THE THERAPEUTICS OF HÆMOPTYSIS.

By G. GODDARD ROGERS, M.D.,

Physician to the Royal Hospital for Diseases of the Chest, etc.

DR. WATERS, of Liverpool, has contributed to the last number of the JOURNAL a very able clinical lecture on hæmoptysis. I gather from his concluding remarks on treatment, that he rightly, in my opinion, gives the preference to gallic acid, next to sulphuric acid, and, failing these, to acetate of lead. I am inclined to accept the correctness of Dr. Waters's observations on the unsatisfactory results which follow the use of digitalis in pulmonary hæmorrhage. The City Road Hospital *Pharmacopæia* contains a formula for its administration, but I have little doubt that to the combination of sulphuric acid and laudanum a great part of its popularity is due. Still, in hæmoptysis depending on a material obstruction in the left heart, I put great reliance on this drug. Dr. Waters closes his paper with an allusion to turpentine, and seemingly intimates that he has exhausted the list of styptics. Surely alumen exsiccatum and diluted acetic acid are worthy of a place. My note-books of cases in the Northampton Hospital contain plenty of instances in which these remedies solely used acted most beneficially. So long ago as 1858, I called attention to the very marked efficacy of the (so-called) tannate of alumina in spitting of blood. Dr. Bence Jones, during the time when I was Medical Registrar at St. George's Hospital, first brought it under my notice. I have never found occasion to look upon it as other than a most valuable styptic, and did space allow I could adduce several instances to prove this, both from hospital and private practice. Iron-alum, a sulphate of peroxide of iron and sulphate of ammonia or potash, is perhaps a still more powerful astringent. The dose as set down in the books is rather too large; it being better to begin with three grains than with five. Ruspini's styptic, although there is no mystery attaching to its composition, deserves a passing notice amongst the astringents of extraordinary power.

CLINICAL MEMORANDA.

OPHTHALMIA NEONATORUM.

It is generally stated in established works on ophthalmology, that the purulent ophthalmia of infants is caused in most cases by direct contact during birth with unhealthy vaginal secretions. A case occurred lately in my practice, which proved beyond all doubt that this is not the invariable cause of the ophthalmia. A lady was delivered by me of a female child, which was expelled with the bag of membranes unbroken. On the third day its left eye was violently inflamed, the lids being swollen and of a dark red colour, with a copious discharge of thin yellow pus. Here, then, was an instance of the disease in question showing itself in its most decided form, under circumstances which precluded all risk of contamination by the vaginal secretions.

Guildford, March 1871. HENRY SHARP TAYLOR.

TRAUMATIC TETANUS TREATED WITH HYDRATE OF CHLORAL: RECOVERY.

HENRY H., aged 6, on October 23rd, caught his hand in a corn-crusher and sustained a compound comminuted fracture of the first phalanx of the little finger; the first phalanx of the third finger was also completely severed. He was treated at the time of the accident by a surgeon of the neighbourhood, and appeared to be doing well up to the third week, when the mother first noticed a peculiarity in the child's walking. By the evening, this had increased so much that he was obliged to be carried. On the following morning, he was unable to move. On Friday, November 17th, he came under my care. I found him in a complete state of opisthotonos, and suffering acutely. The abdominal muscles were rigid, and as hard as a board. The teeth were separated sufficiently to admit the handle of a teaspoon; the facial muscles were contracted; risus Sardonius was well marked; the bowels were constipated. He had no great difficulty in swallowing. He was ordered to have three grains of calomel, to be followed by a dose of castor-oil, and to take five-grain doses of the chloral hydrate every two hours till relief was obtained. After the second dose of the chloral he was easier, and the third dose sent him to sleep for a short time. The chloral was continued every three or four hours during the night. On the following morning the improvement was evident. He drank milk readily. The chloral hydrate was taken regularly; and on November 21st he was free from pain; the rigidity of the muscles was considerably diminished; and the mouth could be opened wide enough to admit the

bowl of the teaspoon. He could raise himself partially from the bed; and, on my entering the room, the little fellow greeted me with a genuine smile. He slept well, and took beef-tea and milk eagerly. The chloral was ordered to be continued in three-grain doses every four hours. On November 27th he was able to leave his bed; and on December 4th he walked into my surgery to have his fingers dressed, looking the picture of health.

Plympton, Devon.

GEORGE MILES, M.R.C.S.

NOTE ON TRACHEOTOMY IN CROUP AND DIPHTHERIA.

IN THE JOURNAL for March 4th, Dr. Buchanan, of Glasgow, cites his latest experience of tracheotomy for croup and diphtheria by the brief narration of his thirteen last operations. In analysing these, we see that four were recoveries, three in diphtheria at the respective ages of seven, five, and eight, and one successful croup case, aged nine.

Of the nine unsuccessful cases, including the one operated upon for an impacted bone in the glottis, one was four years old, three were below and four above that age; in other words, all the cases operated upon of a less age than four years died, the recoveries occurring only in those older. Now this question of age with regard to the operation of tracheotomy in children for disease is a very important one; in fact, so important is it, that in the minds of many hospital surgeons the mere question of the age of the patient often settles the propriety or otherwise of opening the windpipe. It is considered that the operation should not be performed for croup or diphtheria under four years.

At the last meeting of the Pathological and Clinical Section of the Birmingham Branch of the British Medical Association, Dr. Underhill, of the Children's Hospital, exhibited several tracheæ after fatal croup and diphtheria; and in the discussion which ensued Dr. Russell most distinctly stated that, upon clinical grounds, he would not be a party to tracheotomy in a croup-suffering child under four years; and this dictum was assented to by the hospital surgeons present. Upon this point the collected experience of the various Children's Hospitals of the kingdom will be very interesting, and I trust before long to be enabled, in another communication, to lay the information thus obtained before my surgical brethren.

Perhaps Dr. Buchanan would say how his first twenty-six operations tell for or against what, as I venture to think, ought to be considered a surgical law.

VINCENT JACKSON,
Senior Surgeon, South Staffordshire General
Hospital, Wolverhampton.

INVAGINATION OF THE LARGE INTESTINE.

ON July 12th, 1870, I was sent for to see an infant aged 4½ months, said to be suffering from "bloody flux", for which a practitioner had prescribed chalk-mixture. On my arrival, I found the child—a fine one for its age—in a state of semi-coma, almost pulseless, covered with a cold clammy sweat, and rejecting the breast-milk as soon as swallowed. The pupils were contracted. On questioning the mother, I found that, far from suffering from "flux", the baby had not had "a proper motion" for several days, although a little mucus tinged with blood was occasionally voided. On examination of the abdomen, I discovered a tumour, much resembling a small sausage in shape and density, occupying the left lumbar and inguinal regions, its upper extremity inclining towards the umbilicus. I administered an enema, which was immediately rejected, with a little slime and blood. I then ordered brandy—one drop in a teaspoonful of beef-tea—to be given every half-hour. This caused the child to revive slightly; but it soon grew worse, and died the next morning.

In the afternoon, I made a *post mortem* examination. The small intestines were distended with faecal matter and gas, and immediately puffed out as soon as the abdominal walls were laid open. The ascending and transverse colon were not to be found; but the tumour already mentioned was discovered to be in the descending colon, with its denser portion in the sigmoid flexure: the rectum was empty and contracted. The tumour consisted of a portion of the ileum, that had become invaginated into itself, passing through the ileo-cæcal valve, and dragging along with it the cæcum and its appendix, the ascending and the greater part of the transverse colon. The portion of ileum involved in the intussusception was perfectly solidified, and resembled a piece of muscle rather than intestine; it was quite impervious, and its extremity rested, as I have said, in the sigmoid flexure of the colon.

I very much wished to preserve the specimen; but the father so strenuously opposed my taking it away, that I was compelled to relinquish my intention.

W. T. GREENE, M.B.