VOMITING IN GRAVES'S DISEASE AND ITS TREATMENT.

By J. A. NIXON, M.B., F.R.C.P.,

PHYSICIAN TO THE BRISTOL ROYAL INFIRMARY.

THE symptom of obstinate vomiting in Graves's disease is fortunately not of very common occurrence. Sometimes, however, it becomes a complication of grave import. Recently three cases have come under my notice in which the patients' lives appeared to be threatened by the persistence and frequency of the vomiting. In each case the patient had contributed to her own undoing by over-exertion at a time when the general symptoms of exophthalmos, goitre, tremor, and tachycardia were very severe; each of the patients was up and about, doing active house-work, at a time when rest in bed had long since been imperatively indicated; each of them volunteered the statement that the slightest movement in walking, going upstairs, and lifting weights, produced the vomiting.

The vomiting had become an alarming complication, dieting and drugs seemed useless.

In my first two cases absolute confinement to bed with the use of the bed-pan, and strict supervision to ensure that the patient did not move hand or foot to supply her own wants, was combined with the administration of a substantial diet by mouth; milk, bread-and-butter, eggs, fish, chicken, broth, were freely given. At first the patients vomited at rare intervals, but within two days tolerance was established and the food retained. The patients soon discovered for themselves that the vomiting was produced by exertion or movement, rather than by a true inability to digest solid food; and having found this out they took their food with increasing confidence, and improved rapidly.

The third case was admitted to the Bristol Royal Infirmary with similar symptoms. The orthodox method of rectal feeding was adopted, and small quantities of milk given by the mouth; the patient continued to vomit, and her general condition became worse. A marked acidosis developed. Finally, on the fifth day after admission, the plan of dieting was changed, and the patient was given moderate meals of solid food; she vomited on three occasions more, and was after each promptly fed again. After two days of this treatment tolerance was established, the acidosis disappeared, the patient improved in every respect, and her danger from this symptom was at an end.

It seems worth while to direct attention to this mode of dealing with obstinate vomiting in Graves's disease; the more so since the advice usually given and the plan commonly adopted is to withhold food by mouth and resort to rectal feeding, a plan which I believe to be as useless in Graves's disease as it is in the vomiting of whooping-cough.

Memoranda :

MEDICAL, SURGICAL, OBSTETRICAL.

TWO TESTICLES ON ONE SIDE.

In the JOURNAL of September 2nd, pp. 513-14, is a short article on this condition, based on a probable case reported by Dr. Caroline V. Lowe, in which it is stated that, according to Ahlfeld, only one instance is reported in a properly dissected dead body. Ahlfeld's report was made in 1880. As the condition is so extremely rare and so extraordinary, the following brief account of a case recorded by me in the *Journal of Anatomy and Physiology*, January, 1898, p. 216, will doubtless interest both the writer of the article and many of your readers, and throw some light on the case in question.

A boy aged 3 was operated upon by me in the Queen's Hospital, Birmingham, on August 21st, 1896, for a large congenital inguinal hernia on the left side. On exposure of the external ring two cords were seen emerging and passing down to the two testes, enclosed in one tunica vaginalis. The child died of shock some thirty-six hours later, and at the autopsy a careful dissection of the parts was made by my then house-surgeon, Dr. R. A. Bennett.

There was only one vesicula seminalis, situated on the

left side, and considerably larger than normal, and in connexion with it was a very large vas, as thick as an ordinary drawing pencil, which took the normal course as far as half an inch from the internal ring, where it divided into two of equal size, which passed down the inguinal canal into the scrotum to the two testes. The right spermatic artery crossed over the middle line about 3 in. below the umbilicus; and meeting its fellow of the opposite side just inside the internal ring, joined with it to form a single trunk, which divided again before reaching the external ring, the two vessels being distributed to the testes in the ordinary manner.

With this case in view, that of Dr. Lowe—a left-side hernia also—may well be another instance of this curious and remarkable developmental anomaly.

F. MARSH, F.R.C.S.,

Consulting Surgeon, Queen's Hospital, Birmingham, etc.

A CASE OF TUBERCULOUS DISEASE OF THE EYEBALL?

E. N., 21, dressmaker, first came to consult me about five years ago concerning the right eye. She had a large phlyctenule on the outer half of the right cornea, and a moderate-sized pustule on the conjunctiva, about one-sixth of an inch from the corneal margin. There was a good deal of pain, redness, and photophobia. She was pale and thin, and her general condition poor. She had been under another medical man, but had not improved. By the use of atropine and tonics she improved for a time; then I lost sight of her. She came to see me again two years ago; her condition was as bad as ever, and no treatment seemed to benefit her permanently. This unsatisfactory result was no doubt due to her having to keep on with her occupation as a dressmaker, and thus not getting sufficient rest and fresh air. Last year, at the end of July, she again came to see me, and I found matters much worse. The eye was intensely inflamed, and the anterior chamber full of pus. She was suffering great pain, and was looking very ill. After careful consideration I advised her to have the eye removed. To this she agreed, and was admitted into Stockton Hospital on August 4th. After removal of the eye, an examination of it revealed the following conditions: The anterior chamber full of pus. The sclerotic from the outer side of the cornea to beyond the insertion of the external rectus was greatly thickened, and there was an abscess cavity between its layers. A caseous nodule on the sclerotic just outside the cornea led down to the abscess cavity. The vitreous was fluid, and full of cholesteroline crystals, which settled down as a golden-brown residue. For some time after the removal of the eye she continued to look very ill, and suffered so much from severe headaches that I began to suspect she might have some meningeal trouble; but after a long change at the seaside she improved greatly in health and gained in weight. I might add that she had no strumous glands, nor was there any phthisical history in the family.

G. VICTOR MILLER, M.D.,

Ophthalmic Surgeon, Stockton and Middlesbrough Hospital.

ACUTE INVERSION OF THE UTERUS.

ON August 9th I received a call to a Kaffir woman. It was stated that immediately after the birth of a child, her womb, with the afterbirth attached, had appeared outside the body. Owing to the long distance from town, I did not arrive on the scene until eleven hours after the accident. I found a young woman lying on the floor of a hut. Her pulse was 75, and she related her history quite clearly. This was her second child, born easily during the night while she was lying on her back. Soon after the afterbirth appeared, and when they went to remove it they were surprised to find it still attached to the body. The attendants denied having pulled upon the cord or in any way assisted delivery of the afterbirth. This I can believe, as native midwives here exhibit a masterly inactivity, and I have never known one to meddle.

The uterus, with the placenta attached, was turned almost completely inside out, and was lying outside the body, supported by some dirty sacking. About 30 inches of cord was still attached to the placenta, so that shortness of the cord had not caused the inversion, unless perhaps it had been wrapped round the child's neck. On