I must insist that this part of the operation should be done by the surgeon himself, and that an enema-syringe is calculated to pump the fluid into the uterus with unnecessary and even dangerous force. From this risk the Higginson's syringe is comparatively free. The propelling force, even when the ball is firmly compressed, is small.

Further, if the finger guiding the injection-tube be kept in the os uteri, information is given as to the effect produced in checking the bleeding, and the closure of the os upon the tube is obviated. As I have explained in my work on the *Diseases of Women*, when the os uteri is closed, the uterus, contracting concentrically upon fluid contents, tends to drive the fluid along the Fallopian tubes. Dr. Swayne's comment to this effect is perfectly in accordance with observation. It is an imperative condition to preserve patency of the cervix for the outflow of the injected fluid. In the work referred to, and in the third edition of the *Obstetrical Operations*, which will shortly be published, I have discussed with some care the subject of intrauterine injections in the puerperal and non-pregnant woman. In the first work, I have given an example similar to that of Mr. Hodgson of severe collapse, following an ordinary vaginal injection of sulphate of zinc in a non-pregnant woman suffering from prolapse, with patency of the cervix uteri.

Mr. Clark's case is an excellent illustration of the beneficial use of iron-injection in *post partum* flooding. Here again, as in many other cases, it acted after the failure of grasping, ergot, firm pressure on the abdomen, and the injection of cold water. It is not unworthy of remark, that Mr. Clark had previously injected a solution of permanganate of potash. It did no good; although, had the uterus been excitable, the cold might have been expected to act. I have recently been informed by an excellent provincial practitioner that, in a case where previous experience had led him to anticipate flooding, when he had consequently given ergot and used all other means of prophylaxis, hæmorrhage occurring, he injected permanganate solution with apparent advantage. But the uterus relaxed again, filled with blood, and death ensued. He has since trusted to the iron-injection in similar cases, and always successfully. He believes that, had he not been deterred from using it in the case described, the woman would have been saved.

ON THE CAUSE OF DEATH AFTER USING PERCHLORIDE UTERINE INJECTIONS FOR *POST PARTUM* HÆMORRHAGE.

By EDWARD JOHN TILT, M.D.

UNDER the head of "Obstetrical Memoranda", in last week's JOURNAL, Mr. Hodgson of Brighton relates how, while making a vaginal injection, a patient of his passed the tube into the cervix, and thereby caused a solution of zinc to flow from the womb through the Fallopian tubes into the peritoneum, thereby producing what he calls "short-lived peritonitis". I doubt this explanation, unless Mr. Hodgson ascertained that, in this patient, the cervical canal was sufficiently patulous to freely admit the tube of the instrument.

I should not presume to doubt the validity of his explanation, had I not met with half a dozen cases during the last thirty years, in which the use of a vaginal injection was suddenly followed by pelvic symptoms sufficiently acute to suggest peritonitis; symptoms yielding to appropriate treatment in one, two, or three days. In these cases, I had found more or less trouble to introduce the uterine sound, so I cannot suppose that my patients could have possibly passed into the cervix an elastic tube ten times the size of the uterine sound. I should add that, in these cases, the liquid injected was a weak solution of acetate of lead, and that the women had been in the habit of using injections. I submit that a better way of accounting for such cases is to admit that the patients have been awkward, and roughly jammed the extremity of the tube against the sore extremity of the cervix, the concussion being sometimes intensified by the patient, in her fright, pressing the instrument farther in, instead of withdrawing it. Those who so frequently explain the sudden advent of formidable symptoms in disease of the unimpregnated womb, by the passing of a fluid through the Fallopian tubes into the peritoneum, should remember that any surgical treatment of the womb, or even the rough use of the uterine sound, may cause the most formidable pelvic symptoms, and leave traces of pelvic peritonitis even if these symptoms soon abate. They should also bear in mind that Dr. Fontanes has published an account of various experiments in which he found it impossible, by distending the dead womb, to make fluids pass through the Fallopian tubes into the peritoneum. Neither should it be forgotten that the unimpregnated womb has often been injected with various fluids; that the patients have sometimes died and been examined; and that, as far as I am aware, in no case has the fluid in-

jected into the womb been found outside the fimbriated extremities of the Fallopian tubes, except in two cases mentioned in the discussion of my paper on Pelvic Lymphangitis, at the Obstetrical Society of London; one by Mr. Ross Jordan of Birmingham, the other by Dr. Palfrey—cases which have not been published, I believe. It would be singularly illogical to let these occasional untoward results of using injections weigh against their great value in the treatment of diseases of the sexual organs; the more so as these accidents can be prevented by telling the patients to use a flexible tube, and by showing them how to bend it, and how to introduce it into the vagina so that the nozzle of the tube may not run any risk of touching the os uteri.

Dr. Swayne of Bristol has lately explained a death that occurred after the injection of a solution of perchloride of iron into the womb to check *post partum* hæmorrhage by supposing that the solution had passed into the peritoneum. I am not aware that this explanation is warranted by the finding of the perchloride outside the fimbria in similar cases when the bodies have been opened. During the last few years, in the Paris hospitals, a solution of carbolic acid has been often injected into the womb soon after parturition. Many of these patients have died and been examined; but it was not found that the carbolic acid had passed through the Fallopian tubes into the peritoneum. I do not, therefore, think the fear of such an occurrence should bar the use of Dr. Barnes's method of checking incoercible *post partum* hæmorrhage; but I think it would be advisable to use tincture of iodine instead of the perchloride of iron, for reasons that I have given elsewhere.

A CASE OF GENERAL EXFOLIATIVE DERMATITIS (PITYRIASIS RUBRA), ACCOMPANIED WITH FEVER AND GENERAL PROSTRATION.

By EDWARD I. SPARKS, M.A., M.B. (Oxon.), M.R.C.P.,
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THE report in the BRITISH MEDICAL JOURNAL of March 13th, 1875, page 359, of a case of pityriasis rubra exhibited to the Glasgow Pathological and Clinical Society by Dr. Gairdner, has induced me to publish an account of a case in which the temperature was also elevated, which was under my care in 1873, and to which I had previously been unable to find a parallel. The history is as follows.

M. A. D., aged 48, was admitted into Charing Cross Hospital, under my care, on August 9th, 1873. She was brought in a cab, and was too ill to walk. All that could be discovered about her previous history was, that she had for some years been subject to rheumatic attacks. She was in Guy's Hospital twelve years ago with rheumatic fever, and, five years ago, was laid up with another attack for nearly five months. She had had eight living children, the youngest now four years old. Her husband was a strong healthy man. She had lived at Woolwich several years; but, two months ago (June 13th), she moved to New Cross, and had not been well since. She had ailed all the year, and had pains in her elbows and knees, and her joints had been swollen sometimes, but not so much as to prevent her from getting about. Her skin had been for some time rough and dry, but without scaliness, until about two months ago, when it became somewhat redder than natural, and inclined to peel in the bends of the elbows and in the axillæ. About a month ago, her hands were rough and scaly, and she believed that the redness and roughness of her body became much worse about a week before her admission. For some time, she had slept badly, and been thirsty and scarcely able to satisfy her thirst. Her bowels had been much confined; her appetite had been bad for some time. The remainder of the history will be given *verbatim* from the daily notes.

State on Admission, August 9th.—She complains of pains in her knees and shoulders on movement; but the joints are not swollen nor tender. Tongue very white on the dorsum, with red edges. Pulse, 120; temperature, 102.5 deg. Fahr. (4 P.M.). The most striking thing about her is the condition of her skin. There is a diffused redness of the chest and arms; but the legs are less affected, except the inner parts of the thighs, which are of a very deep red colour, and at first sight suggest the idea of scarlet fever. The skin is at the same time considerably thickened and dry, especially below the clavicles and over the front of the chest, and there is a large amount of scaly desquamation about the popliteal spaces, outer sides of the hips, both shoulders, and the front of the chest. The face is unaffected, except that there is a slight patch of redness inclined to scale on the left of the nose. The hands, to the tips of the fingers, are red, dry, and shiny, and there is desquamation in the flexures of the finger-joints. There are three or four flat pustules, of the size of small peas, over the lower end of the sternum. The patient is very weak, and unable to sit up—