the opinion was subsequently confirmed by the appearance of growths at the wound, sprouting round the tracheotomy tube. On several nights after her admission the child suffered from serious attacks of dyspnoea, accordingly tracheotomy was performed by my colleague, Mr. Southam on February 23rd with an immediate relief of all the urgent symptoms.

A week after the operation the silver tube which had been used was replaced by a soft rubber one, and this kind of tube (changed three times a week) was worn from that date until November 16th, 1897, when it was finally removed—a period of 3 years and 9 months—and the opening was then allowed to contract and was ultimately closed by a small plastic operation on December 16th.

The diagnosis of papilloma of the larynx was verified, as I have said, by the appearance at the tracheotomy wound some six months after the operation of growths sprouting round the tube. These were shaved off, and small doses of arsenic were administered internally. With the exception of a slight recurrence eight months later, which was similarly dealt with, there has been no drawback to the child's perfect recovery. The voice and breathing were observed at intervals during the wearing of the tube (by temporarily closing the opening), but it was not thought advisable to remove it until every trace of stridor or hoarseness had disappeared. The tube produced no inconvenience beyond the tendency it caused for the child to take cold easily. The larynx has recently been examined by Mr. Larmuth, who pronounces it to be perfectly healthy. Both breathing and voice are absolutely normal.

CASE II.—CURE AFTER WEARING A TUBE TWENTY-FIVE MONTHS.

Frances G. L., a girl of 4 years, was brought to the hospital on March 29th, 1894, with a history of chronic hoarseness, noisy breathing and croupy cough, with paroxysms of dyspnoea coming on at night. Her parents and four other children were said to be healthy. Two other children had died from croup.

On admission it was observed that she had inspiratory stridor with marked recession of the chest walls (suprasternal and supraclavicular regions and slightly at the ensiform cartilage and outwards). She was very hoarse and had a hoarse cough which was very troublesome. During the night the breathing became more difficult, but there were no paroxysms of dyspnoea. She was examined with the laryngoscope by Mr. Larmuth, and at the third attempt he was able to see warty growths projecting from the ventricle of the larynx and other masses coming between the true cords.

Tracheotomy was performed by Mr. Southam on May 9th and a rubber tube was worn until June 5th, 1896, when all traces of obstruction having disappeared, and the voice having regained its natural clearness, it was finally removed.

Mr. Larmuth has recently examined the larynx for me and finds that after a lapse of eighteen months there is not the slightest symptom of the recurrence of the disease.

REMARKS.

It was determined at the beginning of the treatment of these cases to limit it to tracheotomy, the more radical operations of thyrotomy or endolaryngeal extirpation having proved so very unsatisfactory in children, even at the hands of the most skilful operators. It would appear that the spontaneous atrophy of the papillomata depends upon the removal of all causes of irritation in breathing and more particularly in coughing. I do not attach much importance to the effect of the arsenic administered in the first case, in the second none was given.

I must acknowledge my indebtedness to Dr. G. Hunter Mackenzie's communications¹ for the idea of depending upon tracheotomy alone.

REFERENCES.

¹ *Edinburgh Med. Journal*, 1884; *Lancet*, April 6th, 1889; and *BRITISH MEDICAL JOURNAL*, September 12th, 1896.

THE METRIC SYSTEM.—The *Pharmaceutical Journal* announces that with the view of encouraging and assisting the general adoption of the metric system of weights and measures by pharmacists, all quantities will in future be given in its pages in accordance with the metric system.

A CASE OF CHRONIC INTUSSUSCEPTION.

By J. ORTON, M.R.C.S., L.R.C.P.LOND., D.P.H.EDIN.,
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J. K., aged 58, first seen November, 1893, was then complaining chiefly of the extremely offensive character of his motions, and of pain located over the caecal region. The offensiveness of the stools had first been noticed in the early part of the summer, and it had gradually become more intense, and was accompanied by some amount of pain on straining at stool. On examination of the abdomen, a soft, doughy mass was felt in the iliac fossa, which was thought to be faecal, and disappeared with enemata, without, however, benefiting the pain, which seemed gradually to increase in severity in spite of a careful dietary and drug treatment. Chronic typhlitis with ulceration was diagnosed, and consultation with several other medical men failed to improve upon this diagnosis.

As all palliative treatment had little effect in mitigating his condition operative treatment was discussed, but the possibility of the disease being malignant did not seem to justify its strong recommendation, and the patient did not give his consent. The condition, however, became worse. The pain would cease perhaps for a day or two, only to recur with renewed vigour, and he continued to lose weight. Nothing abnormal, however, was to be found on palpation of the abdomen; the bowels acted fairly regularly, a loose motion being passed, occasionally streaked with blood. The intermissions of rest from the pain, however, became fewer and fewer, and he died from exhaustion in November, 1896, after an illness which had lasted three years and a half, having been for the last six months or so almost constantly under the influence of morphine. As he had expressed a decided wish during his lifetime for a *post-mortem* examination to be performed, this was done the day succeeding his death. The body was very emaciated, the abdomen retracted, and on opening the latter no caecum was to be found in the right iliac fossa. This, together with the ascending, transverse, and descending colons were all involved, together with a great portion of the small intestine, in an intussusception which filled up the left side of the pelvis, and extended to the first part of the rectum. The condition was so chronic that it was impossible to reduce the intestines, the adhesions being so very firm; part of the invaginated portion had become but a fibrous coat. On following up the narrow lumen of the canal with scissors, the part corresponding to the caecum was found to be occupied by a gangrenous, ulcerated mass, the size of a small egg, which had no doubt given rise to the offensive stools.

REMARKS.

The case seems worthy of being reported chiefly on account of the probable great length of time that the intussusception had been forming, and of the large extent of intestine involved without gangrene of any portion taking place. It is hard to say when the intussusception commenced, but it certainly must have extended over many months, as evidenced by the tough, fibrous condition of the tube. The primary mischief was doubtless the chronic inflammation and ulceration of the caecum, which first became invaginated and gradually involved the other parts, and the patient only died very slowly from exhaustion.

SOME CASES OF PELVIC SUPPURATION IN THE FEMALE.

By JAMES OLIVER, M.D., F.R.S.EDIN., F.L.S.

The following cases which have occurred in my practice appear to me to present features of interest:

CASE 1. *Abscess of Ovary: Symptoms Developing One Month after Parturition: Operation: Recovery.*—A. M., aged 28, and married six years; has had three children, and no miscarriage; the last child was born four months ago. This child was not suckled. The menstrual discharge reappeared 24 months after this confinement, and on this occasion it was slightly excessive, but in the following month it was of the usual amount. One month after the last confinement the patient was seized with severe pain in the lower abdomen and back, and during the twenty-four hours succeeding the onset of this attack the catheter had to be used twice, as there was complete retention of urine. Thereafter, and up to the present time, some difficulty has been experienced in voiding urine, and the act has always been accompanied with severe pain. Since the attack, one month

after parturition, that is, for three months, she has complained more or less constantly of pain in the abdomen and lower part of the back.

Physical signs: There is an ill-defined fulness in the left iliac region, but otherwise there is nothing to note abdominally. Vaginal examination: The cervix uteri is located high, and far back. The body of the uterus is felt in front on the right side, slightly enlarged. By bimanual examination a small, firm swelling is detected in the left pelvis close to the uterus. The temperature is normal.

Operation: The tumour, which was the left ovary, was of the size of a hen's egg. It was adherent to the posterior surface of the left broad ligament and the left Fallopian tube was involved in the adhesions. The uterus was half as big again as it should have been. The ovary, when cut into, was a sac containing creamy inoffensive pus. The left Fallopian tube was thickened and very patent, but contained no purulent material.

In this case the patient had apparently recovered well from her confinement, and one month after this event she was suddenly seized with pain. She evidently had had no rigor, and when I saw her there was no elevation of temperature. The left ovary when removed four months after parturition was converted into an abscess, and no trace of ovarian tissue remained.

CASE II. *Suppuration (Tuberculous?) in the Left Fallopian Tube: Operation: Recovery.*—E. H., aged 28, and married three years, has never been pregnant. Since marriage the menstrual discharge has recurred regularly, and has been of the usual amount. Eight months ago, during a menstrual period, she was suddenly seized with severe pain in the lower abdomen. This pain continued off and on for seven days, and then gradually subsided. She was confined to bed for one month. Two months later, in consequence of the continuance of a general feeling of indisposition and loss of flesh, the doctor in attendance advised her to go to Hastings. This change produced some improvement. Ten weeks after her return from Hastings (eight months after the onset of the illness) I was asked to see her, as a small lump detected (four weeks previous to my visit) in the lower abdomen had gradually increased in size, and she was losing flesh.

Physical signs: The patient is emaciated. The hypogastrium is occupied by a central globular and cystic swelling, which pushes forward markedly the contiguous portion of the anterior abdominal wall. It extends upwards from the pelvis to a spot $\frac{1}{2}$ inch below the umbilicus.

Vaginal examination: The cervix uteri is pushed toward the right wall of the pelvis. The vaginal roof, anteriorly and toward the left side, is pushed down by a globular and cystic swelling, which is a portion of the abdominal swelling. The body of the uterus is felt to the right of, and in close apposition with, the abdomino-pelvic tumour. The temperature is 100° F.

Operation: On opening the abdomen in the median line, a large tense swelling was seen lying in front and to the left of the uterus. It was adherent to the anterior abdominal wall. The adhesions were separated and the tumour tapped. About a pint of thick creamy inoffensive pus was evacuated. The interior of the cavity presented a markedly tuberculous appearance. On account of the pelvic adhesions it was found impossible to remove the sac, consequently it was stitched to the abdominal wall and drained. The left ovary was felt adherent to the posterior wall of the tumour very low in the pelvis. Tubercle bacilli were detected in the pus and scrapings of the sac.

The illness in this case was accompanied by elevation of the body temperature and loss of flesh.

CASE III. *Suppuration of an Ovarian Cyst: Inflammatory Thickening of the Cyst Wall: Operation: Recovery.*—E. B., aged 42, and married twenty-two years, has had one child; the child was born 21 years ago. Menstruation recurred regularly until two months ago, since which time there has been complete amenorrhoea. For two years she had remarked that her abdomen was increasing in size. Two months ago she was seized with severe pain in the left iliac region and with sickness, and since then she has complained more or less of pain all over the lower abdomen. She seems to have had an elevation of temperature during the fourteen days succeeding the onset of this attack, and she was confined to bed for one month.

Physical signs: The abdomen is prominent. It is occupied by a central and globular swelling which extends upwards from the pelvis to $8\frac{1}{2}$ inches above the pubes. The tumour over its lower 6 inches feels solid, whilst the upper portion is distinctly cystic.

Vaginal examination: The cervix uteri is located centrally. The vaginal roof on the left side and posteriorly is markedly drawn up. The body of the uterus is directed slightly backwards. The abdominal tumour is firmly fixed, but it appears to be attached to the uterus. The temperature is normal.

Operation: The tumour was firmly incorporated with the anterior abdominal wall over the lower three-quarters of its anterior surface by a pad of dense fibrous tissue an inch and a half in thickness. The omentum, which was greatly thickened, was extensively adherent to the tumour on its upper and posterior surfaces. The tumour was removed entirely. It was a thick-walled cyst of the left ovary, and contained most fetid pus.

In spite of the foetid and purulent fluid in the tumour the temperature was normal, and the state of health of the patient was good. The solid feel of the lower portion of the tumour was due to the organised inflammatory material which had incorporated it with the abdominal wall.

FEMALE MEDICAL PRACTITIONERS IN SWITZERLAND.—The number of legally qualified medical women now practising in Switzerland is 24; of these 10 reside at Zurich, 4 at Geneva, 2 at Basel, 2 at Lausanne, while Bern, St. Gall, Winterthur, Aarau, Schinznach, and Samaden have 1 each.

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

FRACTURE OF RIB DURING COUGH.

Mr. G. some few weeks ago had a very smart attack of influenza, with a good deal of bronchitis. Partial recovery took place, leaving a most obstinate tracheo-laryngeal catarrh, the cough resulting being most distressing. In spite of advice to go to the South Coast for a short time, he went to business intending to "work it off." One morning, on arrival at the office, and whilst in the act of hanging up his coat, he was seized with a sudden and severe coughing bout, and before he could get his hand to his side a pain took him, which, as he expressed it, was like a knife being driven in. Three hours after I saw my patient at his own home, he having travelled by rail some miles, and on examination found a marked fractured rib on the left side. Being a somewhat unusual accident I thought it possibly worth recording.

On February 7th I saw an elderly woman, aged 58, who had had influenza for the previous five weeks with bronchitis and a most persistent cough. On February 5th she was sitting up but complained of her right side. I found the cartilage separated from the rib and crepitus easily felt, in fact almost heard. These cases raise the question of the treatment of the very severe and persistent cough which has followed many of the attacks this season.

Green Lanes, N.

AMB. ATKINSON.

SCARLATINA MALIGNA.

THE publication in the BRITISH MEDICAL JOURNAL of January 15th, p. 145, of a case of scarlatina maligna which proved rapidly fatal recalls to my mind a somewhat similar case, in which, however, the rash was suppressed, which occurred in my practice some twenty years ago, where cold affusion rescued the patient from almost certain death.

I was attending a case of enteric fever in a young man living in the country, when one day his sister, a girl of 19, who appeared perfectly well up to 2 P.M., was suddenly seized with green vomiting and stools, headache, and delirium; she "ran about the house like a mad woman." Next day, when I first saw her, the temperature was 105.6°, pulse 160, respiration 60. She had intense headache, delirium, and great thirst. As her brother had typhoid, at first sight the possibility of her being attacked with same disease, but with a very anomalous mode of onset, suggested itself; but I expressed the opinion that the symptoms were more like what might be expected in suppressed scarlatina. Brandy and ammonia were ordered, and a full dose of quinine. At 6 P.M. I saw her again in company with an elder practitioner, when she appeared to be in a moribund condition. No pulse could be felt except a mere flicker; the first sound of the heart was inaudible, temperature 105°, eyes congested, her face pale. On speaking loudly to her she opened her eyes and stared stupidly at us, but could not be got to utter a word or put out her tongue. She seemed *in extremis*. My friend threw up his hands with a significant gesture, implying that it was "all up" with her.

However, we decided to try the effect of cold affusion as a last resource. Her hair was rapidly removed, and her head brought over the edge of the bed, and two large jugsful of cold water poured over it. The result was marvellous. Her intelligence returned, she spoke almost immediately, and said she was frightened, and put out her tongue, then seemed inclined to fall into a somnolent state. A blister to the nape was ordered, turpentine to the chest and back, 3ss of brandy every half hour, and carb. ammon. mixture.

At 11 P.M. I saw her again; her pulse could just be counted, but was the merest thread, and as she seemed likely to fall into the same comatose state as previously, the douche was repeated, and this time she violently resisted it. Next morning the temperature was 101.2°, pulse 136, respiration 36. Her intellect was clear, she said she was better, but remembered nothing of what had happened. The following morning the temperature had fallen to 100.8, and a bright scarlet rash had made its appearance on her feet, legs, and back of hands. In