The escape of the great vessels and the auricle itself is worthy of note.

I am much indebted to Captain John Tull, C.A.M.C., for his clinical aid and to Dr. T. S. Lister for the notes he supplied me with.

ACUTE INTESTINAL OBSTRUCTION DUE TO PREGNANCY IN A BICORNUATE UTERUS.

BY
C. E. S. JACKSON, F.R.C.S.ENG.,

SURGEON, WEST NORFOLK AND KING'S LYNN HOSPITAL.

THE following case is worthy of record because it is an example of a rare condition which presented great difficulty in diagnosis, and because an interesting question is raised as to what should be done in any future pregnancy.

Mrs. W. was admitted to the West Norfolk and King's Lynn Hospital on October 29th, 1919. The history was as follows: She had menstruated on August 5th, 1919, and had morning sickness in September; in October she noticed that her abdomen was swelling, and her breasts became somewhat tender.

Forty-eight hours before admission she was seized with sudden abdominal pain and vomiting. Her doctor tried turpentine enemata without avail. The vomiting continued, and the abdomen became distended and tympanitic. On admission to hospital the pulse was 104, and of low tension, and the temperature was 98°. Her features were drawn and her expression anxious; the extremities were cold. She vomited twice during her first half-hour in hospital; the vomit was bile-stained, with no suggestion of a faecal taint. The abdomen was somewhat distended, particularly in the left iliac fossa and left flank, and acutely tender all over. In the suprapubic region was a pyriform swelling, obviously the uterus, and I was at once struck by the fact that, although she was less than three months pregnant, the uterine fundus reached a level a fingerbreadth above the umbilicus. On vaginal examination the cervix was found to be softened, and there was marked fullness in both lateral fornices, while from the rectum could be felt a tense elastic swelling, filling up the whole pelvis and pressing firmly upon the rectum. A diagnosis of pregnancy complicated by impaction of an ovarian cyst was made.

Operation.

The abdomen was opened by a left paramedian incision 6 in. long, extending 1 in. above and 5 in. below the umbilicus. The intestines (particularly the large bowel) were very distended, and were with some difficulty packed off from the field of operation. On passing the hand behind the uterus a tense cystic swelling was felt. This swelling quite filled the pelvis, so that it was not easy to insinuate the fingers between it and the pelvic wall. After some manipulation, however, this was done, and the swelling was partly delivered from the pelvis, when the following was found to be the condition of affairs. There was a bicornuate uterus; the first horn was normally placed, while the second horn lay behind and to the left of the first. It was attached to the left side of the cervix; it lay behind the left broad ligament, and there was no direct communication between its cavity and the lumen of the Fallopian tube. It was impossible to expose either the anterior or posterior walls of the second horn, so a transverse incision was made across the fundus of it, and a fetus of two and a half months' gestation was removed, together with placenta and membranes. The horn was sewn up with silk as in Caesarean section. The condition of the patient was not good, and the abdomen was closed forthwith.

After-History.

The intestinal obstruction was completely relieved by the operation, the bowels being well opened by a turpentine enema next morning. Convalescence was normal. I saw the patient again on December 20th, 1919. The median uterine horn was now normal in size, while the abnormal horn could be felt quite distinctly from the rectum as a hard swelling of the size of a large walnut lying behind and to the left of the cervix and slightly above it.

It will be noted that subsequent events showed that only one horn of the uterus contained a fetus. In spite of this, the empty horn was very much larger than the full one. There were no lochia.

As regards further treatment, should the abnormal horn be removed? My own view is that it should. If the patient again becomes pregnant, the best that can happen is that she be delivered at term by Caesarean section; the worst is that intestinal obstruction will develop again.

From what was found at the operation, I feel sure that it would be a safe and simple procedure to remove the abnormal horn. The patient, however, was not willing to have a second operation, unless I considered that her condition was immediately dangerous, and this obviously was not the case.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

ANTISTREPTOCOCCIC SERUM IN PUERPERAL FEVER.

NATURALLY every case of puerperal fever does not respond to antistreptococcic serum, but it is well to remember its remarkable results in some cases. I have used it twice, and on both occasions with the most dramatic results. The chart reproduced speaks for itself. It is from a patient I treated recently, and it is noteworthy that only 10 c.cm. of the serum were used, more not being available at the moment. The directions sent with the serum recommend 30 c.cm. as the minimal dose.

A=10 c.cm. antistreptococcus serum.

The other case was even more gratifying, as the woman had had a temperature ranging between 104° and 105° F. for several days, with repeated rigors, yet responded immediately to the serum.

Northwood.

O. HILTON.

A SIMPLE TREATMENT OF RINGWORM OF THE NAILS.

In general practice onychomycosis is comparatively rare and its treatment is apt to be superlatively disappointing. Two years ago I met with two cases which appeared to be very much alike. Both were women of middle age and in comfortable circumstances. In one a thumb and in the other a finger nail was badly affected.

Examination of scrapings showed hyphal fragments, and a few particles, placed on wort agar gave cultures of rather slow growth resembling specks of damp flour. No conidial fructifications were observed, and the organisms consisted of infrequently branched mycelium with many oidium-like elements and some simple chlamydospores. The cultures died in a few weeks.

It may be objected that such a miserable depauperate mould falls short of what a ringworm should be, but these elements are just the constants of every ringworm culture, and all other elements are variants, more or less perfect, more or less obsolete.

Treatment.—The disease had existed for months in one, for years in the other. They were given a lotion of 3 j of salicylic acid in 3 jss of methylated spirit, to be painted on after scraping every night, and without scraping every morning, and to be used for three months or longer. Both have been cured for twelve months.

London, W.

ROBERT CRAIK.

MODE OF INFECTION IN PULMONARY INFECTION.

HAVING felt for a considerable time that the present view of the mode by which tuberculous infection is carried from the tonsil to the lung—namely, through the cervical glands to the mediastinal and bronchial glands and so to the lung—is not satisfying, I offer the following suggestion:

Might it not be that the infection is carried from the tonsil through the cervical glands to the jugular trunk and then passed directly into the blood stream through the jugular vein and so to the right side of the heart, from which it would pass to all parts of the lungs? This would aid in explaining why it is that the tuberculous process in the apex is manifested in the lung substance, while in other parts it gives rise in the first instance to pleurisy. The movement at the apex is so much less than that of the other parts of the lung that a greater slowing down of the capillary circulation is more likely in this part. It is in the capillary circulation of the pleura that this slowing down would occur in other parts.