The dyspnoea on exertion, and the soft bellows-sound, were also much less considerable than in this disease. Lastly, there was little or no oedema of the legs; a symptom which rarely fails in moderately severe cases of chlorosis.

It would, of course, be rash to assert than an inconsiderable degree of true chlorosis would so necessarily offer all these characters, as to be at once distinguished from the pallid cachectic amenorrhoea of the gastric ulcer, or the not very dissimilar state sometimes present in phthisis, or heart-disease. But such rare exceptions to the above distinctions are themselves the strongest practical argument for our insisting on their importance. Certain symptoms are, as a rule, present in chlorosis. That they are rarely absent is, therefore not merely a suspicious feature against any particular case in which they fail to occur, but one which calls for the strictest scrutiny of various important organs—the stomach, lungs, or heart—before we can justifiably assume that the cachexia, which constitutes one of the chief elements of the patient's malady, is its cause and essence, and, therefore, the chief and only object of treatment.

Lastly, in spite of the imminent danger of perforation that forms the most serious feature of this group of gastric ulcers, there is no reason to suppose them less curable than other varieties of this lesion. On the contrary, if there be any difference in this respect, it is rather in their favour. Rest, however, is generally an indispensable part of their treatment. Occurring, as they so often do, in a class of persons who (either as domestic servants or as shopwomen) are deprived of fresh air, and engaged in constant toil during many hours daily, it is occasionally necessary to enforce this rule by something more than hints as to the danger they incur in regarding their dyspeptic symptoms as due to mere indigestion. Tight lacing, again, is an evil habit, common among those persons, which seriously aggravates the peril they incur; both by constantly compressing the stomach and irritating the ulcer, and by supplying a very efficient and immediate mechanical cause of perforation. It is one of the contingent advantages of blisters to the epigastrium, that they ensure at least a temporary intermission to this constriction, which no moderate amount of pain or discomfort will induce many women to forego. The simple starch and milk diet, by which vomiting is best allayed, may be gradually exchanged for the food usually taken in health, with much greater rapidity than is the case in the gastric ulcer of older persons. Indeed, both as regards food and drugs, the stomach is rarely so irritable and prone to vomiting as in the ulcer of larger size, and longer duration, which occurs in the middle age of adult life. Hence quinine is well borne, and is productive of great benefit. An ordinary rhubarb or colocynth pill, or a grain or two of aloes, is frequently a very convenient aperient. Finally, iron seems to have an influence on the lesion—and (if we may distinguish) on the accompanying cachexia—which is even more direct and unmistakable than in other groups of gastric ulcer;—an influence which really approaches, if not equals, the efficacy it has long been known to possess in true chlorosis.

Brook Street, Grosvenor Square, Jan. 4th, 1856.

ST. GEORGE'S HOSPITAL.

CASE OF DIFFUSE INFLAMMATION AND GANGRENE OF THE ABDOMINAL WALL FROM ULCERATION OF THE APPENDIX CÆCI.

By T. HOLMES, Esq., Surgical Registrar to the Hospital.

I HAVE thought that the following case may be interesting, as illustrating the insidious manner in which ulceration of the intestines sometimes occurs, and the grave consequences to which it naturally leads. This subject I shall pursue in a future examination in connexion with the treatment of hernia.

The instance which I now bring forward was, I believe, an example of the same disease occurring "idiopathically", i.e.,

from some cause which must remain obscure in the present state of our knowledge. The disease I refer to consists, I believe, in ulceration extending outwards from the mucous membrane of the gut, and so forming a fecal abscess, presenting externally; the effusion of feces into the general sac of the peritoneum having been prevented by previous adhesion of the ulcerated intestine to the parts in the neighbourhood. That this was the course pursued by the morbid action in the present case, and that the disease did not consist in the opening of the gut by an external abscess, is proved, I think, by the diffuse inflammation which surrounded the parts destroyed by the effusion, so exactly resembling the state of the perinæum in cases of effusion of urine, and so different from the condition left by the pouring out of feces into the solidified sac of an abscess, as well as by the absence of any collection of pus near the incisions, or of any remains of an abscess on *post mortem* examination. This perforation of the gut was not, it will be seen, preceded by any acute inflammation of the cæcum or its appendages; for although the patient's account was necessarily very imperfect, there could be no doubt from it, confirmed as it was by her relatives, that the bowels had been open without pain for some days before, and that on the first day of attack she was well enough to be out walking. As to the bowel complaint, from which she was stated to have suffered, there was no reason to doubt that it was merely a case of the usual autumn diarrhoea—especially rife about that time. Another interesting particular in the case is the presence of a large abscess of the liver, not preceded by any symptom of pyæmia, or of disease of that viscus. The probability is, that the pyæmia was present, but that the symptoms had been more than usually obscure, and were overlooked.

CASE. E. R., a woman, apparently about 60 years of age, but whose age was stated to be 49, was admitted on October 12th, 1854, under the care of Mr. Cutler, on account of diffuse inflammation and gangrene of the abdominal parietes. She could give no intelligible history of the attack, and was slightly delirious, answering simple questions rationally, but soon rambling off to another subject. It seemed that she had had "bowel complaint" about a fortnight before her admission, but had recovered from this, and was out walking, when she felt a pain in the abdomen, and on coming home and looking at the part, found it red and swollen. This was on the tenth day before admission. She kept quiet for several days, not treating the disease further than by the application of some ointment. The sloughs made their appearance on the third day before admission. Her bowels had been open regularly till the previous day.

On examination, the abdomen was found considerably swollen, from about two inches below the umbilicus to the pubes. This swelling was ill defined, and appeared confined (or, at least, principally) to the abdominal parietes, which were of a bright red colour, and pitting to a good depth on pressure; there was no sense of fluctuation. The redness extended over the hip to the buttocks, and was not terminated by any distinct line. Just below the umbilicus, and about two inches to its right side, were two patches of gangrene, about the size of a crown-piece. There was no line of demarcation to the sloughs. There was tympanic resonance to percussion over the right iliac and hypogastric region, but not in the other parts of the abdomen. There was no emphysema.

Four incisions were made into the inflamed part, care being taken not to go too deep; from the one nearest the gangrene, air of a very foetid odour began to bubble up slowly. The cellular tissue was much thickened, but no pus was found. She was in a state of great depression. Stimulants were given largely, and she soon rallied.

Next morning a quantity of liquid feces were found to pass from the wound above referred to. The gangrene had rather extended, but the area of inflammation was lessened. The bowels were constipated, so that it became necessary to give purgatives. They acted copiously and naturally, and she felt much relief from the evacuation. Fæces con-

tinued to pass from the wound for more than a fortnight. The slough (for the two spots of gangrene had by that time coalesced) separated on the eleventh day of her stay in the house, and the wound assumed a healthy appearance. The communication with the gut appeared to contract to two small sinuses, from which air might be seen to bubble up. After the first fortnight, the faecal discharge intermitted for about a week, and finally ceased about a month after her admission. Large bed-sores, however, formed on the back, involving all the coverings of the sacrum, and it was from the exhaustion occasioned by these that she seemed to sink. No other symptoms were observed except constipation of the bowels, which persisted during the rest of her life, requiring the constant exhibition of gentle purgatives. She died on the 26th of December.

I subjoin the notes of the *post mortem* examination, made by Dr. Ogle:—

There was a large and deep sore above the pubes, and in the right groin, which had healed to a great extent. The muscular walls of the abdomen were, to all appearance, perfectly natural. The general surface of the peritoneum was natural. The great omentum was tied down by adhesions between it and the abdominal parietes below and in front of the caput coli and a small knuckle of the ileum; and the appendix cæci were also attached to the parietes in the same neighbourhood. The former intestine adhered by a long band; the latter was closely united to the abdominal wall. The appendix was exceedingly thickened and indurated, but, nevertheless, quite pervious, as far as the point at which it adhered to the parietes. Owing to the general thickening and hardness of the parts around these adhesions, it was impossible to demonstrate the exact spot where ulceration had existed in the appendix cæci, but there had doubtless been such ulceration originally.

The transverse colon was adherent to the under surface of the right lobe of the liver; and in the latter a large collection of pus was found, communicating with a foul discoloured cavity, formed by ulceration of the walls of the gall-bladder and the neighbouring portion of the substances of the liver. One or two small biliary calculi were found. The state of the gall duct could not be ascertained. The other viscera were natural.

Original Communications.

PLACENTAL PRESENTATION.

By SAMUEL BEECROFT, Esq., Hyde, near Manchester.

Mrs. H., aged 34 years, a weak delicate woman, had had three living children. I visited first time April 1st, 1855, when she stated that she had been flooding for a few days, but the discharge was not very great; she said she was about a month from her time. I prescribed rest and astringents; and there was not much discharge until the night of the 12th, when she parted with a large quantity. The hæmorrhage had ceased when I saw her; and, on a vaginal examination, I found that the os uteri just permitted the introduction of the finger. I detected, as I thought, a placental presentation. As there was no hæmorrhage going on, I recommended a continuance of the previous treatment. All went on well until the 14th, when hæmorrhage returned with great violence, and reduced her so much that, on finding the os uteri dilated about the size of a shilling, and lax, I thought that I could deliver her without any great difficulty, and at once determined to operate.

As anticipated, I did not find the difficulty very great. By inserting the fingers separately, the os uteri kindly dilated, and I passed my hand without great force into the uterine cavity, turned and carefully brought away the child, which was alive, but very feeble, its body dragging the placenta along with it, as, on separating the child, a

portion of it was visible, protruding through the os externum.

The poor woman bore the operation very well; but the hæmorrhage still continued, a constant draining away of blood going on; and, although pressure was constantly kept up in the abdomen by myself and pupil, and though the womb felt small and contracted, and notwithstanding the application of cold, the introduction of the hand within the uterine cavity (which was scarcely admissible), the administration of ergot, opium, brandy, etc., she gradually sank, and died in somewhat less than three hours from delivery.

I was allowed to make a *post mortem* examination, and found the uterus not larger than usual, its interior containing nothing; it was very pale, with the exception of a few inches round the circumference of the os uteri, which presented a raised pile of bright red capillaries, against which I supposed the placenta had been placed. Here, in one spot, there was slight ecchymosis; and, meandering in the submucous tissue, there was a moderate sized vein, though I could not detect its open mouth. The whole of the walls of the inferior portion of the uterus were very thin, and apparently deficient in muscular development, which I thought might arise from the position of the placenta interfering with its growth.

REMARKS. I have had three cases of complete placental presentation, besides the one now related; two terminated favourably, one of which made a rapid and complete recovery, while the other ultimately did well, though suffering from extreme debility for months afterwards. In both of these cases the hæmorrhage had not been so profuse as to make delivery compulsory until the os uteri was moderately dilated. The third case was such an one as Mrs. H.'s case, the os uteri at the time of delivery scarcely being of the size of a shilling; though, from the frequent recurrence of hæmorrhage placing the woman in such a critical state that I was afraid to leave her lest she might have a violent recurrence of it, which might be fatal, I felt called upon to deliver her, the operation being somewhat difficult, as the os uteri was rigid. She continued afterwards in a very dangerous state, from the great loss of blood; and some slight discharge still existed, though, on the whole, I thought her doing well, until, the friends imprudently bringing her downstairs on the seventh day, a return of severe hæmorrhage took place, and she died a few hours afterwards.

If I might venture an opinion, from the experience of these cases, I should say it would be advisable to defer delivery to the utmost possible limits; for it does not to me appear improbable that, if by any treatment we could wait until the os uteri was pretty well dilated, the placenta would be from this cause so much detached that afterwards, on delivery, the bleeding uterine surface would not be so extensive, and consequently less danger of hæmorrhage. I would also wish to know if the plug has been fairly tried, and if it has not succeeded in checking the hæmorrhage, when effectually applied, in cases of undilated os uteri, so that it might have time to dilate prior to commencing delivery; for it appears reasonable to think that on its use no blood could escape into the uterine cavity; and, as none could escape externally, and as the plug might stimulate the uterus to contract, its use appears rational.

In Mrs. H.'s case the operation was borne well; and I have no doubt she would have recovered, if the hæmorrhage—which I think came from the uterine capillaries—subsequent to delivery, had not recurred.

P.S. Since writing the above, I have seen Dr. Barnes' paper, read before the Medical Society of London, on 22nd of December last; but I am afraid that neither he nor Dr. Cohen has discovered the true principle of treating cases of the kind above described; as we occasionally find, as in the last case I had, that in partial placental presentations, when the os uteri is so much dilated that the cervical portion of the placenta must be detached, hæmorrhage still goes on, and delivery is required.