for him to spend more hours in the station than most of the other men did, took the disease not very severely; on April 28th he was convalescent, and was then granted the usual month's leave of absence.

After this, there was a lull for about six months, during which no more cases appeared amongst those connected with the station; and it was hoped that certain measures which had been taken to remedy the sanitary defects of the building, had proved successful in checking the spread of the disease, a supply of water having been laid on to the men's urinal for the first time, and a water-closet which ventilated into the men's parade-room having been closed. I should add that the whole station is condemned, and only used until a new one can be

got ready. A change had also taken place in the family occupying the lower rooms of the station, a new inspector having come, and brought with him his newly married wife, a strong, healthy-looking young woman from Essex. On November 28th, 1885, this young woman was taken ill with diphtheria, and had a moderately severe attack which lasted till December 13th. On examining the walls of the two rooms on the ground floor, occupied as kitchen and sitting-room by her and her husband, I found them damp for a considerable distance from the floor, varying from one to two feet, along the outer wall of the house. No furniture could be left standing against this wall without becoming damp. Even in the kitchen, where a fire was constantly burning, and gas very often alight, as it was rather a dark room, the wall was constantly damp; and the floor-cloth covering the kitchen floor, on being turned up, was found to be damp and mouldy. I advised the authorities that these rooms were unfit for habitation, and the inspector and his wife were in consequence moved into the upper rooms, which the mounted constable and his family had to leave and find lodgings elsewhere. On December 23rd, 1885, this mounted constable, who still of course, was a good deal at the station seeing to his horse, was taken ill with the disease for the second time, not nearly so severely as the first time, and was convalescent on January 5th, 1886.

On January 8th, his youngest child, aged 3, had taken diphtheria, and was ill till January 22nd. Thus, out of a total of about forty persons immediately connected with the station (2 inspectors, 30 men, 2 wives living at the station, 3 or perhaps 5 children, ditto), there have been, in little more than twelve months, no fewer than seven cases of diphtheria, three of which happened after the graver sanitary defects of the building had been remedied, and the dampness alone remained perceptible to the senses. I am far from saying that there may not be other defects which a thorough examination into the drainage and foundations of the house would reveal; but, in the present state of our knowledge of the subject, the above facts seem worth recording.

CONTINUED FEVERS IN EGYPT

By W. H. MACNAMARA,
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THE discussion, at the Royal Medical and Chirurgical Society, on Enteric Fever, reported in the JOURNAL of February 13th, interested me greatly. During a considerable time I have been observing cases of fever at the Citadel Hospital, Cairo, which was used as a base hospital, and received sick from Suakin, far up the Nile, Suez, and from Cairo. The intestinal lesions seen in fatal cases of continued fevers may be divided into four classes.

1. There were the usual lesions observed and described as characteristic of enteric fever: tumefaction, ulceration, etc., of Peyer's patches.

2. Bodies, in some cases as large as almonds, and resembling lymphatic glands, were studded under the mucous membrane of the ileum, ileo-caecal valve, and upper part of the caecum. Most of these were in a broken-down ulcerated condition. In some cases, they were altogether broken down by ulceration and sloughing. Perforations were very frequent. Peyer's patches, as well as the colon and rectum, were normal.

3. In a few cases, there was a combination of the above lesions.

4. The usual lesions of the large intestine described as dysenteric, that is, thickening, softening, pigmentation, ulceration, etc., extending to, and most marked in the rectum, were found combined with Class 1 or 2. These cases have nothing to do with malaria, as they were observed in men who were not in any malarious place—for example, Cairo—where we do not see ague, except in men who contracted it elsewhere, as well as in cases from Suakin, Suez, etc.

The first class of cases ran a pretty uniform course, with typical enteric symptoms. The second class seemed to be of longer duration; remissions not so marked in the third stage, greater tympanitis. Abdominal tenderness was more extensive and more marked; there was more tendency to peritonitis, hemorrhage, and perforation. The stools were very offensive in smell, often containing a little slime or blood. Ipecacuhana did not seem to be of much use.

In Classes 3 and 4, the symptoms seemed to correspond with what would be expected in cases with the *post mortem* appearances combined as described above. Ordinary cases of dysentery, without any symptoms resembling enteric fever, are left out of consideration; many such cases were treated.

At present, I am having more regular and accurate observations of the fevers under consideration made, with a view to connect, if possible,

more definitely the symptoms during life with the *post mortem* appearances. Meanwhile, the following questions suggest themselves.

1. Are Classes 1 and 2 distinct diseases? 2. Is Class 3 a combination of 1 and 2? 3. Is Class 4 a combination of dysentery with Class 1 or 2? 4. Is Class 2 a form of dysentery or enteric fever, or is it a distinct disease?

During the early part of the occupation of Cyprus, I saw a case as described in Class 2. During life, I called it enteric fever. After death I adhered to the same name; but I remember that I was not very well satisfied with it. As to Dr. Squire's remark about scorbutic appearances, I have observed that, in places such as Suakin, where there is very little vegetation, men get scurvy occasionally, though they are supplied with vegetables. I remember that, when I was a young surgeon in India, one of my patients in hospital, with eight ounces of lime-juice marked daily on his diet-card, developed scurvy. On inquiry, he told me he never touched the lime-juice, and that he hated vegetables. Many a man gets on very well without eating vegetables, when he is surrounded by vegetation; but gets scurvy, under similar circumstances, in the desert or at sea.

Many cases, coming from Suez and Suakin, were modified by malarial taint; but I saw nothing which would lead me to wish for the term, typho-malarial.

Was it possible that the condensed water at Suakin became contaminated in distribution, and so spread enteric fever? The young soldiers at Cairo undoubtedly suffer most from enteric fever. Since our occupation of Egypt, a large proportion of our young surgeons have had the disease, eight of whom died of it; all, except one, being quite young. Not a single surgeon-major had the disease.

CLINICAL MEMORANDA.

MELANOSIS OFTEN NOT BLACK: MELANOTIC WHITLOW.

WHEN melanosis fungates, and when it affects the glands, we must not expect the larger growths to be of a black colour. The power of producing black pigment appears to be, in most persons, very limited. The original growth, beginning it may be in the rete of the skin, or in the choroid of the eye, is coal-black, but the later and larger growths are white, or show only here and there a pigmented streak. To make the diagnosis at these stages, it is necessary to look carefully at the skin near the margin of the fungus. Here a little coloured border may often be found, looking as if lunar caustic had been applied, which tells the tale.

Melanotic Whitlow.—There is a rare form of disease of the nail-bed which is malignant, and usually takes the type of melanotic sarcoma. It is generally attributed in the first instance to injury, and its diagnosis is always missed in the early stages. Because it resembles whitlow, and is usually so named at first, I prefer to give it that name. It is, however, from the beginning, malignant. Careful observation will find at the edge of the inflamed nail a little border of coal-black colour, and this, however slightly marked, must be allowed to make the diagnosis. I have seen at least half a dozen of these cases. Early amputation is demanded.

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OBSTETRIC MEMORANDA.

INVERSION OF THE UTERUS IMMEDIATELY FOLLOWING LABOUR.

ON February 21st, I was called to attend a patient, aged 32, pregnant for the first time. About 3 A.M. I found that the os had just commenced to dilate. The head was rather far down in the pelvic cavity, pressing on the anterior wall of the uterus; but this condition is not unusual in primiparae. Labour proceeded very satisfactorily, and a fine male child was born about noon. The cord was coiled once round its neck. I separated the child, and gave it to the nurse, and grasped the uterus externally, that being my usual procedure. About fifteen minutes later the patient complained of a pain in her left side, and I felt the uterus suddenly slip from my hand. Thinking the placenta was discharged, I placed my hand under the clothes to take it away, when I felt a hard substance, which I first thought was the head of a second child. On removing the clothes, I was horrified to find the uterus prolapsed and inverted, with the placenta still attached. I immediately separated the placenta, and endeavoured to return the uterus, which was then about the size of two large oranges. I placed a thin towel, previously well oiled, over the inverted surface, and pressed a large composite candle against the slight cup-shaped depres-