CASE II.—Miss M., aged 27. I first saw this patient in July, 1893, when she complained of severe pain upon the least movement in the cervical and upper dorsal region, and pain with a choking sensation upon attempting to swallow. The symptoms had been attributed to hysteria, but they increased rapidly. The patient was then seen by an eminent physician, who thought more seriously of the case, and at his desire I was consulted. I formed the opinion that caries of the cervical vertebræ existed. When the spine was thoroughly supported the pain was greatly relieved, and the patient from that time very slowly but steadily improved.

Fig. 1.—Skiagraph of Case I showing even shadows of the three lower cervical and six upper dorsal vertebræ.

At the early part of this year (1896), although the patient had improved very greatly in strength and in ability to walk about, she still very much dreaded any movement of the neck or disturbance of the supporting apparatus, and I became anxious to determine how far this was due to any active disease at the present time, or to other causes. The skiagraph (Fig. 2) shows from the second to the seventh cervical vertebra. The intervertebral spaces between the fourth and fifth, the fifth and sixth, and the sixth and seventh are distinguished by light shading, but above the fourth there seems to be a mass of bone, there being no sign of cartilage. The appearance of the bones demonstrates the severity of the disease which has existed and the amount of repair which has taken place. The value of this information can hardly be overestimated. It cleared up all doubt as to the nature of

the case, and also indicated the line for future treatment. Upon this evidence I have commenced a course of massage of the neck and shoulders carried out very cautiously, and so far the result is satisfactory. It is in the neck that this diagnostic process must be most applicable, for, except in very young children, the obstruction caused by the sternum and other dense tissues interferes with a satisfactory shadow of the vertebræ.

The skiagraphs were kindly taken for me by Mr. Sydney Rowland, whose medical training enables him to apply the method of Roentgen with an aptitude impossible to the non-medical operator. In future cases we shall endeavour to get profile views, as they will possibly show the disease more definitely.

Fig. 2.—Skiagraph of Case II showing clear shadows of 5th, 6th, and 7th cervical vertebræ with the lighter intervertebral cartilages. From the 5th upwards there is an irregular mass of bone; A indicates the junction between the 5th and 4th cervical vertebræ.

A METHOD OF TEMPORARILY CLOSING THE OPENING AFTER GASTROSTOMY OR ENTEROTOMY.

By HARRISON CRIPPS, F.R.C.S.,
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THE chief trouble after gastrostomy or enterotomy is the keeping of the wound clean. The gastric juice or fluid faeces, if allowed to escape, excoriate the wound, making the surface raw and tender for some inches round. Dressings or trusses, however carefully applied, quickly get sopped, while plugs put into the wound unnecessarily enlarge it. In three cases recently under my care I have found the following plan effectual in overcoming the difficulty. The opening in these cases is, of course, always small, seldom larger than a sixpenny piece. A circular disc of sheet india-rubber the

thickness of a shilling is cut. Its diameter should be nearly double that of the orifice to be closed. A thread of No. 4 silk is passed by a needle a little to one side of the centre of the disc, and is passed back again, coming out a little distance from the original puncture and on the same side (see Fig. B). The two ends of the thread are now parallel to each other, and should be left 6 inches long. The india-rubber disc is now folded into a circular roll and kept in this position by a fine pair of dressing forceps (Fig. A). The roll is thus introduced lengthways through the orifice into the interior of the bowel or stomach, and when released from the forceps immediately expands to its original circular form. By drawing up the two strings the

disc is lifted up against the mucous surface, and in this way effectually stops anything coming through. Indeed, the greater the pressure of the fluid within the firmer is the disc pressed against the mucous wall. A little roll of lint the thickness of a pencil and an inch long, stiffened with a pin or a piece of wire down the centre, is laid over the external opening between the two strings, which are then tied in a bow across it, with just sufficient firmness to press the roll well down on the skin (see Fig. c). It requires some experience in each particular case to find the exact size and thickness of the disc required.

For feeding the patient or obtaining relief all that is necessary is to untie the bow, remove the lint roll, and then, holding the thread lightly, press back with the director the disc into the bowel. It can be at once drawn back again into position when required. I have found this method absolutely effectual in keeping the patients dry and clean.

ASSAULT ON A DOCTOR BY A LUNATIC.—Professor Tolly, Physician-in-Chief to the Lunatic Department of the Charité, was attacked suddenly by one of his patients the other day. The man had been considered a harmless lunatic, and left at liberty. When Dr. Tolly passed on his morning round, the man suddenly took up a chair, and dealt him a severe blow on the head, making a considerable wound. Consternation was great at first, but luckily the injury proved trifling, so that Professor Tolly was enabled to resume his duties next day.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

PUERPERAL ECLAMPSIA: RECOVERY FOLLOWING VENESECTION.

Mrs. S., aged 20, sent for me to attend her in her first confinement on February 3rd, 1896. I visited her about 6 P.M., and left as labour had scarcely begun. I called at 8 and again at 11 P.M. On the last occasion she was kneeling beside the fire, holding on to a chair, and in that position the baby was born in a few minutes. The child was a female, small but full period, and presented by the head. I put the patient into bed, and with a moderate amount of pressure on the fundus the placenta was expelled.

I left at 12 P.M. for home, but before I reached there I was requested to return, as she was in a fit. I was called again at 6 A.M. to see patient, who had four more fits, and when I entered the room she had a violent one. I drew off two ounces of urine, specific gravity 1030, and loaded with albumen. The legs were swollen, and pitted on pressure; and the tongue was bitten. I applied two leeches to the temples, and gave an enema of hot water. Fit followed fit rapidly, and the thirteenth looked as if it would terminate life.

I opened a vein in the right arm, and drew therefrom a pint of blood. Two slight fits followed quickly. I then injected 10 drops of solution of morphine hypodermically. The temperature was 99°.

At 10.30 A.M. on the following day she was unconscious. At 1 P.M. I passed a catheter, and gave an injection of hot water. At 9.30 P.M. I drew off some smoky urine. The patient was restless and unconscious, the temperature was 100°. On February 5th the temperature fell to 98°. On hearing the baby cry she inquired whose child it was. She stated that her mind was a blank up to this point. I injected 5 drops of pilocarpin hypodermically (that is, $\frac{1}{4}$ grain), and two 8-ounce mixtures of mist. alba with digitalis completed the cure within three weeks.

Jarrow-on-Tyne.

M. M. BRADLEY, M.D.

HEART DISEASE TREATED BY SALINE BATHS.

IN his article in the BRITISH MEDICAL JOURNAL of May 9th, Dr. G. V. Poore quoted two cases of heart disease treated by saline baths. The baths employed by him contained 4 lbs. of sodium chloride, and 6 ounces of calcium chloride to 40 gallons of water. I have seen many cases of heart disease treated by saline baths, and the most noticeable point in such treatment is that the baths are varied in kind, strength, frequency, duration, and temperature, according to the requirements of each individual case.

As regards the strength, commence the weaker baths and gradually increase the strength. As much idiosyncrasy is shown by patients for baths as for certain drugs. Each case must be carefully considered and carefully examined throughout the whole treatment. In some cases, with the weaker baths as employed by Dr. Poore, the results are negative, and it is not till the stronger baths are taken that any definite result can be hoped for.

As regards duration, here again great discrimination must be exercised. Some few patients experience great depression on taking a bath, even if only of 4 or 5 minutes, while others stand the stronger baths of long duration with impunity. The duration of baths varies from 4 to 20 minutes.

The temperature is another important element. If the bath is too hot the results are not only negative, but positively harmful. It is often necessary to alter the temperature as the treatment proceeds. As the solid constituents of the bath are increased, a lower temperature can be borne by the patient.

The frequency of the baths must be regulated to individual cases. It is necessary for some patients to take them only on alternate days, while others take them missing only every third or fourth morning. Lastly—a most important point—the kind of bath which is prescribed. Some must be toned up with the saline baths before passing on to those impreg-