southern coast; or with a place in the interior, such as Cheltenham, 60.8 deg. But English patients of other classes than consumptives are in the habit of exposing themselves to high temperatures, and are apt to neglect the best season for baths. In former days, most baths were visited in spring and at the fall, as the Americans still call it, or in the early summer and late autumn months. But the English crowd all their visits into the hottest season of the year. They rush to foreign or to home baths in one mass at the end of July or beginning of August. At that period of the year the sun is very powerful; and most of the Pyrenean and a great many German baths, being situated in narrow gorges or in small basins, become heated up intensely, and may prove injurious in cases in which the influence of high temperature should be avoided.

Ems in particular, which is the German spa most resorted to for pulmonary affections, becomes especially warm and oppressive. Many people, including the Germans, who need scarcely be in these days characterised as stolid in any of their practices, have begun to think that it may be well to avoid these high temperatures, and have begun of late years to seek in summer the higher lying baths, or even to be satisfied with a residence in places of considerable elevation above the plains. The balance of evidence seems to show that, for consumptive patients in particular, an elevation of from 3000 to 4000 feet in Switzerland, and of course less in more northern regions, is quite sufficient. Cases of threatened consumption certainly often derive much benefit from summer visits to such heights, especially along with the judicious use of a milk diet.

How well aware the Germans are of the value of visits to such places in improving the general health—*Sommer Frische*, as they call them (and they are equivalent to the Hill Stations to which we have now for a long period resorted in India with a wonderful degree of refreshment)—is evident from the long classified list of elevated health-resorts in different parts of Germany to be found in Reichert's elaborate report in Schmidt's *Jahrbuch* for last year.

English readers may find an account of some of them in Dr. Theodore Williams's book on the *Climate of the South of France*, and a more extended list of them in an article in the *Quarterly Review* for July 1870, just before the war broke out. It is well worthy of consideration, whether many a patient may not gain more by the pure air he will breathe, and the quiet life he will lead at such places, especially such as it has not become the rage of the English to frequent, than by a hurried visit to a fashionable bath, where, amidst its amusements and dissipations, all regular treatment is often forgotten, and the waters of the spring do not obtain a fair trial.

NOTES ON MEDICINE AND SURGERY.

By P. CRAMPTON SMYLY, M.D., F.R.C.S.I., L.K.Q.C.P.I.,
Surgeon to the Meath Hospital.

OVARIOTOMY.

CASE I.—Miss S., aged 40. The disease was first observed two years before she came under observation. Fluctuation was distinct. The uterus was healthy. The tumour was removed, and found to be bilocular, without any solid matter. The pedicle was long, and was secured by Mr. Spencer Wells's clamp. The sac contained seventeen pints and a half of a thick brown fluid. The patient has made a complete recovery, and is now in good health, five years after the operation.

CASE II.—Mrs. F., aged 32, fair, with light red hair, well made, married ten years, but had never conceived. Menstruation was regular, but scanty. About fourteen years ago, she suffered from irritation of the bladder, and complained of a burning feel low down at the left side of the abdomen. After she was married, she consulted a physician, who told her that she had an enlarged womb. Five years before she came under observation, the abdomen began to enlarge, and the irritation of the bladder completely subsided. For four years, the swelling gradually increased; but in the last six months, it had more than doubled its size. The wave, on percussion, was distinctly perceptible from side to side; no creaking sounds were detected with the stethoscope. The uterus was healthy.

The tumour was removed on October 8th, 1868. Just as the first incision was about to be made, violent vomiting set in, and the operation was postponed to the afternoon, when it was performed. On the cannula being plunged into the tumour, about seven pints of dark clear fluid escaped. The lower part of the abdomen became flaccid, but the upper remained unchanged. The cutting portion of the cannula was again protruded and pushed through the septum. The rest of the fluid then escaped, and the cyst was withdrawn without any difficulty, and, the pedicle being long, was secured with the clamp. The wound was

closed with carbolised silk-sutures. The whole quantity of fluid removed was thirty pints. On the fifth day, the sutures were removed; there was not a drop of suppuration. The clamp was removed on the fourth day. On October 31st, she left town well. She is now, more than two and a half years after the operation, in robust health.

CASE III.—Mrs. P., aged about 45, came from the country. The tumour had existed for a long time. She had repeated attacks of inflammation. The tumour was so large that she could not rest in bed, and the only position in which she could sleep was sitting on the floor on a pillow, leaning forward with her arms on the seat of a chair. She was of dark sallow complexion, with black hair, and very much emaciated. The tumour was evidently adherent over the whole anterior surface. There was distinct creaking, and a very large quantity of solid matter. The case being unpromising, her condition and the probabilities of the operation being explained to her, she elected to have the tumour removed.

She was completely chloroformed, and the usual incisions were made down to the cyst, which was found adherent—partly by new, partly by old adhesions. These were easily separated. The trochar was then plunged in, and the tumour partially emptied, when it was found that the greater omentum was spread out over the whole upper portion of the cyst, and was adherent in many places to it. It was carefully separated, and all bleeding points were carefully secured with fine silk ligatures. There were no adhesions behind. The pedicle was secured with the clamp, and the wound closed with sutures. She went on well up to the third day, when peritonitis set in, with darting pains through the abdomen. However, she took plenty of nourishment, though she frequently vomited. On the eighth day, she got a sudden start, a friend unexpectedly coming from the country, and entering her room without notice. She sank rapidly, and died on the ninth day. At the necropsy, there was found to be extensive peritoneal effusion, but no bleeding whatever into the cavity.

CASE IV.—Mrs. —, aged 35, came to town, as she considered, about the eighth month, to be confined in Dublin. Her medical attendant visited her occasionally until she had gone two months past her time, when Dr. Churchill saw her, and discovered an ovarian tumour of large size. She was nearly twice as large as a woman at her full time. After several examinations and consultations, ovariectomy was decided on. The steps of the operation were most curiously like the last; there were numerous adhesions, and the omentum was spread out over the tumour, and adherent. The pedicle being very short, the coil clamp was used, and answered very well. She lived to the fourth day, and then sank from diffuse peritonitis. The *post mortem* examination showed extensive peritoneal effusion, but no bleeding.

UTERINE TUMOUR OBSTRUCTING DELIVERY.*

By HENRY J. YELD, M.D.,
Surgeon to the Sunderland Infirmary.

The history of complicated cases occurring in midwifery practice is always of interest to practitioners of the obstetric art. When the case terminates in the recovery of the patient, the medical attendant narrates the facts of the case with a certain amount of self-pride and gratification at his success. At the same time, the accounts of cases ending fatally are of equal, if not greater, interest, although there is not the same amount of satisfaction in relating them. The case, the particulars of which I am about to narrate, belongs to the latter class; and it is only on account of its presenting peculiar features that I bring it before you this evening.

On Easter Tuesday afternoon, I was sent for to see Mrs. D., aged 37, who was in labour with her ninth child. I had previously attended her in several of her confinements, all of which were tedious: the last child was still-born, it having been dead some days previous to birth. On the present occasion, I found the funis and left foot presenting. The liquor amnii had escaped, and the uterus was firmly contracted round the body of the child. The pains were only slight and at long intervals. I found it impossible to reach the other foot, and a considerable amount of traction on the foot presenting, had no sensible effect upon the child. Consequently I considered it advisable to leave nature to herself, in the hope that, in a few hours, uterine action would set in and the labour be terminated. The patient had very little pain during Tuesday night; and on Wednesday morning, finding that no progress had been made, I gave her a good dose of ergot. This had the effect of bringing on the pains, which, however, produced little or no effect upon the child. The patient seemed to be becoming exhausted, so I determined to obtain assistance, administer chloroform, and deliver. Mr. Welford was kind enough

* Read before the Sunderland Medico-Chirurgical Society.

to go with me. At this time the foot was outside the vulva, and quite black and œdematous. Chloroform was given; and, after a little difficulty, owing to the narrowness of the brim of the pelvis, I reached the other foot and brought it down. Even then we had great difficulty in bringing the child away, and it was only with an immense amount of traction, exerted by Mr. Welford and myself at the same time, that the delivery was completed. On examining the child, we found it to be hydrocephalic, the head being very large; the left leg from the hip downwards was perfectly black and œdematous. The funis had given way at the umbilicus, and the child had been dead two or three days.

The delivery of the child having been completed, the next step was the removal of the placenta. Mr. Welford examined, and found a large mass firmly adherent to the walls of the uterus. This was thought to be the placenta, and we at once proceeded to remove it. This was not accomplished, however, without very considerable difficulty and patient perseverance; in fact, so difficult was it that, when we had all but entirely detached the mass, our hands became completely powerless, and Mr. Hopgood was sent for. On his arrival, I managed to introduce a blunt hook into the tumour, and so kept up a certain amount of traction, whilst he broke down the remaining adhesions. The mass came away, when it was found to be a fibrous tumour, weighing four pounds and a half, and nine inches in circumference. The placenta was found attached immediately behind where the tumour had rested. There was no guide to the placenta previously to this, as the funis was decayed and broke down under the fingers. Although there was no hæmorrhage, there was little chance of the patient recovering after such a labour. She gradually sank, and died two hours after delivery.

In reviewing this case, there are a few points worthy of notice. The first is the peculiarity of the presentation; namely, the foot and the funis in almost its entire length. The gangrenous and œdematous state of the foot and leg was to be accounted for by the fact that the tumour, by the uterine action, was pressed firmly against the back and buttocks of the child, and thus strangled the limb against the brim of the pelvis. The tumour itself was attached to more than one half of the uterus from the neck to the fundus; the attachment at the two extremities being excessively strong, that at the fundus being almost ligamentous. Hence the extreme difficulty with which the child was extracted, the hydrocephalic head only making the case more complex. The position of the placenta, hidden as it was behind the tumour, led to the belief that the tumour itself was the adherent placenta which had undergone some organic change. The fallacy of this was only proved by the discovery of the placenta after the removal of the tumour.

The last remark which I would make in reference to this case is the possibility of removing a fibrous tumour of the uterus by breaking down its attachments with the fingers. The task was difficult to us, as I have already said; but it was nevertheless completed without any hæmorrhage ensuing, and, I should say, with little if any injury to the uterine walls.

Such is the history of this interesting case, one similar to which has not, I believe, been recorded in the annals of midwifery practice.

SUBCUTANEOUS INJECTION OF ERGOTINE IN HÆMOPTYSIS.

By WM. ALLAN JAMIESON, M.B., Berwick-on-Tweed.

IN the July number of the *Edinburgh Medical Journal* for last year, Dr. George W. Balfour recommended the hypodermic injection of ergotine in hæmorrhages of various kinds; and I determined to try it in the next case of hæmoptysis which occurred in my practice. The result in the following is, to say the least, remarkable.

A. B., aged 41, a tobacco-pipe maker, a fresh-looking man, and not intemperate, fifteen years ago, about the New-year, fell asleep when rather tipsy, out of doors, one wet night. He caught cold then, and had a cough ever since, which had not, however, interfered with his pursuit of his trade. On November 20th, 1870, he had to walk quickly up a steep hill, and then stood, when overheated, exposed to more or less of a draught. On the morning of the 21st, while at work, and not using any unusual exertion, he brought up a mouthful of florid blood. This recurred at intervals during the day, and in the evening he called for me. I did not then strip him for examination, as he was somewhat overheated, but at once injected five grains of ergotine (procured from Messrs. T. and H. Smith of Edinburgh), dissolved in ten minims of distilled water, into the cellular tissue of the arm.

On November 22nd, no more florid blood had come up after the injection, only one or two dark coagula. At the base of the left lung, both anteriorly and posteriorly, there was fine crepitation audible at

the close of inspiration, but no dulness on percussion. He felt well and returned to work, an aperient pill being given to avoid constipation. On the 23rd, there was slight return of the hæmoptysis; and on the 24th, it was again considerable. I therefore repeated the injection of ergotine, enjoining strict rest in bed. The result of the injection was the same: the expectoration of florid blood immediately ceased, only a dark clot or two coming away. Rest was continued till December 1st, when he resumed his employment, quite well, with the exception of the moist sounds at the left base.

He continued well during the severe winter of 1870-71, taking, from time to time, a little cod-liver oil, until May 7th, 1871, when he came to me in great trepidation, the hæmoptysis having recurred. While in my house, he spat up some bright blood; and I therefore had recourse again to the ergotine. The expectoration of bright blood at once ceased, and a tickling cough which preceded it disappeared also. Next day, I found him well, only one or two brownish clots having come up. The crepitation was still audible, though less clearly at the left base; and though there was no appreciable dulness, there was slight flattening of the chest-wall. I ought to have mentioned that I examined the expectoration in November, in the manner recommended by Dr. Fenwick, without finding any fragments of elastic tissue.

Should the result of this case be borne out by further experience, we shall have to thank Dr. Balfour for introducing a remedial agent sadly wanted, an efficient and rapidly acting styptic in hæmoptysis. No local effect, save slight irritation of the skin, lasting a few hours; and no influence on the pulse, which remained at 72, resulted from the injection.

PROFESSOR FLOWER'S HUNTERIAN LECTURES ON THE TEETH AND ALLIED ORGANS IN THE MAMMALIA.

Delivered at the Royal College of Surgeons of England.

LECTURE XV.—*Wednesday, March 22nd.*

THE Artiodactyle Ungulata have many more existing genera than the Perissodactyles; there are also numerous fossil species. At first sight, the animals of this suborder vary much. The ruminating animals were formerly placed in a separate order; but, as they are closely allied in structure to many of the Artiodactyles, and are united to these by extinct forms, they are now regarded as forming only a portion of this suborder.

The Artiodactyles are divided into five groups: Anoplotherina, Suina, Camelina, Tragulina, and Pecora. The latter three constitute the former order Ruminantia.

The group Anoplotherina includes many animals all now extinct, presenting various resemblances to members of the other groups. The Anoplotherium had the full typical number of forty-four teeth; and these were continuous in each jaw, without any interval, and nearly of the same height throughout. There were three incisors, a small canine, four præmolars, and three true molars, larger and more complex than the molars. In the lower jaw, the last molar was large and had three lobes; the other molars had two lobes.

The dentition of Suina is illustrated in the Pig, in which the teeth are somewhat modified from those of the wild Boar. The formula is $i \frac{3}{3}, c \frac{1}{1}, p \frac{4}{4}, m \frac{3}{3} = 44$. All the teeth are functionally developed; but there are differences in size. The upper incisors are short, the third being smaller than the others; the middle ones do not meet at the middle line of the jaw, but touch at their apices, and each has a lobe on the inner side of the cutting edge. The second incisor is simple, flat, and marked with vertical indentations. The lower incisors are long, narrow, and project forward; the outer ones are the shortest, the others being nearly equal in length. The canines are large, especially in the male. The upper canines in the Boar pass outwards, upwards, and then inwards, forming the tusks. The lower canines project more directly upwards; and their posterior surface rubs against the anterior surface of the upper teeth. The enamel, in the lower canines, is confined to the posterior surface of the tooth; in the upper canines, it covers the tip, and from this three longitudinal tracts proceed down the tooth. The canines in the Boar have persistent pulps; and the upper ones, if not worn down, may grow till a circle is formed. The molar teeth form in each jaw two nearly straight and parallel rows. In the upper jaw, they lie together; in the lower, the first præmolar is separated by an interval from the others. The teeth increase in size from before backwards. The præmolars are compressed from side to side, and thick in the antero-posterior direction. Before they are worn down, they present a remarkable pattern. The first and second upper