A PAIR OF FORCEPS IN THE ABDOMINAL CAVITY FOR TEN AND A HALF YEARS.

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MRS. S., aged 40, visiting this town for a change after a long attack of diarrhoea, dating from February, 1906, sent for me on May 4th, as she was not feeling much benefit by the change of air. Her chief complaint was in respect of the condition of her urine, which was ammoniacal. On examination of the abdomen by palpation I detected a very hard substance in the left iliac region, which,

owing to the lax abdominal wall, I could catch between finger and thumb. This procedure caused the patient no discomfort, though pressure on the hard body directly downward (the patient being recumbent) caused acute pain. I succeeded in outlining what I felt no doubt were parts of the rings of the handles of a pair of pressure forceps. The patient stated that she had been operated on ten and a half years previously for an ovarian tumour, and having experienced no benefit from the removal of the tumour had refused all subsequent proposals of operation. The abdominal scar was broad, and suggested that union had not been by first intention, which surmise the patient's statements corroborated.

I told her I believed she had a surgical instrument left in the abdomen, which could not be removed except by operation, and to convince her I suggested the use of the x rays.

Dr. P. Seed, of Perth, took sufficient interest to x ray the case, and produced a radiograph (taken with the patient standing) which distinctly shows the forceps lying in the pelvis, the handles being directed forwards and upwards.

Operation.—The patient now consented to operation, and on June 6th, 1906, Dr. Seed anaesthetizing her, and Dr. J. M. Y. Stewart, of Guildford, assisting me, I opened the abdomen, excising the scar, to which I found omentum adhering. I found the intestines matted together by adhesions, and the forceps inside the lumen of the bowel. What at first appeared to be a cicatricial band between the rings of the handles kept the forceps in place, and capable only of moving with the portion of the bowel into which they had got. I incised the gut, and, owing to the patient's condition, had to rather hastily remove the forceps, when I found that the supposed cicatricial band was the point of anastomosis of two loops of bowel which had been caught between the handles of the forceps, and thus caused a "short circuit" between two points, about 12 in. apart. The patient's state being rather unsatisfactory, I only hastily examined the left ovarian region, where I found many adhesions and no trace of an ovary. The uterus had a couple of small fibroids on its posterior aspect. I unfortunately had not time to examine the ureters carefully, but the bladder seemed uninjured. The bowel incision was closed with catgut, the "short circuit" being left alone, and after removing the part of the omentum which had adhered to the wound, I closed the abdomen. Recovery was uneventful, a slight rise in temperature on the fifth day being due apparently to recurrence of cystitis, and easily got rid of by resuming urotropin, and so improving the condition of the urine.

REMARKS.

The accompanying photograph of the forceps (actual size) shows their length to be nearly 5 in. and the width across the handles about 2 in. That the forceps should have

attained the position in which they were found without causing death is extraordinary.

Though the patient's health had been wretched during these years, and a large part of this time spent in bed, it is worthy of notice that she had occasionally felt well enough to participate in dances! Her chief symptoms during these years were: Sudden acute pain, sometimes causing her to faint; constipation alternating with diarrhoea, and pains in the lower limbs, which prevented her getting about.

She has only been pregnant once, and that ended in miscarriage at five months, and was before the operation on the ovary. After the operation, though menstruation was regular, she never became pregnant.

She suffers from strabismus, the left eye being affected, which she herself associates with the operation ten and a half years ago, but whether it will disappear or not now the forceps have been removed remains to be seen.

No doubt the reason of the forceps having escaped the notice of her previous medical attendants (and she had many) is that formerly she was much stouter than she is now. The last attack of diarrhoea is the most

severe she has had, and was accompanied by haemorrhage. I have reason to believe that no record of the former operation can be found in the books of the hospital where it was performed.

MEMORANDA: MEDICAL, SURGICAL, OBSTETRICAL.

SCARLATINIFORM RASH AFTER BURN.

THE following case, which has recently been under my care, is of interest, as Dr. MacCombie, in his address on scarlet fever which appeared in the BRITISH MEDICAL JOURNAL of December 22nd, 1906, states that "Punctate scarlatiniform rashes (following burns) without attendant throat and tongue signs of scarlet fever may be, but probably are not, scarlet fever unless they be followed by the typical general pinhole desquamation, which, if it be general, is, I think, characteristic of scarlet fever."

On November 23rd, 1906, a boy received a large superficial burn involving the left shoulder and the whole of the left arm as far as the wrist. Four days later a bright red punctate erythema made its appearance and spread over the whole body; this gradually faded away, but persisted on certain parts of the body for as long as twelve days, at the end of which time it had entirely disappeared.

Six days after the appearance of the rash desquamation, which was typically pinpoint, commenced on the front of the chest and on the limbs, and subsequently became general as the rash disappeared. There was also at this time some slight superficial ulceration of the buccal mucous membrane.

During the whole of this period there were no general symptoms, the child stating that he felt quite well. There was no sore throat, the highest temperature recorded was 101°, and that on the fourteenth day of the illness, the tongue did not peel, and the urine contained no albumen. The patient made an uninterrupted recovery.

In this case the rash and subsequent desquamation were characteristic, but at the same time I do not think that it was a case of scarlet fever for the following reasons:

1. Absence of fever and general initial symptoms.
2. The rash appeared when suppuration had commenced in the area that had been injured, and persisted so long as septic absorption was taking place.
3. During the whole course of the illness no attempt