I found her in a violent convulsion, and was told that she had had about eighteen fits during the night. The first occurred at eight o'clock on the preceding evening. On examination *per vaginam*, I found that the os uteri was about the size of a crown-piece, and somewhat rigid. The uterus possessed the *anterior obliquity* to such a marked extent, that the os was situated very far back in the pelvis. The membranes were entire; and the brow presented. The patient had bitten her tongue; I desired the attendant to place something between the teeth on the approach of the next convulsion. I passed the catheter and drew off a great quantity of urine, which was so albuminous that it solidified with heat and nitric acid. The pulse was 130, weak and compressible. The head and the whole surface of the skin were intensely hot. I proceeded at once to rupture the membranes, and then left her in order to get instruments for the purpose of delivery. On my return, about an hour afterwards, I learnt that she had had another fit. No foetal heart was audible on careful auscultation by myself and Dr. Basan, the present House-Surgeon of the St. Marylebone Dispensary, who kindly accompanied me. I now introduced the whole of my left hand into the vagina, and tried to dilate the os uteri with the ends of my fingers. Her body became very much convulsed. I therefore desisted for a while, and asked Dr. Basan to give some chloroform. The anæsthetic had the effect of producing some amount of relaxation of the uterine orifice. Having again introduced my left hand into the vagina and my fingers as far as I was able within the os, I perforated the head just above the orbit; having enlarged the opening, I removed the bulk of the cerebral mass, and, fixing the crotchet within the posterior portion of the cranium, I extracted the head within ten minutes. The body soon followed, and the placenta also. There was no hæmorrhage. Before we left the room, which was about noon, the patient was again slightly convulsed.—11.30 P.M. Four fits occurred between noon and seven o'clock. I had recourse to the same medicinal treatment as in the previous case, including leeches to the temples and dry cupping; and, although the convalescence was slow, it was perfectly satisfactory.

CASE III.—Mrs. A., aged 26, primipara. This case occurred in the British Lying-in Hospital. I first saw the patient about 2 P.M. on the 9th of December. I was informed that she had been subject to epileptic fits; she had also been in the Hospital for Women, in Soho Square, for some uterine disease. On examination *per vaginam*, I found the foetal head presenting in the first position; the os uteri was fully dilated; the waters had escaped about seven hours. The head was midway in the pelvis; the pulse was 90 and of fair strength; the foetal heart was distinctly audible in the left iliac region. A little before 8 P.M. I received an urgent message to visit this patient at once. I found that she had had one fit of convulsions; the pulse was now over 100, the foetal head had advanced but little, the ear nearest the os pubis could, however, be reached. Having emptied the bladder by means of the catheter, I at once delivered her of a fine living male infant. The placenta followed in a few minutes; there was no hæmorrhage. About a quarter of an hour afterwards, she had another distinct convulsion. On testing the urine, I found that it contained albumen. The medicinal treatment pursued was very much the same as in the other cases. There was, however, no necessity to have recourse to leeches or even dry cupping. I was told by the nurse in attendance that the patient had a slight convulsive fit on the 16th of December, exactly a week after the birth of her child. She shortly afterwards left the hospital, well, and in good spirits. Although formerly epilepsy was supposed to be a predisposing cause of puerperal convulsions, the experience of Drs. Hardy and McClintock and others prove that such is not the case; indeed, it is a rare occurrence for epileptics to be attacked with puerperal convulsions. This third case, therefore, may be considered one of interest on this account.

SANGUINEOUS EFFUSION INTO THE PONS VAROLII:

PARTIAL RECOVERY: DEATH FROM EFFUSION INTO ONE VENTRICLE.

By JAMES RUSSELL, M.D., F.R.C.P., Birmingham.

THE following is the sequel of the case to which I made a brief reference in the JOURNAL of October 24th.

I may premise that the original attack, as described by the patient's friends, occurred last May twelvemonth. It was characterised by sudden insensibility and convulsive movements of the left side. The left side of the face also was "drawn". The patient perfectly regained consciousness, but remained with imperfect paralysis of the *left* limbs and of *all* the muscles supplied by the *right* portio dura. I have already described the paroxysms of recurring congestion of the right eye to which she became subject. She was attended by my friend Mr. Hicken-

botham, who was again summoned to her suddenly at the beginning of this week. He found her speechless, but quite conscious, earnestly endeavouring to form words. A few hours afterwards, she was quite unconscious, and died within twenty-four hours of her seizure. Her age was 42.

I saw her twice during her illness, and am indebted to Mr. Hickenbotham for the opportunity of witnessing the *post mortem* examination. The head only was allowed to be opened. The morbid appearances were the following. A narrow irregular slit existed at the upper part of the right side of the pons, about one-third of an inch in length. Close to it, possibly communicating with it, were two small passages, about half a line wide and twice that length, burrowing across the septum of the pons. There was a faint yellow staining in the surrounding tissue. The tissue of the pons was firm, and there did not appear any wasting of the right half. The medulla oblongata and crura were healthy. The root of the seventh nerve was not lessened in bulk. The right cerebral ventricle contained about an ounce and a half of loose fresh coagulum. The outer half of the corpus striatum and thalamus, and the cerebral tissue enclosing the ventricle on the other side, were broken down, converting the ventricle into a large irregular cavity. The septum lucidum was preserved, and the left ventricle contained only some clear colourless fluid. The arteries at the base of the brain were unusually stiff and patulous; both the trunks and the primary branches were spotted with thickened patches, very visible in their interior aspect. In all other respects, the brain and its membranes were healthy.

I may add to the comments suggested by the recurring attacks of congestion of the eye in this case, the observation that, in hæmorrhage into the pons, even though, as in this case, of very limited extent, unconsciousness attends the commencement of the attack, together with convulsions; whilst a much larger quantity of blood may be poured into the substance of the hemisphere without inducing *primary* loss of consciousness. Trousseau asserts that "apoplectic stupor is a very exceptional symptom of invasion in cases of cerebral hæmorrhage, unless there be lesion of a central part, on an attack of convulsions." The contrast afforded by the two attacks in this case supports the accuracy of his assertion. Now, the occurrence of the insensibility together with convulsion in pons-hæmorrhage is a significant fact in relation to the ordinary explanation of an epileptic fit, to which the attack bears much resemblance. It seems to form a link of connexion with the disturbance in the condition of the conjunctival vessels noted in this case, and with the proptosis and change in the size and shape of the pupil observed under similar circumstances by Dr. Ogle. In making this remark, I am not unaware that the *contracted* state of the pupil which ordinarily attends the first occurrence of hæmorrhage into the pons is a circumstance not to be neglected in our speculations upon the subject.

NOTES OF A CLINICAL LECTURE ON STUTTERING AND STAMMERING.

By HOLMES COOTE, Esq.,
Surgeon to St. Bartholomew's Hospital.

WE are occasionally consulted on behalf of patients troubled with one of those imperfections of utterance known by the familiar names of stuttering or stammering. All persons are not aware that between these two there is a difference more marked than may be supposed, and which will be understood by a reference to the etymology of the words.

The word "stutter" is derived from an old German word—"stoten" or "stossen", to toss. The modern word is "stottern", and implies to stutter, to falter, etc. It is not confined to faults of utterance. Thus you may say, "Ein Rad das stottert," a rickety wheel; you might say equally a stuttering arm or leg, but not a stammering arm or leg.

The word "stammer" comes from "stamm" or "stem". The word "stemmen" is synonymous with "anhalten", and implies to stop in the middle of a word—to utter the root, and not the terminal syllables. It is children who "stammer", when they first begin to talk; they do not "stutter". To stammer means an interruption of words or syllables; to stutter is to falter in any way, and repeat. "Dieses Kind fängt an zu stammeln," "This child is beginning to stammer;" or "Mit stammelnder Zunge etwas zu sagen," "to say anything with a stammering tongue," means that the child says part of the word, and lolls out the rest; so that "stammeln" and "lallen" are sometimes used synonymously. To give one familiar example: a stammering child would say, "There is a-a-butter-er-er-fly." A stuttering person would say, "Th' th' th' at is a bu-bu-bu-butterfly." But, as I have said, you may speak of a stuttering wheel or a stuttering limb, although it is inelegant.

You will ask, What is the practical value of this knowledge? Well, you may cure stammering more frequently and more easily than stuttering. Stammering may proceed from timidity; from want of familiarity with the construction of sentences; from some temporary defect in the tongue, which will pass away with age. Hence it may be cured by patient instruction, aided by time. But stuttering implies a want of power to co-ordinate muscular action; and I fear we must seek its source (when "stuttering" is applied to speech) in the sensorium. When the word is applied to limbs or organs, we must refer to the spinal cord.

Many years ago, Professor Dieffenbach wrote a short work on stammering and stuttering, wherein he endeavoured to prove that the cause of this imperfection of utterance depended on a want of control over the muscles of the tongue. He argued that the muscles were too long for their office; and that it would benefit the patient to extirpate a part, particularly a portion of the linguales and long muscles of the tongue. He accordingly cut out a wedge-shaped slice from the middle of the tongue, and then sewed the edges of the wound together. But against this operation was justly urged the double objection—first, that it was based upon a wrong principle; and secondly, that it was both severe and dangerous. And, after the occurrence of one or two unfavourable cases, it gradually fell into disuse. But a partial improvement in the patients' utterance in some cases of stammering gained for him great temporary notoriety in the matter.

A stuttering person should be told to talk slowly, and to be circumspect in the choice of words, beginning to speak with one that comes to him easily. Many stutter only when called upon to pronounce particular letters, such as "l" or "r", etc. A little practice will enable them to avoid such words, and to substitute others. By such means, the evil may be greatly diminished, but not entirely removed. Some believe that they get on better by speaking both slowly and pedantically—often, I am sorry to say, deceiving themselves very much as to the amount of improvement. But I believe that we can give no better advice than that of teaching the patient first to utter some easy word or sound, and then to speak slowly and distinctly; also, when possible, to desist from speaking until the stuttering spasm has passed away. By the study of languages, a greater command of words will be obtained, and by this a corresponding advantage of selection in the means of expression will be gained.

CLINICAL MEMORANDA.

A CASE OF STRANGULATED FEMORAL HERNIA.

By CHARLES H. RALFE, B.A. Cantab., M.R.C.S., etc., Doncaster.

THE following record is interesting, from the masked nature of the case at its outset; and it illustrates well the necessity of making frequent examination of the groins and labia in all cases of vomiting with constipation; for, in this instance, *no hernial tumour* could be detected, although frequent examination was made, till thirty-six hours after vomiting had commenced.

Mrs. H., of Sporbrough, aged 73, a thin, spare woman, whom I had previously attended for cardiac disease, anasarca, and uterine tumour, sent for me on October 8th. She stated that, on the previous night, she had had a hard and difficult stool; and, since that time, "she had suffered much pain in her body, and had vomited some filthy black stuff." I at once suspected the nature of the case, and instituted a minute and careful examination of the labia and groins, but could detect no tumour whatever; neither was there any marked tenderness in those regions. As the evidence, so far, was only negative, I determined to wait, and prescribed a full dose of opium.

On my next visit, I found the symptoms more urgent, the vomiting more frequent and distressing; pulse 97. The groins were again examined; and I then found a tumour in the right groin, as large as a pigeon's egg. I at once requested the attendance of my friend Dr. Sykes, and my partner, Mr. Kiernan; and we determined, after giving the taxis a fair trial, to operate at once.

Making a limited longitudinal incision on the inner side of the tumour, and dissecting through the fasciæ till the sac was reached, then insinuating the nail of my forefinger under the edge of Gimbernat's ligament, I divided the stricture, and returned the bowel without opening the sac. The wound was then sponged out with a weak solution of carbolic acid, and the edges brought together with a single suture; and carbolic acid dressing was laid over.

Oct. 22nd. The patient has made an excellent and quick recovery, the wound healing rapidly. The bowels acted naturally three days after the operation. She sleeps well at night, has a good appetite, and is able to sit up a little every day.

ON ENUCLEATION OF THE EYE-BALL.

By R. H. McKEAND, ESQ.,

Senior Surgeon to the Manchester Royal Eye Hospital.

To those members of our profession whose attention is more particularly directed to ophthalmic surgery, the question of enucleation of the eye-ball cannot fail to be a subject of much interest. In all cases requiring this operative proceeding there has been some violent injury, succeeded in general by total loss of vision in the eye, with a tendency to inflammation and structural disintegration in the other eye-ball. The principal difficulty lies in giving an opinion as to what period after the accident this operation should be performed. It is now well known that, after the eye has sustained such a formidable blow as to lead to its destruction, at some period afterwards, ranging from a few weeks to some months or even years, an inflammation of a highly irritative character is set up in the uninjured eye, which is commonly known by the term "sympathetic inflammation." This, in many cases, proceeds with the greatest rapidity, when once it has commenced, defying all palliative measures, and being arrested only by the complete removal of the cause of its excitement; viz., the lost eye.

It is desirable to suggest some systematic plan or rule to determine at what time medical treatment should cease, and when, anticipating the future trouble when the injured organ has to all appearance become quiescent, we should recommend operative interference. It must frequently have fallen to the lot of the ophthalmic surgeon to be consulted on this subject; and in my own experience I have found it a very difficult task to convince the patient of the necessity of resorting to this proceeding, particularly as the time when the sympathetic mischief may come on cannot be predicted, and the patient, living upon the hope that he may escape the calamity, delays as long as possible before he consents to the operation, frequently agreeing only when the very mischief it was wished to avoid has commenced, and, making its way with giant strides, leaves only the alternative of enucleation or total blindness. Cases are frequently presented to me when this secondary disintegration has already set in, and only by the above operation could it be stayed; and even then, too often, the delay has proved sufficient to establish considerable structural changes, and the sight has been permanently deranged.

I think it behoves us to point out to our patients that serious consequences must unavoidably ensue by waiting for such an event; that medical treatment can be of no avail; and that, unless complete enucleation be at once resorted to, irreparable mischief may occur.

An eye, slightly dimmed in its vision, recovers its integrity frequently enough after the operation of enucleation of its fellow; but, on the other hand, so difficult is it to say at what point the disease may stop when once begun, that in my opinion the most prudent course to adopt is to remove the eye-ball as soon after the accident as the health of the patient will allow.

Abscission of the eye-ball has by some surgeons been considered a sufficient check to the progress of sympathetic inflammation; and doubtless both patient and surgeon may be anxious to accept such a proceeding on account of the great advantage obtained in forming a bed for an artificial eye, which should possess as much mobility as possible. I have frequently, against my better judgment, been induced to make a trial of its efficiency, from the persuasion of the patient, when the necessary explanation previously to operation took place as to the different processes with their results; now, however, after many years' experience, I never consent to adopt any other measures than perfect enucleation in all cases of the kind.

I cannot recall one successful instance where abscission sufficed to preserve the other eye from danger; but the complete removal of the eye-ball has, in all, been necessary, with this result, that the delay has given to the eye what we wished to save an opportunity of a more extended period for derangement, which in many of my former cases has been serious. Iridectomy, as a palliative measure where the eye-ball has not lost its contents from the injury, has the same objections open to it as abscission; in a word, it is of no use. I now, therefore, whether perception of light remain or not, always propose the removal of the eye-ball.

A certain difference of opinion must necessarily exist amongst operators in cases where variety is possible; but on this subject I hope to be borne out, when I say that delays are dangerous, and to be supported when I express myself an advocate for the thorough uncompromising operation, and that at the earliest stage, erring then, if at all, on the safe side. If the operation be well performed, a large bed of muscles remains, which, after all, when an artificial eye is placed on it, has a certain amount of mobility; while the lid, drooping more over the eye than in cases of abscission, conceals any defect; so that, with the excep-