mucous membrane of the alimentary canal, due to sudden occlusion of the umbilical arteries, brought about by too early ligature of the umbilical cord. As, however, in the above case the cord was tied a good many minutes after the child was born this hypothesis is evidently untenable here.

Landau's theory, which is similarly excluded here, is that the condition is brought about by thrombosis of the umbilical vein caused by ligature of the cord before respiration has been fully established; emboli are thus set free into the vena cava inferior, and, passing through the right heart and the pulmonary artery, find their way through the ductus arteriosus into the pancreaticoduodenal artery. Wickham Legge suggests congenital absence of the common bile duct, but as there was no icterus in our case, this cause must also be excluded.

We can further exclude the probability of the child having swallowed blood from the maternal passages during parturition by the fact that the quantity of blood was very large and the stools also contained blood.

According to Epstein and Klebs, and Townsend, the condition is one of infectious origin; but the absence of fever in the above case is not in harmony with this suggestion. Düsser, who collected reports of 24 fatal cases, found ulcers of the stomach in 9 and of the intestines in 4. Gastric ulcer seems to be the most probable cause of the mischief in this particular case, as the attacks followed immediately after feeding, and the condition has also yielded to the ordinary treatment for gastric ulcer.

The recovery in this case is highly gratifying, as infants do not stand great loss of blood at all well. Riilliet records 50 per cent. of fatal issue. According to Eichhorst the mortality is still higher, and he is even of opinion that in cases in which the haemorrhage lasts longer than thirty-six hours recovery is exceptional. We may mention here that in our case the haemorrhage extended over three days.

As regards treatment, whilst there is a difference of opinion concerning the temperature of external applications—Eichhorst suggesting cold, and Alfred Vogel, in common with English authorities, recommending hot poultices—all agree as to the drug treatment, which should be of a styptic character—for example, iron perchloride, calcium chloride, suprarenal extract, and other haemostatics.

A CASE OF LONG-STANDING CONSTIPATION.

By HARRY GREY, M.D. EDIN.,
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THE patient came under my observation at the age of 13½, and for eleven of these years he had been accustomed to have his bowels relieved only at intervals of three to six weeks.

On one occasion two months elapsed between the acts, and the mother of the boy fixes this time by the fact that she had taken him to a seaside resort, where she stayed that period, and she was quite positive that no action of the bowels had taken place the whole time they were there. A significant incident of that sojourn was a visit paid to a local doctor, who quite flatly disbelieved the mother's story and told her to give the boy a dose of castor-oil, which had no effect. I got a hint for treatment from a question by the mother as to whether alcohol acted as a cathartic, as on one occasion when the boy was very poorly she had given him half a glassful of whisky, which was followed by a copious evacuation.

An interesting point in this case is the age at which the trouble began. At 2 years of age the sigmoid flexure of the colon is still much longer than in later life, and, as I found, this redundancy had persisted in the patient and aggravated his condition. It is surprising, however, how little the boy suffered from it. Occasional colic and vomiting, faintness, and headaches were his main symptoms. Latterly he had complained of pain in the front of the thighs, caused partly by pressure of the faecal accumulation on the anterior crural nerve and partly by the stretching of the fascia and skin over Poupart's ligament. More severe damage had been done to his physical and mental development. Though nearly 14 years of age he is still a child in manners, and though his stature is about normal (4 ft. 10 in.) he weighs only 4 st. 8 lb., as against the average at that age of 6 st. 4 lb.

The appearance of the abdomen is shown in the photograph, taken before treatment was begun, and any doubt as to the truth of the facts narrated above was dispelled by a palpation

of the enormous tumour, which felt like a full-term fetus *in utero*.

Verification, if such had been needed, was afforded by the result of treatment, as in the first week I removed 26½ lb. of nearly solid faecal matter, one day's record being 7½ lb. in four movements. These weights were carefully noted by the matron in charge of the Cottage Hospital, to which, for convenience of initial treatment, the boy was removed. Dr. Webb, of Kingsbridge, also saw the patient frequently, and can corroborate the facts of the case, incredible as they appear.

I have referred to the infantile condition of the descending colon; altogether 29½ lb. of retained faeces was passed in nine days; and the course of the bowel could be traced by the movement of the last solid lump; it felt like a 16-lb. cannon ball under the fingers, and just before evacuation was found in the right iliac fossa; from there one could move it down into the pelvis, up again into the left iliac fossa, and thence into the rectum. I mentioned the failure of castor oil to produce catharsis, and of course purgatives of every sort and size had, without success, been tried at the recommendation of both friends and doctors.

On rectal examination I found the sphincter ani firmly contracted, so much so that at the first attempt I failed to pass my finger, and I think it is quite likely that the whisky given on one occasion by the mother, was really the producer of the evacuation which followed, owing to its sedative and analgesic action upon the sphincter muscle. Acting upon this hypothesis, I administered ¼ gr. of cocaine by suppository, and was able thereafter to pass the finger into the rectum, which was distended with a huge faecal mass, very hard and firm. I then put the boy on morphine, administered in the form of ½ gr. suppository three and four times a day, and proceeded to remove the faeces by enemata of hot olive oil, 30 oz. twice a day. These continued for nine days, until the colour of the faecal matter began to change from slaty blue to more normal brown, by which time 29½ lb. had been voided.

Thereafter a suitable dietary, with Kepler emulsion, a pill of aloes and iron four times a day, massage to the whole body, and especially the abdominal muscles, and gymnastic exercises were ordered. The aloes-and-iron pills were gradually reduced in number until after three months only one a day was taken. In three weeks, again, this also was dropped, and now for two months no medicine of any kind has been taken, the boy has had an evacuation every day to the minute, he weighs 6 st. 4½ lb. (an increase of 24 lb. in six months), has lost the peculiar facial appearance and

protuberance of the abdomen shown in the photograph, eats well and sleeps well, and is making great progress in his studies, in which, owing to his ill-health, he was very backward.

In recorded cases of constipation the fortnightly evacuation is almost common, and longer periods not unknown, as instance a case recorded by Oliver in the *BRITISH MEDICAL JOURNAL* in 1896 (vol. ii, p. 839), where there was complete closure of the bowels for two months, and an extreme one, quoted by Eustace Smith, of three months.

This case owes its interest rather to the duration of the condition of constipation, the enormous amount of the retained material—practically a third of the body weight—and the satisfactory result of treatment.

ERGOT AND ARSENIC IN CHOREA.

By OLIVE RIVIERE, M.D., M.R.C.P.,

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IN the *BRITISH MEDICAL JOURNAL* of July 18th, 1903, Dr. Eustace Smith introduced to general notice the value of ergot in the treatment of chorea. Dr. Smith had used this treatment in his wards at the Shadwell Children's Hospital for a long period previous to that communication, and, having been favourably impressed with what I saw of it, I determined to give it a systematic trial among out-patients, where the favourable surroundings of in-patient treatment are not present to throw doubt on the action of the drug. Accordingly, between December, 1902, and May, 1903, I made notes of some 35 such cases coming under my care in the out-patient department at St. Bartholomew's Hospital, and have since treated a number of cases both there and at the Shadwell Children's Hospital. It is the result of this treatment that I now desire to record.

It will be seen that the determination of drug action on out-patients has certain advantages and certain disadvantages. The chief advantage is that the patient remains in the same general surroundings, so that whatever changes arise may more fairly be attributed to the effects of drug treatment. The main disadvantages are the risk that the medicine is not administered (not a serious one, I think), and the difficulty of giving sufficiently powerful doses without fear of poisoning. With certain diseases, and especially with chorea, comes in besides the fallacy of spontaneous temporary or permanent improvement, and the various changes to be observed from week to week in all such cases, apart from treatment. In consequence of these sources of error, and the great variety in the types of cases treated, I have decided that a statistical table of the results of treatment would be valueless, a general statement of results and impressions being more likely to prove reliable. The ergot was given in doses of 3j or 3jss of the liquid extract thrice daily, with 2 minims of liquor strychninae as recommended by Dr. Eustace Smith. These doses gave rise to no symptoms of poisoning, nor, indeed, to any physiological effects that were appreciable to myself. Among such out-patients I have found no signs of arterial spasm as indicated by slowing of pulse, increase of pulse-tension to palpation, or accentuation of the aortic second sound. The slowing of pulse, perhaps the most delicate sign, is of course valueless among child out-patients owing to the disturbing effects of temporary excitement or exertion.

My early conviction was that the ergot mixture had a marked curative effect on certain cases of chorea, and that in other cases the disease remained unchanged or became worse. My results show that about half of the cases were rapidly improved or cured by this means, and that most of the remainder improved when arsenic was substituted. I have endeavoured, but with negative results, to separate by some clinical features the type of case which responds to treatment by ergot. Several divisions of chorea may be made, all more or less arbitrary. Thus, cases may be divided into rheumatic and non-rheumatic, into those with much and those with little voluntary control, into those with little or much movement, into first attacks and later attacks, etc. To none of these divisions do the ergot-cured cases belong; examples of such may be found in all these classes. That it is the drug treatment which acts in these cases there is no doubt, since often if it is stopped the case relapses, and is again cured or improved by its readministration.

When the ergot treatment was found to have failed, arsenic was given, and in many cases improvement dated from that

moment and progressed slowly to cure. These may have been cases where arsenic would have benefited from the first. On the other hand, in two cases a curious thing happened. Their first ergot treatment was ineffectual, arsenic made them worse, but, on returning to ergot after arsenic had been tried, they were immediately improved or cured. This suggested to me the advisability of trying ergot and arsenic in combination. This I did with a mixture containing 3j of extract of ergot and 3 minims of liquor arsenicalis, these doses being increased as seemed desirable. I have used this mixed treatment for the past year, and have had such desirable results with it that I have been tempted to make this communication for the purpose of recommending it. Its good effects embrace, no doubt, three kinds of cases: (1) Those that are benefited by ergot; (2) those that are susceptible to arsenic; and (3) those, perhaps few in number, where, as in the two cases already mentioned, the one drug seems to supplement the other. I may say that among out-patients there are few cases which remain unbenefited by this treatment, and I confess to a feeling of great helplessness when I meet with such. In the majority the improvement begins at once.

The unbenefited cases consist mainly of those violent choreas for which so little beyond isolation can be done. Ergot and arsenic, given in such doses as one dares prescribe for out-patients, have no beneficial effect, and admission to hospital soon becomes imperative. The effect of ergot on those violent and protracted cases which gain admission to the hospital wards has been already described by Dr. Eustace Smith in the article to which I gave reference at the beginning of this communication.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

THE PETECHIAL RASH OF VOMITING.

IN certain cases of whooping-cough a petechial rash has been described as occurring on the patient's brow and temples;¹ and in certain cases of epilepsy a similar petechial rash (known as Trousseau's) has been described as occurring on the patient's brow and neck. In both cases the rash is obviously due to a sudden rise of intrathoracic pressure caused respectively by prolonged and violent coughing and by the violence of an epileptic fit. This pressure is transmitted against the hydraulic stream back along the superior vena cava and its tributary veins to the capillaries of the face and neck. Where those capillaries are least effectively supported, that is commonly in the skin wall, rupture may take place and a petechial rash be formed.

But there is another petechial rash, of which I have found no description in any textbook; nor have I ever heard of it except in the oral teaching of Dr. Graham Steel, whose clerk and house-physician it was in turn my privilege to be. This is the petechial rash of vomiting, which, I think, deserves a few lines in our textbooks.

A year ago I was consulted by a domestic servant, aged about 22, concerning a rash on her face. She was not alarmed about it, because she had had it once before, and believed it to be due to the common aperient pills which on both occasions she had taken a few hours before the rash came out. Her fellow-servants feared it was "something catching," and she had failed to reassure them. I found the pulse, respiration, and temperature normal, the tongue moist, but slightly furred. The patient declared that she felt well. Two days before she had suffered from acute indigestion; the previous day she had taken an aperient pill, and had vomited with great violence, standing up and leaning over a basin. Then she found the rash had appeared, and she consulted me on the morrow. The rash consisted of petechiae of various size, from a pin's head to a shirt button, irregular in shape, and often confluent, not disappearing on pressure; it extended thickly all over the areas of the temporal fossae and the brow between them, most marked in front, and fading away till it vanished on its upper and outer limits almost exactly where the hair normally begins, and at its lower limit, more suddenly, at the line of the eyebrows. Epilepsy, pertussis, and the violent onset of a haemorrhagic form of one of the exanthemata

¹ "During the extensive venous congestion, haemorrhages are very apt to occur in the form of petechiae," Osler's *Principles and Practice of Medicine*. Third edition, p. 93. See also p. 1097 for Trousseau's petechiae in the case of epilepsy.