case (one of recovery) of Mrs. Sankey. (See *Lond. Med. Gazette*, vol. xlvii, p. 804.)

Frequent examinations *per vaginam* are often productive of very serious mischief. Inflammation, followed by suppuration and sloughing, are not unusual results. Two or three examples will be found reported, in which great tumefaction of the external genitals and an inflamed state of the vagina existed. These results are alone attributable to frequent and unwarrantable interference.

Long and ineffectual attempts to deliver by the perforator and crotchet are highly dangerous. Contusion, lacerations, inflammation, infiltration, suppuration, and sloughing, are consequences which are not unusually to be found in cases in which violent efforts have been made to drag a mangled infant through a contracted pelvis.

II.—*On the Causes of Infantile Mortality.* The fœtus *in utero* sometimes dies from diseases which occur in its own system, and also from morbid changes in the structure of the placenta, which interrupts the supply of blood from this organ. These causes are not, however, confined in their operation to any particular class of cases. The duration of labour exercises very great influence upon the infant. If the membranes remain entire, and the liquor amnii undischarged, it will endure the continuance and violence of the labour-pains for a considerable length of time without injury. But after this event has happened, there is much more risk of mischief; and the danger increases in a ratio proportioned to the length of time the labour is protracted. The deaths of the infants which have occurred in Cæsarean cases are generally to be attributed to the long continued and violent pressure which they have endured during labour.

There is, however, another cause of infantile death which more especially belongs to the Cæsarean section. I mean the spasmodic seizure of the neck or body of the infant during its extraction through the incised opening of the uterus. In general, there is no difficulty experienced in these cases in withdrawing the infant from the uterus; but sometimes some portion of its body becomes so firmly grasped by the uterus in its passage through the incised opening that great difficulty is experienced in extracting it. There is, however, more danger to the infant when the neck is seized by the uterine grasp than when it is held by any other part of its body. In such cases the body of the infant has been most easily brought along until the shoulder had passed, when the neck is instantaneously seized, and so firmly held, as to require long and continued efforts to be made in order to extricate the head.

The fact, that the uterus in natural labour is energetically roused to expel the placenta which has been separated, first led me to attribute the seizure of the neck of the child during the Cæsarean section to the partial or complete detachment of the placenta. It has lately been doubted whether this theory will suffice to explain it, as "numerous instances are recorded in which the placenta either protruded through the incision, or was found lying loose in the uterine cavity, and in which no inordinate contraction ensued." I am, and was from the first, aware of the truth of this assertion, from an accurate analysis and tabulation of all the published cases; but, notwithstanding the apparent force of this objection, my opinion remains the same.

There are seven cases (two within my own knowledge) in which this event happened; and, as far as I can ascertain, the placenta has been partially or entirely detached in all these cases, or at least presumptively so.

How far the violent uterine action may resemble the spasm of hour-glass contraction, I cannot determine; yet analogy would lead me to think it did.

There is only recorded one (another case) in which the infant was grasped round the abdomen above the hips; the head, shoulders, and trunk, having been first drawn forth. The child was previously dead; and the only effect recognised was the squeezing out the meconium into the uterine cavity. Turning had been unsuccessfully attempted; and during this operation, it was found that there was hour-glass contraction. Does not the occurrence of hour-glass contraction before, and seizure of the child's hips after, the operation, favour the above mentioned opinion?

Clinical Lecture

ON

THE GERMS AND VESTIGES OF RHEUMATIC FEVER.

Delivered at the Royal Infirmary for Diseases of the Chest.

BY

HORACE DOBELL, M.D.,

PHYSICIAN TO THE INFIRMARY.

I PROPOSE to-day, gentlemen, to bring before you two classes of cases, specimens of which are always under treatment at this hospital.

In one, we see the most formidable effects of disease, damaging and incapacitating vital organs; in the other, a few marked symptoms of functional disturbance, producing temporary pain or discomfort. At first sight, there does not seem to be any connexion between the two; but I shall endeavour to show you that they are, in truth, but episodes in a continuous story, although often widely separated by time and circumstance.

The detailed notes of all the cases are on the table. The first case is that of G. T., aged 33, case-maker, admitted a fortnight ago, complaining of great oppression and tightness across the front of the chest, much increased by exercise; occasional vertigo and cold sweats; distressing palpitation, and short cough; quite unable to follow his work. He had old standing valvular disease, the vestiges of rheumatic fever fourteen years ago, from which he had suffered no particular inconvenience until he engaged in a day's rowing a week before admission; but this undue exertion had put his life in peril. Treatment directed to the relief of his oppressed thoracic circulation, and complete rest, have in fourteen days removed all his painful symptoms, and he is able to resume his occupation.

The next case is that of G. H., aged 40, a lithographic pressman, who was admitted for the first time two years ago, in a condition very similar to that of the last man (G. T.), and discharged in a few weeks with similar satisfactory relief. He was cautioned that, if he continued to follow the same laborious occupation, it would eventually kill him. This caution he

recklessly disregarded; and you will see by the notes that he has, in consequence, returned to this hospital every few months, each time worse than before, and each time obtaining less complete relief, as his organs have become more and more damaged. He is now, as you have seen, in a most perilous condition, and will never again be able to return to work. When first admitted, he had disease of the aortic and mitral valves, the vestiges of rheumatic fever. Now, the incompetence of the valves is more marked than before; and he has also great dilatation of the heart, retrograde congestion of all his vital organs, pneumonia of the left lung, considerable anasarca and albuminuria, and he is much exhausted.

These two cases, which are only examples of the class of which we see such numbers at this infirmary, serve well to illustrate the valvular damages which may result from rheumatic fever; the sort of complications which may follow the valvular disease; the striking and pleasing relief which can often be obtained by simple rational treatment; the great influence of habits and occupation upon the course of the disease; and they show how absolutely necessary it is that these should be strictly regulated, if we wish for any permanence in the relief obtained by treatment. But I have introduced them now for the purpose of reminding you of the grave importance which we must always attach to these vestiges of rheumatic fever.

It is to the next class of cases that I wish to direct your more especial attention to-day. They are so numerous here, that we are apt to get tired of them. They appear so simple, and, as a rule, are so easily relieved by a little regulation of the diet and a few weeks' medicines, that I do not wonder if you have considered them utterly devoid of interest or importance. A long course of clinical observation, however, has taught me to regard them in a very different light; and I wish to bring them before you to-day in an aspect and relationship which, I hope, will quite alter your ideas of their import, and give them a peculiar interest—an interest such as we attach to a commonplace-looking egg, so soon as we discover that, instead of being that of a bird, it may be developed into a python.

I refer to the cases which every day you see me mark with the letters "A. D.," to signify acid dyspepsia. A very simple group of symptoms, monotonously similar in most of the cases, serves for a correct diagnosis.

1. Pain at the epigastrium, coming on within an hour after food, generally within half an hour, very often within a few minutes, especially excited or aggravated by cheese or malt liquor.

2. Urine very acid, of high specific gravity, high coloured, and depositing urates on cooling, and uric acid crystals after standing some time; often suddenly changing to limpid and low specific gravity, but quickly returning to the other condition.

3. Tongue red at the tip, with elevated papillæ; often red at the edges also.

4. Appetite usually good, often very good, especially for animal food.

5. Epigastrium tender on pressure.

Such are the features of the majority of the cases, of course complicated and modified by the existence of other diseases, the habits of the patients, etc.

The most marked of these is the time at which pain begins after food: it is very soon after. Sometimes we find an old neglected case in which the pain comes on later, even an hour and a half, or, rarely, two hours after food; but, if it be a case of acid dyspepsia, you will find, on close inquiry, that when the symptoms first set in, the pain was directly after eating; and that the time of its onset

has become later and later. In these cases, too, the appetite will be bad, instead of good; and the food will often be vomited. They are, in fact, exceptional cases, in which the digestive power has become paralysed by the neglect of the original disease. With these exceptions, if the pain does not begin till more than one hour after eating, the case is not one of acid dyspepsia. To demonstrate these exceptions, I may mention to you Case 64,297, domestic servant. She complained of pain in the pit of the stomach, beginning from one to two hours after food, with much flatulence; but said that when it began, five weeks before admission, it came on much sooner after food; and as the complaint yielded to treatment, the pain came on sooner and sooner after food, till it ceased to come at all. In Case 64,525, the food was brought up undigested; and in Case 64,207, there was no appetite and no taste for food on admission; but when the complaint began, two months before, the appetite was very good.

So much, then, for the symptoms of this complaint. The next point is as simple and as striking as the symptoms; viz., that the cases almost invariably get well in a few weeks under a very simple plan of treatment.

1. We order them to take out-of-door exercise, and to attend to the condition of the skin.

2. We forbid them to take malt liquor or cheese, and allow whisky or brandy instead; and advise water to be drunk freely.

3. We neutralise the secretions by soda and potass in full doses, with lemon-juice or citric acid; then follow this with an alkaline stomachic powder of soda, potass, ginger and calumba before meals; and, if the patient be weak, give iron and quinine to finish. Sometimes we have to put a very small blister over the pit of the stomach, but not often. This alkaline plan of treatment must be thoroughly carried out; and it is surprising what large quantities of alkali are often required. If you find the symptoms obstinate, you will be sure to find that the secretions are still too acid: they must be completely neutralised at the onset; and then you will quickly find the tongue lose its red tip and edges, and there will be no more pain after food. This feature in the treatment brings me to the point upon which all the interest turns—the link which connects these common cases of acid dyspepsia with the cases of disease of the heart.

It lies in the fact that this acid dyspepsia is a symptom of a rheumatic state of the system. If you inquire into these cases carefully, you will discover in the majority a rheumatic history. You will find that they belong to rheumatic families, or that they have themselves been the subjects of rheumatic affections. This fact is illustrated by many cases now under treatment.

Case 64,035 had rheumatism two years ago.

Case 64,207 had frequently suffered from rheumatism.

Case 64,525 had been subject to rheumatism in the limbs.

Case 62,690 had rheumatic fever six years ago.

Case 61,827 had acid dyspepsia three years ago, and pleurisy and rheumatism at this hospital two years ago.

Case 64,297 had rheumatic fever badly thirty years ago, and slightly since.

Case 62,635 has had rheumatic fever every two or three years for eighteen years.

A patient admitted this morning with acute acid dyspepsia never had any rheumatic affection; but her parents and nearly all her brothers and sisters were rheumatic. One brother and her father had had rheumatic fever.

And these are only examples of what I shall be

able daily to point out to you, as fresh cases come before us.

There is every reason to believe that the acid, which is found in such quantities in the stomachs of these patients, is either identical with or closely allied to the *materies morbi* of rheumatism—the acid which must exist in excess in the organism before a person can have rheumatic fever.

Whether it is first generated in, or poured into, the digestive tract, and afterwards absorbed into the blood, may be open to question; but, whatever be the exact order of events, it is quite certain, from clinical observation, that it appears in the stomach very early in its career of mischief, and there gives rise to the symptoms of acid dyspepsia, which may, therefore, be taken as an important signal for alarm, never to be disregarded. It shows that the enemy is collecting his forces for an attack.

For this reason, as you may have observed, I seldom discharge patients who have been under treatment for acid dyspepsia without giving them directions for their future management, and the prescriptions of their alkaline medicines to be resorted to whenever they find the symptoms of their complaint returning. By adopting this plan, I have known many persons keep free from rheumatic fever and rheumatism for years, who previously had been subject to periodic attacks at short intervals.

If you inquire into the histories of persons who are subject to rheumatic fever, you will find, as a general rule, that they frequently suffer from acid dyspepsia; and, if you inquire into the histories of persons subject to acid dyspepsia, you will generally be able to make out either that they have suffered from some rheumatic affections, or that they belong to rheumatic families. In these two sets of cases, then, which are so numerous at this infirmary, we see the two ends of a long and sad story. So far as I am aware, the connexion between them has never before been specially pointed out; but I believe that I cannot too strongly impress upon you the importance of bearing in mind, when you get into practice, the fact that acid dyspepsia and valvular disease of the heart are to be regarded as the germs and vestiges of rheumatic fever; and that, if you keep in check the acid dyspepsia, you will not have the rheumatic fever; and that thus you may prevent the occurrence of the valvular disease.

A CONVENT CHANGED INTO A LABORATORY. We have, in the *Moniteur Scientifique*, the announcement of a grand chemical school which Signor Cassola has opened at Naples. He has hired a large convent and turned it into a laboratory. Italy did much for alchemy, the great grandfather of chemistry, and monasteries were the homes of science in the middle ages. Let us hope, then, that Signor Cassola's establishment will flourish and produce abundant fruits.

SPONTANEOUS GENERATION. The commission appointed to review the experiments of M. Pasteur and his opponents, MM. Pouchet, and others, relative to "*Spontaneous Generation*," report entirely in favour of M. Pasteur, and therefore oppose spontaneous generation. The report establishes that fermentable liquors may remain either in contact with confined air, or exposed to air which is often renewed without changing; and that if changes do take place, and organic beings are generated, this result cannot be attributed to the gaseous elements, but must be caused by solid particles introduced with air, and of which it may be completely deprived. Some of the experiments were objected to by the supporters of heterogenesis, and the commission will make further researches when warmer weather arrives. (*Chem. News.*)

Illustrations

OF

HOSPITAL PRACTICE:

METROPOLITAN AND PROVINCIAL.

SAMARITAN HOSPITAL.

ACUTE TRAUMATIC PERITONITIS: VENESECTION: RECOVERY.

Under the care of T. SPENCER WELLS, Esq.

THE following case is a very striking confirmation of the truth of the principles advocated by Dr. Markham in a lecture on Blood-letting in Inflammation, published at page 107 of our present volume.

A housemaid, single, 22 years of age, the subject of a tumour of the right ovary, was submitted to operation by Mr. Spencer Wells on Feb. 6th, 1865. The cyst was exposed by an incision five inches long, and was tapped and emptied; but the pelvic connections were so intimate that Mr. Wells made no attempt to separate them or to remove the sac, but closed the wound at once, uniting the trocar-opening in the cyst to the abdominal wall by a hare-lip pin, as bleeding was very free from the vessels in the cyst-wall. A very acute attack of peritonitis came on. In less than six hours after operation, the pulse was up to 120, the respirations to 48; the skin very hot, the lips dry, the tongue parched, and thirst excessive. But, as the aspect and voice were both good, Mr. Wells waited two hours longer; hoping that free perspiration might come on, and give relief. But, eight hours after operation, there being even greater heat of skin, the pulse 136, respirations 52, and vomiting had begun, he took ten ounces of blood rapidly from the arm in a full stream. In half an hour, the pulse fell to 124, the respirations to 48, and the pulse became fuller, though it remained incompressible. In another hour, though the pulse remained at 124, the respirations sank to 40, and she vomited for the last time. The next morning, eighteen hours after operation, the pulse was 120, respirations 28; the skin hot, but perspiring. There was much thirst; and the tongue was quite dry all day, but it became moist towards night; and the pulse had sunk to 104, and the respirations to 30. After this, there was nothing further to note beyond gradual convalescence. As she had only two small opiates in the first thirty-six hours after operation, the venesection alone seems entitled to the credit of cutting short a very acute attack of traumatic peritonitis. Probably no other remedy could have had anything like such an effect.

We need say nothing at present as to the treatment of the ovarian cyst; as it will depend upon circumstances, whether Mr. Wells will wait until the tumour in growing elongates its pedicle, or whether it may be desirable to inject iodine, or to insert a drainage-tube.