seen recorded in the tracing. Two injections of adrenalin were given; the effect of each was to increase the volume of air entering the lung as the result of dilatation of the

bronchioles and to cause a rise of blood pressure. The effects were temporary. The third injection was atropine, which produced permanent and maximal broncho-dilatation by paralysing the broncho-constrictor nerves, and increased cardiac rate, and therefore blood pressure, by paralysing the cardiac vagus.

RUPTURE OF VEIN OF DERMOID CYST:

INTRAPERITONEAL HAEMORRHAGE: OPERATION:
RECOVERY.

By J. O. BEVEN, M.A., M.R.C.S.,
CAIRO.

THE following case is of interest as illustrating a cause of intraperitoneal haemorrhage which must be of considerable rarity, since no mention of it is made in the works on gynaecology with which I am familiar.

A married woman aged 29 was seized with severe abdominal pain at about 7 p.m. on November 24th, 1919. She had been quietly walking home from a friend's house when the pain came on very suddenly, at first on the right side, but soon becoming more general. There was a history of a similar attack in June, 1917, when nothing abnormal was detected in the pelvis, and neither renal or appendical trouble had been suspected. She was kept under close observation, but the trouble cleared up, and by July 10th no sign of it remained. She had had a much milder attack in October, 1918, but had not called in a medical man. She had two children, aged 4 and 2. The first labour was a very difficult occipito-posterior, which had called for forceps delivery, and had resulted in extensive laceration. Recovery had been satisfactory, and there was no history of obstruction to labour. In November, 1917, there had been a miscarriage at the seventh month, brought on by the shock of seeing an aeroplane smash. The menstrual history was suggestive. She had been regular till October, when the period had come on ten days late and been very scanty. The November period, also late, had begun the previous day, and was also scanty. When I saw the patient (at 3 a.m.) she was markedly blanched, and in very great pain. There was no air hunger or restlessness; she lay very still, moaning with pain. The temperature was 98° and the pulse 80. There was no distension, but movement was limited, and the lower half of the abdomen was extremely tender and rigid. I could detect no dullness, but the tenderness was too great to allow of thorough percussion. On vaginal examination I found the cervix low, not softened, and the fornices distinctly "boggy." No tumour was palpable, and the uterus, as far as the difficulties of the examination allowed me to judge, was not enlarged. The gloved finger had a little blood on it. The patient retched and vomited after the examination, the vomit containing about half an ounce of bright blood, which I disregarded as being probably pharyngeal.

The sudden onset, combined with the very extreme pain and tenderness, pointed to haemorrhage into the peritoneal cavity, which together with the rather suspicious menstrual history, strongly suggested a ruptured ectopic gestation. On the other hand, the history of the two previous attacks had to be taken into account; if they had been appendical, the present trouble might be due to the rupture of an appendix abscess, though this did not seem very likely. Neither the history nor the signs suggested a perforated ulcer, gastric or other. There was no reason to suspect an ovarian tumour as the cause of the mischief, since none had been discovered at previous examinations, or was palpable now.

In view of all this, I diagnosed a ruptured ectopic gestation, gave morphine gr. $\frac{1}{4}$, and ordered absolute rest, and an ice-bag

over the hypogastrium. Seen early next morning with Mr. F. C. Madden, F.R.C.S., the patient's condition was much the same, but the pulse had risen to 96. The morphine had not given much relief. Mr. Madden agreed with my diagnosis, and it was decided to move the patient into the Anglo-American Hospital, Cairo, for operation at once. Morphine was given again, and the eight mile journey in an ill-sprung ambulance was well borne.

As soon as the patient had been prepared and given saline by the rectum, Mr. Madden operated (4 p.m.).

A median subumbilical incision revealed the peritoneal cavity full of blood and clot. On clearing some of this away, a dermoid cyst of the right ovary, the size of a polo ball, was found and delivered. The tumour involved the whole ovary, and the right tube was seen running on the side of the cyst. The long pedicle contained a number of large veins, and near the base of it were three transverse tears. The upper and lower of these were superficial, but the middle one, about an inch long, had opened a vein, from which the haemorrhage was seen to proceed. This vessel was with difficulty secured, as it ran directly into the folds of the broad ligament. The pedicle was finally transfixed near its base, and the tumour removed. The adnexa on the left side were normal.

The cyst showed no signs of torsion beyond the tears in its pedicle, and contained the usual grumous fluid, and rudiments of hair and teeth.

Beyond a little difficulty with the bowels on the fourth and fifth days, the patient made a rapid and uninterrupted recovery.

The striking points of the case are the rare nature of the accident, the rather close way in which the history simulated that of an ectopic gestation with rupture, and the fact that three labours had been passed through without the cyst giving rise to trouble, or even being discovered. This last was probably due to its free mobility and the length of the pedicle.

The two previous attacks of pain were probably caused by slight torsion. The coincidence of the catastrophe with the menstrual period is what one would expect, but apart from this it is difficult to assign any cause for the very acute torsion which must have been required to rupture the pedicle in the manner described. There was no history whatever of violent exercise or a sudden strain. Whether a varicose condition of the veins in such a situation has been described, or ever exists, I do not know. It seems unlikely. In any case the rupture of a vein *per se* would not account for the three tears found at operation.

My thanks are due to Mr. Madden both for his help and for most kindly supplying me with details of the patient's previous illness and confinements.

LIGATURE OF THE FIRST PART OF THE RIGHT SUBCLAVIAN ARTERY FOR TRAUMATIC ANEURYSM OF THE SECOND AND THIRD PARTS.

BY

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EVEN in the recent war, in which almost every conceivable injury due to direct violence has been met with, lesions of the subclavian artery, requiring ligation of the first part of the vessel, seem to have been comparatively rare, and possibly on this account there is some justification for the publication of this case.

The lesion was accompanied by damage to the brachial plexus, either directly or by concussion, and the later history of this damage is not without interest.

Private B., aged 20, was hit by a piece of shell between the vertebral border of the right scapula and the spine at the level of the third dorsal vertebra, at Arras on April 22nd, 1917. The missile made its exit by a small wound about one inch above the junction of the middle and outer thirds of the right clavicle. The patient was sent to England and reached the base hospital on May 19th with the wounds mentioned soundly healed.

He stated that he had coughed up small quantities of blood for about a fortnight after his injury, and he complained of pain in his chest occasionally, and severe pain and loss of function in his right arm. His voice was hoarse, his right pupil distinctly larger than his left, and his right hand and fingers presented trophic lesions. His arm hung limply at his side and he was unable to move it; wrist-drop was, of course, present. There was considerable wasting of all the muscles of the limb, and this increased while he was in hospital. He had no cutaneous sensibility in the forearm and hand, and only a very limited amount over the upper part of his arm.

There was a small swelling immediately above the middle of his right clavicle, but no pulsation could be felt in it at first. The pulse at the right wrist was, however, considerably weaker than that at the left. The swelling increased in size fairly rapidly, and pulsation could soon be felt in it. With the increase in size there was diminution in the strength of the radial pulse, and increase in the severity of the pain in the right arm.

Firm pressure on the inner side of the swelling, directed backwards against the transverse processes of the lower cervical vertebrae, produced complete cessation of pulsation in the swelling and loss of the radial pulse. There was no evidence of haemothorax.

Operation.

On June 6th, 1917, an incision resembling the letter J was made, the vertical limb being along the lower two-thirds of the anterior border of the sterno-mastoid, and the curved part being directed outwards, so that resection of the clavicle might be performed if found necessary. The sternal head of the sterno-mastoid was divided about one inch above its attachment, so as to allow of suture at a later stage; it was necessary to divide also a few fibres of the clavicular head of the muscle. The divided portions were kept out of the way by means of tissue forceps.

The anterior belly of the omohyoid muscle was next identified, but not divided, and the common carotid artery was easily found and followed downwards, the internal jugular vein being carefully separated from the vessel and retracted outwards. The vagus nerve was also identified and retracted outwards with the vein.

After some further dissection, the bifurcation of the in-ominate artery was reached, and it was observed that this point was quite three-quarters of an inch above the inner end of the clavicle, and that the subclavian artery took an upward course before turning outwards to pass behind the scalenus anticus muscle. Possibly the high position of the vessel was due to the presence of the aneurysmal sac behind the muscle, but the site of bifurcation was certainly higher than was expected. A floss silk ligature was easily passed round the artery from below upwards, and when it was tightened all pulsation in the sac ceased. The loop of the ligature was divided, and the vessel was gently tied in two places close together, so as not to divide the tunica intima. The sac of the aneurysm involved both the second and third parts of the artery. It was not necessary to divide the infrahyoid muscles, as these were readily retracted inwards.

The wound was closed in the usual way, after suture of the sterno-mastoid muscle, with catgut, and a small drainage tube was inserted in its lower end.

The operation was not so difficult as was anticipated, but the spare condition of the patient was, no doubt, a very valuable help.

Recovery was uneventful, and there was never any sign of gangrene. The patient was sent to a convalescent hospital, where electrical treatment and massage could be obtained for his paralysed arm, on August 11th, 1917. There was no pulsation in the sac of the aneurysm, and no pulse at the right wrist.

He returned on November 15th with no signs of recovery of his arm; and electrical treatment and massage was continued until January, 1918, when it was decided that the brachial plexus should be explored. Three days before the date fixed for this operation, the patient stated that he could move his fingers, and this proved to be the case. He was therefore brought before a medical board in February, and was discharged as an invalid on February 25th, 1918.

A letter from him in November, 1918, stated that he could move his arm in all directions, and he could put his hand on the top of his head. He could also move his wrist and thumb and first finger, and sensation had returned to these parts. His head movements were normal. He was seen in April, 1919. The movements of the arm and forearm were then normal. Sensation was natural over the arm and forearm, except over the lower third of the area supplied by the ulnar nerve, where it was diminished. There was wasting of the thenar and hypothenar eminences, and some interference with the function of the ulnar lumbricals and interossei. He was able to write, and stated that the movement of his fingers and the sensation in the area mentioned were improving.

I desire to acknowledge my indebtedness to Colonel Carless for his valuable advice and assistance at the operation on this case.

DELMAS reported recently to the Medical and Biological Society of Montpellier a case of some practical interest. A woman who had had three abortions again became pregnant. The serum reaction in her case was negative, but it was positive in her husband. She received a course of neo-salvarsan and gave birth to a healthy infant.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

TREATMENT OF GALL STONES BY INFUSION OF PARSLEY.

THE following case recently under my care has struck me very much: A lady over 70 years of age had suffered for many years from gall stones, with severe colic and jaundice. In November, 1918, she had a prolonged attack in which she was reduced to the lowest extremity. In the region of the gall bladder was a large palpable mass in which gall stones could be felt.

On November 9th, 1918, she was seen in consultation by a surgeon, who had seen her several times before, and had always advised operation. He recommended operation now as the only possible chance, and with this opinion I agreed. The patient was most strongly opposed to undergoing any operation, and quoted the case of a friend who had been cured when in a similar condition by drinking infusion of parsley. She began using this, taking about 1½ pints daily of an infusion made by soaking a good double handful of fresh parsley leaves in cold water, which was afterwards brought to the boil, strained, and allowed to cool. To put it shortly, this treatment, persevered with practically ever since, seems to have cured her. She remains free from pain and sickness, and the mass felt in the region of the gall bladder has disappeared. She is no longer emaciated, and the general condition is satisfactory.

The whole case is most striking, and it would seem that the improvement must certainly be the result of the treatment, for practically nothing else was done.

Common garden parsley (*Apium petroselinum*) is not mentioned in the *British Pharmacopoeia*, but it occurs in the French *Codex medicamentarius*, where it is inserted along with garden celery (*Apium graveolens*), apparently because with three other aromatic plants they are used for making a diuretic compound called *sirop des cinq racines*. The fruit of parsley, and apparently also the whole plant, contains an essential oil, which is pretty well known under the name of "apiol" as a remedy for dysmenorrhoea. "Apiol" is in most of the pharmacopoeias, but the French pharmacopoeia directs crystallized apiol (the stearoptene from the oil) which is known also as white apiol and sometimes as parsley camphor. I can find no mention of parsley in the many infusions and decoctions given in Buchan's *Domestic Medicine*. In one edition of Squire's *Companion to the Pharmacopoeia* I find an entry about "parsley breakstone," but this is a totally different plant (*Alchemilla arvensis*), belonging to the order Rosaceae; a decoction of the flower-heads is said to be diuretic, and it has been given to discharge small calculi from the kidneys and bladder.

At any rate here are two cases—for my patient assures me that her friend's case was equally striking—in which the use of parsley infusion, persevered with, seems to have given immense relief, if not cure, to gall stone impaction.

Bromsgrove.

H. CAMERON KIDD, M.B., F.R.C.S.

PREGNANCY AFTER LIGATURE OF FALLOPIAN TUBES.

IN a previous communication (BRITISH MEDICAL JOURNAL, October 20th, 1917) I recorded a case of contracted pelvis which had been treated by Caesarean section thrice; at the last operation, at the request of the patient, sterilization was attempted, both Fallopian tubes having been ligatured with No. 1 Chinese twist and then divided, and the peritoneum sutured over each cut end with No. 1 chromic catgut. This operation was done on June 10th, 1917, and the patient left the hospital on the twentieth day, nursing her child.

In the middle of September, 1919, she had a normal menstrual period, and on January 10th, 1920, she came to me and stated that she had "seen nothing since." Abdominal examination revealed a uterine enlargement of about the size of a sixteen weeks' pregnancy. In March strong fetal movements could be detected, and there could be now no doubt of her pregnancy. She was admitted to the Norwich Maternity Institution on June 18th, and on the 20th I performed Caesarean section. There was little