antiseptic gauze is quite sufficient to prevent any prolapse, while it secures drainage, even if a drainage tube be not used, and this sometimes, at least, can be dispensed with.

A troublesome accident happened in the first of the cases I have related, which I am unable to account for. The catheter was passed every eight or ten hours for some days. After the operation the patient was allowed to use the bedpan, and she was able to empty the bladder without trouble, but on the tenth day after the operation urine was observed to escape *per vaginam*, and continued to do so for several weeks, when it ceased to flow. What was the cause of this? The bladder could not have been wounded during the operation, or urine would have escaped sooner. As the wound was a very large one three or four sutures had been placed in the flaps to cause them to approximate. Could the needle have penetrated the wall of the bladder while one of these was being inserted? I cannot say. I state the facts of the case.

I do not like to close this paper without alluding to those cases in which the cervix is the primary seat of cancer, and the advisability or otherwise of performing hysterectomy in such.

Pathologists are not agreed as to the direction in which in such cases the disease progresses. Dr. Cullingworth seems to believe that it spreads upwards. Dr. Williams, discussing the cases shown by Dr. Cullingworth, contended that the specimens exhibited showed that the tendency was for it to grow outwards, and to invade the parametric tissues,² and stated that his experience convinced him that where amputation of the cervix had been practised the disease, if it recurred, was found to have invaded the adjacent cellular tissue and not the stump. This tallies with my own experience, and was well marked in the case of a patient on whom I performed supravaginal amputation of the cervix for cancer. The patient appeared at first to have been cured, but after an interval of a year or more came again under my observation, and died in hospital; and a *post-mortem* examination proved the uterus to be healthy, but all the adjacent parts were extensively infiltrated with cancer cells.

Inclining as I do to the views expressed by Dr. Williams, I have the greatest disinclination to recommend any surgical treatment in the majority of these cases. Amputation of the cervix I deem, except as a palliative, to be useless, and unless the case be seen at a very early stage indeed, hysterectomy I consider inadvisable.

I have deemed it best to confine this paper to the consideration of cases in which malignant disease attacks the uterus. To enter into a discussion of the question of hysterectomy in connection with myomata would be to extend it unduly; but it is not to be supposed that I do not recognise its value in such cases, only I fear that there is a tendency to have recourse to the operation nowadays somewhat too frequently. Nor do I ignore the fact that it seems to me that as our confidence in the safety of the operation extends, so will the frequency of its employment also extend. Thus there are certain forms of prolapsus uteri in which I am of opinion it should without hesitation be practised. Take those extreme cases, not so infrequently met with amongst the poor, in which nearly the whole of the uterus lies outside of the pelvis and the organ hangs down between the thighs, no plastic operation can be relied on in such cases, and no instrument will retain the organ with comfort *in situ*. These cases, too, are most favourable for vaginal hysterectomy because the organ is so accessible, and I believe that in such it will by-and-by be not infrequently performed.

² BRITISH MEDICAL JOURNAL, April 19th, 1890, p. 900.

UNIVERSITY OF PENNSYLVANIA.—Professor Pepper, who has resigned the office of Provost of the University of Pennsylvania, will continue to hold the Professorship of Medicine. During the thirteen years of his administration the teaching staff of the University of Pennsylvania has increased from 88 to 268, and the number of students from 981 to 2,180. About four million dollars have been added to the value of the lands, buildings, and endowments. Professor Pepper's own gifts to all departments of the University have been many and generous. On resigning the Provostship he made a contribution of 50,000 dollars, which will be applied to the extension of the hospital buildings.

EPIDEMIC JAUNDICE.¹

By WILLIAM RANKIN, M.D. GLASG.,
Churchtown, Londonderry.

A CORRESPONDENCE on the subject of epidemic jaundice has been going on for some time back in the columns of the BRITISH MEDICAL JOURNAL, and as a number of cases of an epidemic nature have come under my own notice within the past twelve months, a few observations on the subject may not be without interest.

Early in July, 1893, a lad aged 11 years, came to me complaining of feeling generally out of sorts. He had been troubled with headache, sick stomach, vomiting, and no desire for food for about a week previously. He had not kept to bed, and had walked over a mile to see me that morning. The tongue was furred, and the skin and conjunctivæ tinged yellow. Looking upon the case as one of jaundice due to ordinary gastro-duodenal catarrh, I treated it as such, and thought no more about it.

On that day fortnight two other members of the same family—one a girl aged 13, the other a boy aged 10—appeared, complaining of a precisely similar train of symptoms. There were the three young members of this family, and they were the only persons in the house affected. These two received the same simple treatment, and they also quickly recovered. I may mention here that my whole medicinal treatment consisted in two sharp calomel purges at an interval of three days, and a mixture of nitro-muriatic acid and nux vomica given for a week or ten days.

At that time I had a number of cases of a similar nature, and they all yielded rapidly to these simple remedies. During the months of July and August I saw eleven cases of jaundice in young persons, and all within a limited area—I should say not more than a mile long and half a mile wide—and I am quite sure there were other cases in the same locality at the time which did not come under my observation. When one case occurred in a house, as a rule other members of the family became affected, but in no instance did I see jaundice in an adult at this time, and occasionally—as in the three cases first referred to—all the children in the house suffered. They all occurred in the low-lying part of my district.

The disease seemed to have exhausted itself during the months of July and August. It was evidently of an epidemic nature, but as regards the precise cause I could not then satisfy myself. I may mention, and I have since seen the theory advanced, that it occurred to me at the time that it might have been a sequela of influenza. Influenza, however, at least influenza in epidemic form, was certainly not in the neighbourhood at the time.

During March and April, 1894, an almost similar series of cases have cropped up in the high-lying part of the district. The first case I saw, early in March, was a boy aged 10 years, one of a family of six children, who came to me suffering markedly from jaundice. In this family the whole six children, one after another, became affected, and other cases occurred in the immediate neighbourhood, all within a radius of half a mile. The last two cases were in children of different families, but neighbours. Both these cases I saw on the same day, April 7th. At the time these different cases occurred I was not aware of the existence of what is generally recognised as influenza in the district, nor have I since seen any cases of influenza.

In almost every instance the friends had been able to satisfy themselves quite readily as regards causation. One had seen some repulsive sight, while another had been where there was a bad smell, as they said, and yet another had taken a drink out of a dirty pool; some had eaten too heartily and some had eaten something which had "gone against them," and one at least had got a fright. The two cases which I saw on April 7th, occurring in different families, were both ascribed to the patient having eaten eggs on Easter Sunday. In regard to treatment, the popular notion was quite in keeping with the views of the majority in regard to causation, some going so far even as to apologise for seeking medical aid at all, saying they understood the affection

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was either incurable, or at most yielded only to some magic "charm" or "cure," the secret of which was known but to a few—mostly old women.

In almost all the cases the stools had been observed to be pale and clay-coloured, and generally of stiff consistence. In some, however, there was diarrhoea, and in these the appearance would be deceptive. The colour of the urine had also been noted in most cases. Suffice it to say that these were cases of jaundice, and jaundice in a comparatively simple form.

I kept the patients on milk diet. The medicinal treatment I have already indicated. In no case did I find it necessary to confine them to bed. There was seldom any rise of temperature or quickening of the pulse. They were generally out of sorts for a week or ten days, but recovery was rapid and complete. Whether the treatment adopted had much to do with the cure I am not at all certain, but of this I am satisfied—that other cases which received no treatment, or at most a dose of senna or castor oil, also recovered, and recovered rapidly.

Here are a series of cases in regard to which one cannot say they belong wholly to either the obstructive or the non-obstructive form. If to the obstructive, they must have been cases of gastro-duodenal catarrh, starting probably as a primary catarrh of the stomach, which extended to the duodenum and thence to the gall duct, which became blocked with exudation. The only admissible causes in these cases would be "errors in diet" or "catching cold." Possibly they may have been due to errors in diet; possibly they may have been due to catching cold, but if so, to me it seems very remarkable that so many cases should have occurred within a comparatively short time, and that they should have been limited to a comparatively small area. If, on the other hand, these cases belong to the non-obstructive form, they must come under the division "Poisons in the blood interfering with the normal metamorphosis of bile," and under the subdivision "Poisons of a specific nature."

Now these cases all occurred in young people (eldest 13 years). Sometimes all the children in the house became affected but in no case an adult. They occurred in a particular district of country limited in area, but not having a common water supply, and they occurred, as far as I can make out, when there was no influenza, or, at least, not what is commonly recognised as influenza. Influenza, however, assumes so many different forms, that it is quite possible to have it attacking chiefly the gastro-intestinal tract instead of the bronchial or nervous, as under ordinary circumstances. We might thus have jaundice due to a specific poison and yet of the obstructive form. But, it may be said, is it at all likely that you can have jaundice due to the poison of a specific fever and yet unaccompanied by fever? In all the cases which I saw the jaundice had already developed when I was called in, and it is quite possible that, even had there been a premonitory febrile stage, it had passed off, for, as a rule, when jaundice develops, the temperature and pulse fall. I am forced to the conclusion that, like influenza, we have here to deal with an affection of a distinct specific nature, fortunately of a mild type, and not attended with the many and serious consequences so often met with in influenza. As regards the exact nature of the poison, I am unable to form any definite opinion. Whether it is the influenza poison or whether the affection is a sequela of some obscure form of influenza or whether due to a poison of its own are questions on which I am still undecided, but that the disease is due to a poison of some kind is, I think, beyond doubt.

[Since writing this paper four fresh cases have come under my notice, all in the same district of country as those before referred to, now making a total of 23 since the beginning of March last.]

PRESENTATION.—Dr. James Skeen, who has acted for four years as junior assistant physician in the Stirling District Asylum, has been presented with a gold hunting watch, together with albert and pencil case, on the occasion of his leaving the Asylum for Bothwell, having received the appointment of medical superintendent of Kirkland's Asylum there.

INTESTINAL OBSTRUCTION DUE TO OCCLUSION OF THE ILEUM BY PRESSURE BAND: OPERATION: RECOVERY.

By ROBERT JONES, F.R.C.S.E.,

Honorary Surgeon, Royal Southern Hospital, Liverpool.

On Tuesday, December 19th, 1893, I was asked by Dr. Hugh Shaw to examine a case of intestinal obstruction. The patient was H. A. S., a milliner's apprentice, aged 14. On December 7th, whilst at her work, she was suddenly seized with violent pains shooting across the abdomen in the line of the umbilicus. She vomited several times on her way home, and, on her arrival, went to bed. A little later her bowels were freely moved. This attack was not regarded seriously by her family, and as the acute symptoms seemed to abate domestic antidotes were relied on. For two or three days she remained in considerable pain, with occasional sickness, when her mother administered a copious soap and water enema. This gave temporary relief by emptying the large bowel of gas, but the pain and vomiting returned with severity, and on December 13th Dr. Shaw was sent for. He found the patient in great pain, with moderate distension, good pulse, moist tongue, and normal temperature, and, thinking it best to act conservatively, he gave appropriate directions with a view to lessening intra-abdominal pressure and to relieving pain. All the symptoms, however, increased, the pain becoming intense, and the vomiting more and more frequent, while the temperature remained at about 102° F. On December 15th the vomiting became fæculent, and from that time until December 19th, when I first saw the patient, nothing was retained. She then presented symptoms of impending collapse—a small quick pulse, dry tongue, a haggard look, listless demeanour, and rapid shallow respirations. The abdomen was distended and tympanitic, especially round the middle line. Fæculent material was being vomited every few minutes, thirst was intense, and there was pain on pressure over the right side of the abdomen. The patient, despite all this, was mentally alert, and took an intelligent interest in her affairs.

I was told she had been a well-developed girl, and well nourished, and had never needed a doctor in her life. For the last four years, however, she had been subject to what were called bilious attacks, the prominent symptom of which was vomiting, which lasted for one or two days, and was often accompanied by pain and sometimes by diarrhoea. For twelve months she had had considerable pain in the epigastrium, which came on directly after food, and often resulted in sickness. About two years back she suffered great pain in the right side on exertion, more particularly if she attempted to walk quickly or to run.

We decided, in view of the previous history and the patient's condition, that laparotomy should be performed without delay. That evening a median incision 3 or 4 inches long was made below the umbilicus, and the cavity of the abdomen exposed. Distended gut, pinkish in colour and dotted with flaky lymph, presented. On introducing my finger, the coils of intestine were sufficiently adherent to each other to require care in separating them. I was able quite easily to recognise the cæcum, and found it collapsed. There were also in the pelvis a few coils of empty small intestine. By very gently following this without exposing bowel, I felt a distended loop of intestine, which was carefully brought towards the wound. Immediately below I found a band about half an inch broad, which obviously compressed the intestine. I did not feel justified in accurately defining its limits, but it stretched transversely across the gut from the direction of the right kidney. The bowel was not kinked, but was sufficiently pressed upon to be quite occluded. Ligatures were applied and the strand severed. The wound was adjusted, and the patient placed in bed. Here a somewhat dramatic incident occurred. It was found that owing to a blunder a sponge was short. After a brief and fruitless hunt in basins, pails, and *débris*, I decided to reopen the abdomen. Luckily this was done, and the sponge recovered from within.

It is needless to report the subsequent events at length. The operation, which only lasted twenty minutes, had but a