proceed to destroy a larger surface of the indurated uterus. She did not, however, return to me till three months; and then I found the uterus quite fixed. There was no ulceration, but the pain was increased. I could do nothing more for her than try absorptive measures in the way of bromine lotions, and destroying one or two indurated projections. She died insane some months afterwards; the uterine disease, so far as I could learn, having made no further progress.

The other case was that of a cabman's wife, with extensive malignant uterine ulceration and the usual concomitants, which first occurred about three years back. The uterus here was not fixed. I could only destroy the ulcerated surface; but her husband would not allow her to remain in the hospital, threatening to introduce some lewd woman into his house to take charge of his children; and so she left me. About three years afterwards, I was agreeably surprised to see this poor woman walk one morning into my study, looking well and fat. She had come to me not professionally, but to sign some club-paper. I demanded an examination, which she granted. I found a healthy uterus; and she informed me that, since she had seen me last, she had had a healthy child.

CLINICAL MEMORANDA.

THE TREATMENT OF ACUTE RHEUMATISM BY TINCTURE OF PERCHLORIDE OF IRON.

By J. RANDLE BUCK, L.R.C.P., M.R.C.S., etc., Inkberrow.

A PAPER by Dr. Russell Reynolds appeared in No. 468 of the BRITISH MEDICAL JOURNAL, in which he related the beneficial results which had been produced by the perchloride of iron, in eight cases of acute rheumatism. This amount of success led me to try the remedy in a very severe case at that time under my care. Two other cases have since occurred; and in all three the result clearly convinces me that iron ought to hold a most prominent place in our list of remedies for this most formidable disease. I will enumerate, briefly, the essential points of each case.

CASE I.—Jane C., aged 32, had a second attack of rheumatic fever, mostly affecting the lower extremities. There was a high state of fever; the temperature 103 deg.; the pulse 110. The heart was weak and irregular in its action; dilated, with aortic regurgitation. She was ordered 60 grains of the bicarbonate of potash in an effervescing draught every three hours, with 10 grains of ipecacuan powder with opium at night. At the end of seven days, with this treatment, there was absolutely no improvement; the upper extremities, in addition to the lower, had become affected; the pulse and temperature were rather higher. I then substituted 30 minims of the tincture of perchloride of iron every six hours. On the following day, there was very marked improvement; the pulse was 100; the temperature 102 deg.; the pain was relieved, and there was less uneasiness about the heart. This improvement continued till the sixteenth day, when there was an attack of urgent dyspnoea, with tumultuous action of the heart. I added 10 minims of tincture of digitalis, which soon relieved the heart; and from that time there was no bad symptom. The digitalis was continued in five-minim doses in combination with the iron, and recovery was complete on the thirtieth day.

CASE II.—Ellen M., aged 18, had a first attack; she was seen on the second day of illness. Both knees were affected; there were great heat of skin and prostration. She was ordered 30 minims of the tincture of perchloride of iron every six hours. In thirty-six hours the pain was relieved, and the patient was better in every respect; there were no cardiac symptoms, and on the twelfth day she was convalescent.

CASE III.—Henry H., aged 26, ill with a first attack, was seen on the fifth day of illness. The feet and hands were most affected. He had profuse perspiration and great prostration. In this case, I gave the tincture of the perchloride every four hours in 30-minim doses, and on the following day the patient expressed himself as easier. On the third day of treatment, he complained of pain in the cardiac region, and a blister was applied. From this time there were no further bad symptoms; and on the twentieth day (the fifteenth of treatment), he was sufficiently recovered to sit up in the room.

I may remark, in conclusion, that in none of the cases did the iron induce any feeling of discomfort; the tongue cleaned, and the patients all expressed themselves relieved after its use. I therefore think we shall do well in adopting this mode of treatment as one productive of better results than any other.

CLINICAL LECTURE ON THE DIAGNOSIS OF ANEURISM.

By MR. PAGET, F.R.S.

ON Wednesday last Mr. Paget lectured on a case, under his care, of *Aneurism of the left Common Iliac Artery*. The patient is a man aged 29, who stated that about eighteen months before admission he first began to suffer from pain in the back and lumbar region after bathing in the sea. The pain, which was of no great intensity, persisted, and was believed to depend upon lumbago. Towards the end of 1869, he first noticed a tumour, and, in addition, some numbness in the feet after exertion; about this time Dr. Gull saw him, and, after a physical examination, at once diagnosed the nature of the disease, and sent the man to Mr. Paget, by whom he was afterwards admitted. Mr. Paget remarked on the negative character of this man's symptoms, and on the readiness with which, in the absence of a manual examination, the case might have been mistaken for lumbago, commencing paraplegia, or even hypochondriasis. On admission, he was pale but fairly nourished, and complained of pain in his back and loins and of numbness in the lower extremities after exertion. The heart-sounds were normal, but the circulation generally was somewhat excited. He did not complain of pain down the thighs or in the legs, nor was there any oedema or enlargement of the veins of the lower extremities. On examination, a pulsating tumour was found in the abdomen, situated below and rather to the left of umbilicus; the pulsation ceased when the abdominal aorta was compressed. Slight pulsation could be felt in the left common femoral artery, but the pulse could not be detected over the posterior tibial of the same side; on the right side, the pulse was detected with ease in both these vessels. A slight soft *bruit* was heard on auscultation over the tumour. Mr. Paget considered that the aneurism probably occupied the extremity of the abdominal aorta, and the whole of the left common iliac, and that four vessels communicated with it, viz., the aorta, right common iliac, and left external and internal iliac arteries.

In speaking of the diagnosis of abdominal aneurisms, Mr. Paget said that the difficulty in these cases was twofold; for, *first*, there were many pulsating tumours not aneurisms, and, *secondly*, aneurisms were occasionally met with which, at the time of examination, did not pulsate. In the case under consideration, the second source of error did not interfere, for the tumour pulsated strongly. The pulsating tumours from which aneurism was to be distinguished, were arranged under the heads of *medullary cancer, arterial vascular tumours, tumours growing from bone, and enlarged lymphatic glands*, or any other tumour seated upon or around a large artery; and the following points were insisted upon as furnishing, collectively or singly, the means for arriving at a correct conclusion. The *character* of the pulsation: the pulsation of an aneurism was described as "firm, full, and strong," while that produced by any of the other pulsating tumours was said to be weak and soft. Mr. Paget laid great stress on this difference, and considered it a most important aid to diagnosis. The *direction* of the pulsation: the "expanding pulsation" of an aneurism was to be carefully distinguished from the merely "forward push or throb" communicated to the fingers by a tumour seated on an artery; if a tumour, such as a mass of enlarged glands, however, *surrounded* an arterial trunk, Mr. Paget considered that it might be quite impossible to determine whether an aneurism existed or not, for the pulsation in such a case would be truly expanding in all directions. *Pain* of a "rending" character, and coming on in paroxysms, was mentioned as a valuable sign of aneurism, and probably denoted the occurrence of rapid increase in size. The existence of a *loud rasping bruit* over the tumour and along the artery above and below was said to be a symptom of some value when present, although its absence, as in the patient under consideration, by no means negated the existence of aneurism, for a soft *bruit* was heard in many cases of vascular tumour.

Mr. Paget alluded to another class of cases in which the diagnosis of abdominal aneurism was sometimes made, and in which there was not only no aneurism, but no tumour of any kind. In some persons, a large artery, generally the abdominal aorta, pulsated very strongly; and it was this strong pulsation of a healthy vessel that was mistaken for aneurism. It occurred, Mr. Paget observed, chiefly in hysterical women or nervous men; sometimes in association with pains in the back, which rendered the resemblance to aneurism still closer; or in persons in whom the bodies of the lumbar vertebrae were unusually prominent, the head of the pancreas enlarged, or the colon distended; and, lastly, a certain number of cases were found to be connected with incessant nausea and vomiting in nervous people—a case being mentioned of a woman who was supposed by several observers to be the subject of abdominal

aneurism. She was suffering from excessive and continued sea-sickness, and, in fact, died of exhaustion from this cause; and Mr. Paget had an opportunity of confirming his previous opinion that no aneurism existed. The absence of the lateral or expanding pulsation in these cases of excessive arterial pulsation was mentioned and insisted on. The lecturer alluded to one case in which a phantom tumour of the rectus abdominis muscle was superadded to a pulsating aorta. In this instance, the diagnosis was at length made by placing the patient under chloroform, when the tumour disappeared completely.

Mr. Paget added that the same state of excessive pulsation was sometimes noticed in other arteries, especially the subclavian and the carotid. If the patient happened to possess a cervical rib over which the pulsating subclavian passed, as in a case lately under Mr. Paget's care, the resemblance to aneurism might be very close. The simulation of carotid aneurism was said to be most deceptive when the internal carotid was elongated and tortuous in old persons, and when the naturally somewhat bulbous condition of the lower part of this vessel was more than usually marked.

REPORTS

OF

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS OF GREAT BRITAIN.

WARNEFORD, LEAMINGTON, AND SOUTH WARWICKSHIRE HOSPITAL.

[BY OUR OWN REPORTER.]

THIS hospital contains ninety-two beds, a considerable majority being medical, and as many as twenty out of the whole number devoted to children. A good many of the latter, however, were said to have been unoccupied for some time. The ward floors are oiled with boiled oil, which produces a sort of varnish on the surface when it has been freely used. The floors are washed as ordinary floors; and the oil prevents the substance of the wood from being wetted. There is a separate building, intended, we believe, for a fever-house, should it be required for that purpose, but used chiefly as a sort of convalescent hospital for patients from the general wards. The hospital is pleasantly situated, and has a good piece of garden behind.

Dr. Carter showed us the following very interesting case, which had been under his care, on and off, for about five years. The patient, a girl aged 7½ years, had suffered ever since about two years old from slow dry gangrene of the distal ends of some of her fingers and toes; this had been accompanied by great emaciation, and at times by ulcerations, which were described as having been rupial, on various parts of the skin. The child's mother is believed to have had syphilis; and her eldest child died at the age of a few months, with sores on the skin. When we saw the patient, she was extremely emaciated. The skin of her face was dusky, almost cyanotic; but this appearance was said to vary a good deal. The condition of the hands and feet was most peculiar; she had lost almost the whole of the *left* little finger; the corresponding part of the *right* hand was dead, dry, brown, and shrivelled up; and there was a distinct line of separation. Part of the index finger of the left hand was in the same condition, as were also the ends of several toes. The nails of several fingers and toes were distorted and shrivelled up. The gangrene was always preceded by a painful and inflammatory condition of the part about to mortify; and the process of separation was slow. There was symmetrical ulceration and scarring of the posterior part of each ear, of the *alæ nasi*, and of the upper lid. There were small circular scars about the forehead, and one or two on the right hand; and a large patch of scar, with some ulceration, still in progress, was seen at the back of each elbow. The ulceration was every where confined to the skin. The upper permanent central incisors were just coming through, and were well formed. There had been no keratitis; and, unlike most tertiary syphilitic ulcerations, the disease was accurately symmetrical. There was dry eczematous scab on the scalp, and the whole skin was dry and harsh.

Fracture of the Skull, Depressed, and probably Compound; Recovery, followed by Optic Neuritis and Atrophy.—Under the care of Dr. Slack, we saw a girl aged 22, who had become blind after a fall on the head. She stated that, five months before our visit, she fell and struck her head against some sharp portion of a wheel. She was insensible for about two hours, and her nose bled. A day or two afterwards, her eyes

became bloodshot. She was troubled with sickness for several days after the accident, but did not seem to have vomited blood. There was neither deafness nor discharge from the ears. About four weeks after the accident, she suffered for several days from headache and sickness; and about the same time her sight began to fail, the right eye being affected first. She stated that, simultaneously with the failure of the right eye, she partially lost power on the right side; but that she afterwards quite regained it. The left eye afterwards became affected in the same way as the right. She had no medical advice for the injury to her head, but stated that there was a wound of the scalp which bled somewhat. When we saw her, there was a depression, admitting the tip of the index finger, in the scalp, nearly over the supero-posterior part of the right parietal bone. She was quite blind. The pupils were widely dilated—the right somewhat more so than the left. In the right eye, the retinal veins were congested and somewhat tortuous; the disc was pale, and its margins very indistinct, from the existence of semi-opaque effusion, which, however, did not completely hide the vessels at any point. In the left eye, there were a crescent and myopic refraction; the retinal veins were markedly less distended than in the right eye; the disc was quite white; and there was no trace of effusion.

We are indebted to Dr. Haynes, the house-surgeon, for the opportunity of seeing this case, and for much information about the hospital.

BIRMINGHAM AND MIDLAND EYE HOSPITAL.

[BY OUR OWN REPORTER.]

WE paid a short visit to this institution on January 31st; and, although the morning was wet, we saw a considerable number of serious and interesting cases under the care of Mr. J. Vose Solomon.

The hospital contains fifty beds; the wards are roomy; and there are two large day-rooms for male and female patients. The outpatient consulting-room is large, and fitted with two dark compartments for ophthalmoscopic examinations. About five hundred out-patients are seen every week; and the in-patient accommodation is large enough to allow of many cases requiring careful attention and good diet being admitted, which at some of our larger ophthalmic hospitals would be compelled to put up with treatment as out-patients.

We saw one operation by Mr. Solomon for the removal of a bit of capsule left after a needle-operation for congenital cataract. The cannula-forceps was employed. Mr. Solomon has hitherto used chloroform in preference to all other anæsthetics.

A large number of operations is performed yearly at this hospital. Thus, we see from the Report for the year ending March 1869, that one hundred and fifty operations were done in the previous year for cataract, twenty-three of which were by Von Græfe's method. There were one hundred and sixty-seven cases of iridectomy, and a large number of minor operations upon the ocular appendages, including nearly two hundred cases of strabismus.

Counterirritation.—Mr. Solomon makes use of counterirritation largely in inflammatory conditions of the conjunctiva, cornea, and ciliary region. He often employs the caustic stick, wetted, and rubbed on the skin around the orbit; combining this treatment with a seton when a more continued action is required. Mr. Solomon finds the wetted caustic rubbed on the eyelids very serviceable in cases where it is important to keep the lids at rest. The swelling and soreness which follow the application effect this admirably.

In using solutions of atropia, Mr. Solomon remarked that its irritating effects on the conjunctiva may sometimes be advantageously prevented by adding a very small quantity of nitrate of silver (one-twentieth of a grain to the ounce) to the atropine solution.

Administration of Iodide of Potassium.—Mr. Solomon sometimes uses carbonate of ammonia in combination with the iodide, for the purpose of stimulating a weak stomach. He considers it unnecessary and inconvenient to give iodide of potassium more than twice a day, inasmuch as the blood does not become free from the salt even after so comparatively long a period as twelve hours. He also advocates the use of small doses of *strychnia*, in combination with mercurials or iodides, in all syphilitic patients who are markedly cachectic.

Operations for Cataract.—Mr. Solomon, as a rule, completes the operation for cataract at one sitting. He considers that an interval of five or six weeks between the iridectomy and the extraction is not only needless, but sometimes injurious; and assured us that he had seen worse results follow this mode of procedure than when the whole operation is done at once. In cases of choroidal disease, he sometimes prefers the preliminary iridectomy; but always allows five or six months to elapse between it and the extraction.