from the placenta was free but not excessive. No vessels, except those of the cord, required ligature during the operation. The edges of the sac were fixed to the abdominal parietes with a continuous catgut suture. The upper and lower $1\frac{1}{2}$ in. of the abdominal incision were closed by mass sutures of silk-worm gut. At the end of the operation, which lasted an hour and a quarter, the patient was nearly pulseless. No superficial vein being visible the deep brachial veins were exposed in the upper arm, and 4 pints of hot saline with $\frac{1}{2}$ oz. of brandy were injected; hypodermic injections of strychnine were also given.

Death.—The patient completely recovered consciousness with a slow, steady pulse; but three hours after operation the pulse again failed, and, in spite of stimulation, death occurred five hours after operation.

COMMENTS.

Case I is an example of the common variety, in which, after rupture of the tube, the blood, being slowly and intermittently poured out, is limited to the lower abdomen by adherent omentum and intestines, from which are derived the bacteria which infect the blood clot. Portions of blood clot found to be incorporated with the peritoneum covering the pelvis and viscera should not be disturbed. Their complete removal is impossible, while partial removal only injures the peritoneum, which, if left undisturbed, is quite capable of dealing with these adherent clots. The majority of cases of this class recover after removal of the affected tube and the loose coagula.

Case II exemplifies the fulminating type of haemorrhage following rupture. I have on several occasions noted the fact that some strain or extra exertion—in this case the result of a purgative—has immediately preceded the rupture. In some instances strong purgatives have been taken in order to produce abortion.

Case III illustrates what is probably the most usual condition found after rupture of the tube, not involving the death of the fetus, which continues to develop between the layers of the broad ligament. Operation was performed in this case because pain was continuous and the patient was daily becoming weaker. Death from cardiac failure could only be attributed to the shock of the operation on an already enfeebled patient.

Haemorrhage during the operation was moderate, and quite insufficient of itself to account for the fatal issue. Operation gave the patient her only chance, but should have been performed at least two and a half months earlier.

NOTES OF A CASE OF REPEATED EXTRA-UTERINE GESTATION ON THE SAME SIDE.

By ALEXANDER GOODALL, M.D., F.R.C.P. EDIN.,
MEDICAL CLINICAL TUTOR, ROYAL INFIRMARY, EDINBURGH.

The following case is of interest not only because extra-uterine gestation occurred twice on the same side, but owing to the comparatively early period at which rupture occurred in both instances (seven weeks and five weeks respectively), and the rapidity with which the tube must have again become pervious after the first rupture.

A woman, aged 33, complained on March 26th, 1905, of pain in the back and hypogastric region, and of a slight haemorrhagic vaginal discharge. She had suffered from a "nervous breakdown" two years previously. Menstruation had occurred regularly every twenty-eight days and lasted four days, and had never given rise to any discomfort. She was married in November, 1904. Menstruation took place about the end of January, 1905, and had not recurred. On March 25th she began to feel indefinite pain in the abdomen, which gradually became more severe, and a vaginal discharge began the following afternoon. On March 27th the discharge was more profuse and some blood clots were passed. Vaginal examination revealed a slightly enlarged uterus, with a patulous cervix almost admitting one finger, and low down in the right inguinal region there was a rounded, non-pulsating tumour about the size of an orange, suggesting the possibility of either an extra-uterine gestation or a fibroid tumour. As the symptoms were indicative of abortion, the cervix was dilated and an attempt was made to empty the uterus, but only pieces of a thickened mucous membrane were brought away. For the next fortnight the patient was treated with hot fomentations and corrosive sublimate douches, and the discharge gradually lessened. Pain in the right inguinal region persisted, and the tumour seemed unchanged. On April 9th Dr. Haultain saw the patient in consultation, and thought that the case was one of extrauterine gestation, although there was a possibility that the tumour might be a

fibroid. As pulsation was absent, it was thought safe to continue palliative measures, and at Dr. Haultain's suggestion an icebag was applied over the tumour. The benefit following its use was most striking, as within a few hours of its application all tenderness and pain had disappeared; after this the tumour began to diminish in size. On April 21st Dr. Haultain again saw the patient; it was now found that the tumour could no longer be palpated externally, and on vaginal examination all that could be made out was a thickening of part of the right Fallopian tube near the uterus to an extent not exceeding the diameter of a man's thumb. By May 1st this thickening had diminished considerably, and all symptoms had disappeared. There was now practically no doubt that the condition had been one of ruptured extrauterine gestation. Menstruation returned in June, and occurred once a fortnight till August, when it resumed its normal type.

I was again asked to see the patient on January 12th, 1906. Menstruation had occurred in the last four days of November, and had been scanty. No period occurred in December. On January 9th a slight vaginal discharge took place. Next day she had a bad attack of abdominal pain and diarrhoea, and what seemed to be an ordinary menstrual flow began. On January 12th a tumour, closely resembling that found during the first illness, was discovered in practically the same situation, although it seemed in closer relationship with the uterus, which was again slightly enlarged. The cervix was soft. An icebag was again applied, and hot douches twice daily were ordered. On January 15th a complete cast of the uterus came away while a douche was being administered. This was examined microscopically in the laboratory of the Royal College of Physicians, and found to be a decidua. From February 18th to 23rd a very profuse brown discharge took place, and then completely stopped. The tumour rapidly decreased in size, and on March 9th a thickening of the right Fallopian tube, giving the impression of a swelling about the size of a small walnut, in close relationship to the uterus, was all that could be made out. On March 18th a normal menstrual period began.

My impression is that the second ovum had reached a point nearer the uterus than the first, and the patient is of opinion that the second "lump" was lower down than the first. The question of operative treatment has been considered, but the patient and her husband are averse to that course; and, in view of the favourable outcome on both occasions, I do not feel justified in strongly insisting upon it. The patient has, of course, been warned about the urgency of seeking medical advice regarding the occurrence of even apparently trivial symptoms. The application of an icebag on both occasions made all the difference between acute suffering and comparative comfort.

A CASE OF PUERPERAL SEPTICAEMIA DUE TO THE DIPLOCOCCUS PNEUMONIAE.

BY

G. BELLINGHAM SMITH, and N. I. SPRIGGS,
M.B., B.S. LOND., F.R.C.S. ENG., M.D., B.S. LOND., F.R.C.S. ENG.,
ASSISTANT OBSTETRIC PHYSICIAN, LATE OBSTETRIC RESIDENT,
GUY'S HOSPITAL. GUY'S HOSPITAL.

OWING to the rarity of recorded cases of puerperal fever in which the presence of the *Diplococcus pneumoniae* has been established, we have thought the following case worthy of a detailed report:

Jane B., aged 24, was delivered on June 16th, 1905, in poor surroundings, of a male child.

She had had two previous children, healthy, and born at full term.

A single examination was made, some hours before labour commenced, the usual precautions being taken. The midwifery attendant was not present at the birth of the child, but there seems to have been no difficulty. The child was full time and alive.

The temperature remained normal till the fourth day after delivery (June 20th), when it ran up to 102.8° F. and the pulse-rate to 130. On vaginal examination the os was patulous, but nothing abnormal was felt. The uterus was more than usually tender, the lochia and milk were suppressed, and there was constipation. The uterus was washed out with lysol, and quinine administered.

On June 21st the temperature was still high, 102° F., and the pulse-rate was 135. The abdomen was slightly distended, and towards evening vomiting commenced. The patient refused to come into the hospital, so a further douche was given. A purge followed by an enema resulted in a free movement of the bowels. On examination of the chest a few fine crepitations were heard at the base of the left lung behind, and the question arose as to whether the patient was not suffering from pneumonia rather than puerperal fever.

On the following day (June 22nd) she was admitted to Guy's Hospital. On admission the temperature was 102.8°, the