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.