thoroughly restored to health and there were no signs of there ever having been any trouble in the neck. To take no risks I gave her three more similar applications.

CASE III.

A boy, aged 4, one of a large family, nearly all of whom had suffered from tuberculosis; several had died. His mother and one or two uncles and aunts had died of phthisis. When I first saw him he had extensive tuberculous adenitis on both sides of the neck. The glands had suppurated, and sinuses secondarily infected were present.

I gave him ten applications of from eight to twelve hours each, twice a week. On several of these occasions, after four hours the applicator was moved to cover another group of glands, and so on. The same strength, 15 mg., of radium was employed. At the end of this treatment all the sinuses had healed, and the masses of glands had shrunk till only a few fibrous nodules could be felt. The boy had also improved much in health, and when I saw him a few months later one would hardly recognize him.

Carious teeth or unhealthy tonsils and adenoids, if present, must be dealt with at the beginning of the treatment, as it would be folly to cure the existing glands and leave a future source of infection behind.

FATAL CEREBRAL HAEMORRHAGE AT 34.

BY

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THE following report may be of interest owing to the difficulties of diagnosis the case presented and to the comparative rarity, as far as I am aware, of the condition:

A single woman, aged 34, of healthy parentage, whose previous health had been good, and who had had no serious illnesses, was in her usual health till September 8th.

On that day, while straining to reach up to a high shelf, she had a sudden sensation "as though someone had struck her on the back of the head," followed by a "fainting attack" (though she did not lose consciousness) and severe occipital headache, which prevented her sleeping that night.

On September 9th she came to my surgery complaining of occipital headache. The temperature and pulse were normal; she was given aspirin and told to report again in the morning. She then said that she had had a good night and that the headache had practically disappeared. She was given a tonic and told to report again if necessary. The "attack" was attributed to the sun, the weather being very hot at the time.

She remained quite well except for slight occasional stiffness of the neck until the afternoon of September 14th, when she had a sudden seizure; without any warning she fell suddenly unconscious. I saw her ten minutes after the onset of the attack. She was then deeply unconscious, the conjunctival reflex was absent, and the complexion ashen grey; there was very marked Cheyne-Stokes respiration and very feeble pulse (100). The reflexes were variable during the attack, which at first was characterized by slight spasmodic contractions of the arms and chewing movements of the jaws, alternating with periods of complete relaxation. There was no definite paralysis of any part. After about an hour she was suddenly seized with violent convulsions with most extreme opisthotonos, which lasted on and off nearly another hour, when she vomited and began to come round. She passed water and sweated during the fit.

On partial return to consciousness she screamed out with agonizing pains in the occipital region, rolling her head backwards and forwards apparently in extreme distress. There was no retraction. Kernig's sign was doubtful, as were the plantar reflexes. The knee-jerks were equal and variable.

She was given morphine gr. $\frac{1}{2}$, which eased the pain, though she had no sleep; she vomited frequently during the night.

On September 15th she was completely conscious and mentally clear. She complained of very severe occipital headache and vomited occasionally. The temperature was 98°, and the pulse 100; systolic pressure 150. The skin was moist. She was passing water freely. Urine, specific gravity 1025, acid, very faint cloud of albumin; partially reduced Fehling's solution; microscopically a few blood casts and red cells. Ophthalmoscopic examination showed clear discs and the fundus normal on both sides. During the day the vomiting ceased and the headache improved.

On September 16th the headache was more severe and there was definite retraction and well marked Kernig sign. The temperature began to rise (99.2°); the pulse fell from 100 to 60. Lumbar puncture was performed in the afternoon. The fluid was under great pressure, spurting out on withdrawing the trocar; about 1 c.cm. was withdrawn. The bacteriological examination was difficult, as the specimen was contaminated with blood. The report stated that the fluid was sterile and polymorph leucocytosis absent.

From September 16th to 25th there was steady improvement, the chief difficulties being the headache (which gradually

became frontal as well as occipital, though less severe) and a persistent insomnia. The albuminuria disappeared after the first forty-eight hours. The glycosuria became more pronounced, but was less than 1 per cent.; there was no acetoneuria. A most marked feature, considering the severity of the symptoms, was the general good spirits of the patient in spite of the headache, and the mental clearness. There was no further vomiting; the optic discs remained clear.

On September 25th, after a good night, and while appearing better than usual, she had a seizure similar to that of the 14th, which was fatal in about two minutes.

Post-mortem Examination.—Brain: There was a large clot of blood between the dura and the brain; the bleeding point was apparently in the frontal region, in the neighbourhood of the crest of the ethmoid. The clot extended between the frontal lobes and on the outer surface of the right frontal lobe as far back as the motor area. In places the brain substance was torn. There was no evidence of disease of bone nor any sign of cerebral tumour or abscess. There was no evidence of any inflammatory condition at the base or elsewhere. The other organs were healthy.

Presumably the first seizure was caused by a minute haemorrhage, which was not discovered *post mortem*. The haemorrhage seen at the *post-mortem* examination was presumably the one which caused the fatal seizure.

The interesting features from the point of view of diagnosis were: The basal symptoms accompanied by evident raised pressure in the spinal canal, the marked mental clearness all through, and the absence of vomiting and optic neuritis.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

CAESAREAN SECTION FOR PLACENTA PRAEVIA WITH CONCEALED HAEMORRHAGE.

ALTHOUGH the case reported below had a fatal termination, most probably from pulmonary apoplexy, I consider the treatment by Caesarean section was correct and satisfactory. I cannot remember reading of a case of placenta praevia with concealed haemorrhage so profuse as to fill the uterus, distending it and causing tonic contraction; and, although some authorities on the subject agree that Caesarean section is correct in certain cases of placenta praevia, I have not yet seen the operation recorded in any such cases.

On November 6th, at 5 p.m., I was called to a woman aged 39, primipara, eight months pregnant. She was in agonizing pain, and on examination of the abdomen the uterus was very distended, and in a state of tonic contraction, so that nothing but the shape of it could be made out. Examining per vagina, I found the os dilated to the size of half a crown, rigid, and a soft mass presenting with no landmarks; the vagina was very narrow and rigid. The pulse was about 120, and the patient very restless; on inquiry I found she had been in this condition since 2 o'clock. I came to the conclusion that she must be delivered as soon as possible; I therefore decided to call in Dr. W. S. McDougall to see if he agreed as to removal to hospital and Caesarean section. During the interval before he arrived the presenting part gave way, and a large haemorrhage occurred, blanching the patient. On arrival Dr. McDougall made an examination and found the placenta at the os, and nothing else presenting; the patient was bleeding. He agreed with me, and the patient was removed to the Carshalton, Beddington, and Wallington District Hospital.

At 9.30 p.m. the patient was put on the table; Dr. McDougall gave the anaesthetic, and Dr. W. H. Passmore assisted me. Operating by the abdominal route, I opened the uterus with a median longitudinal incision, and found the uterus full of clots. I extracted the child already dead, and cleared the uterus, and sewed up with five or six catgut sutures through-and-through, missing the mucosa. Having completed the toilet of the peritoneum, the uterus was returned, and the abdomen closed with three layers of sutures; during the later stages of the operation ergotinine and pituitary extract were injected. The operation was completed in fifteen and a half minutes, a pint of saline was given on the table, and later she was given a continuous saline.

The next morning the patient's condition was satisfactory, except that she vomited when she took feeds, chiefly of Valentine's juice. On November 8th the abdomen was much distended, and the vomit becoming offensive and enemas giving very little relief, it was apparent that the bowel was paralysed. Towards evening I made an opening in the ileum, which relieved the situation; the sickness stopped, the distension disappeared, and in twenty-four hours the bowels acted in the ordinary way. On November 9th the condition was good, the patient taking some food. Next day the condition was still