satisfactorily for weeks together without any attention, and its temperature does not alter to an extent that is appreciable to an ordinary thermometer.

The apparatus is simple, but difficult of explanation in a few words. My excuse for entering into minute detail is that I have desired to render myself clearly understood. There are probably not a few who have felt the want of such a contrivance, and who, like myself, have been informed by instrument makers that an electrical regulator was an impossibility.

Before closing, I desire to acknowledge my indebtedness to Mr. Weatherby, engineer, for constructing the apparatus and for valuable practical suggestions, and to Mr. A. C. Cossor, Farringdon Road, for making the thermostat.

PROLONGED ACTION OF THE HEART, MAINTAINED BY ARTIFICIAL RESPIRATION WITHOUT OTHER SIGNS IN A NEW- BORN INFANT.

BY
JOHN J. REDFERN, and GERVASE NEWBY,
M.D., M.Ch., F.R.C.S.,
Surgeon. Assistant-Surgeon.
Croydon General Hospital.

A WELL-DEVELOPED male child was delivered with forceps, under chloroform, at full term, at 3.30 P.M. on August 24th, 1901. The delivery showed no unusual symptoms for a primiparous one, the amount of pressure on the head being about that usual with instrumental delivery. The cord was wound twice round the child's neck, and respiration was entirely absent. The heart beat normally, and there was pulsation in the cord. Artificial respiration was attempted, and the chest and face flicked with towels wrung out of cold and hot water, and brandy was rubbed on the chest and along the spine. The trachea was free of mucus.

As all efforts to start respiration, including rhythmical traction on the tongue with the head dependent, were unavailing, and as the heart still continued to beat normally, and the cord to pulsate, intubation was attempted; but a tube small enough to pass into the trachea not being at hand, the cord was tied, tracheotomy was performed, and a catheter introduced into the trachea. Through this tube air was blown into the lungs, and expressed by compression of the ribs. This was continued for over one hour, the heart continuing to beat regularly as long as the inflation was kept up, but if this was stopped the heart began to fail almost immediately, and at times the rate fell to about 50.

The use of the mouth to inflate the lungs proving very fatiguing, a bicycle pump was used, but a small pair of hand bellows acted more efficiently, and raised the heart-beat to over 100.

At the end of two hours and a half, during a short intermission of the bellows action, the first inspiratory effort was made; and again a few minutes afterwards, on stopping the bellows for a moment, it was repeated.

From this time breathing efforts were regularly repeated, three successive breaths being followed by an interval of 15 seconds. The bellows was still occasionally employed, as it seemed to quicken the heart's action, which was, however, remarkably strong and regular. By about 6.45 P.M. the respirations had increased in frequency, being two in every five or seven seconds, and this continued without artificial help until 10 P.M. The temporary tracheotomy tube was now removed, and as respiration through the mouth was only partially possible, another, softer and larger tube was inserted, with a lateral opening to allow respiration through the mouth, as well as through the tube. This tube tended to get blocked with mucus, and was kept free by passing a feather down in the usual way.

During the early hours of the night the respiratory rate was once in two and a half seconds and of this type . . . —. About midnight the respiration became gradually shallower and at longer intervals, say five to seven seconds. The lips turned colour about 2 A.M., the colour then returned and kept good until 4 A.M. when it became darker. The body was warmed with hot water bottles, and wrapped in cotton wool.

Between midnight and 1 A.M. clonic spasms of the right hand occurred.

About 4 A.M. the respiration was of the type . . . — instead of . . . — as it had been during the preceding six hours. Then it faded gradually. Death occurred about 4.20 A.M. After death the lips, ears and tongue were deeply cyanosed.

The points of unusual interest in this case are (1.) That the heart beat continued good for two and a half hours, without any voluntary respiratory effort, during which time artificial respiration was carried out; (2) increased use of the bellows produced marked quickening of the heart beat; (3) the child never gave any other sign of life than action of the heart and lungs, and clonic spasms of the right hand.

The causes of respiratory failure in this case involve the consideration of the following possibilities: (1) That it may have been caused by strangulation on the neck by the cord possibly producing pressure on the vagus, or phrenic nerve fibres, or (2) by the action of the chloroform inhaled by the mother and carried through the cord to the child, or (3) by injury to the respiratory centre through pressure of the forceps on the child's head.

If the second of these considerations may be entertained, the case would afford a striking example of respiratory failure preceding cardiac failure, and due to chloroform anaesthesia. As bearing on this case, it is interesting to read the opinion of Dr. Robert Kirk of Glasgow, published in the *BRITISH MEDICAL JOURNAL* of July 10th, 1897, in which he states that inversion without artificial respiration, is the way to treat cyanosis of chloroform. In the above case it was during the cessation of attempts at artificial respiration that the child first gasped, and it breathed better when artificial respiration was discontinued.

HERNIA OF A DIVERTICULUM, A TRUE LITTRE'S HERNIA.

BY T. RUDOLPH SMITH, M.B., B.C. CANTAB., F.R.C.S.,
Surgeon to the Stockton and Thornaby Hospital.

C. B., female, aged 34, married, was admitted into the Stockton and Thornaby Hospital, September 26th, 1901, complaining of pain across the lower part of the abdomen, and of a swelling in the left groin. Dr. Densham being absent, I took charge of the case at his request.

For the last two years the patient had had a swelling in the left groin when standing or straining; this always disappeared on lying down. For a few days before admission she had had a bilious attack; on the morning of September 26th, while retching, the swelling in the left groin became much more prominent and could not be pushed back. She vomited several times during the day and her bowels acted naturally three times. In the evening Dr. Taylor saw her and sent her into the hospital.

She was examined under an anaesthetic shortly after admission. There was a sausage-shaped swelling on the left side parallel to and half an inch below Poupart's ligament, extending from the situation of the femoral ring to half an inch internal to the anterior superior iliac spine. The swelling was very tense and moderate; taxis failed to reduce it. A vertical incision was made over the position of the femoral ring, and a tightly-distended hernial sac exposed. On incising the sac, blood-stained fluid escaped and some deeply congested gut was seen. This proved to be part of an intestinal diverticulum, the blind end forming the remainder of the swelling extending out towards the anterior superior iliac spine. The sac contained nothing else. The diverticulum was six inches long and of the calibre of the ileum slightly distended. Owing to the congestion of the gut and to the tightness of the femoral ring, there was great difficulty in dividing the constriction which was at the upper and inner margin of the ring.

On drawing down the gut, it was found to be nipped about three quarters of an inch from its point of origin from the small intestine. As the intestine could not be brought into view sufficiently to remove the diverticulum, and the condition of the patient did not warrant any further delay, the herniated diverticulum was returned and the ring sewn up.

The wound healed by first intention, though the temperature

ran a rather varied course for the first ten days, and the patient left the hospital in three weeks, promising to lie up for a further period at home.

This is, I believe, a case of true Littre's hernia as described in Mr. A. Bowlby's *Surgical Pathology*, and is of interest as a rare occurrence. Undoubtedly, the preferable course, if circumstances had permitted, would have been to remove the diverticulum at the time. It remains a constant source of danger, and I shall advise the patient to consent to its subsequent removal if opportunity occurs.

MEMORANDA:

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

HERNIA INTO THE UMBILICAL CORD.

WITHIN the last fourteen days I have operated on two cases of hernia into the umbilical cord, and as I have always understood that it was a very rare deformity, and have never seen a method of operating described in textbooks, they seem worthy of publication.

CASE I.—A healthy male infant, 12 hours old. There was a very large hernia distending the cord for about 3 inches, and clearly visible through it. The cord was opened; the cæcum with appendix and several inches of large and small intestine were in the sac. The umbilical opening was too small to allow reduction, and was enlarged upwards; the intestine was then reduced with some difficulty, the cord cut off at its junction with healthy peritoneum, and the wound closed in the usual way with silkworm gut. The child was sent back to its mother, and recovered without a bad symptom.

CASE II.—In this case the umbilicus was distended; the opening at its attachment to the cord measured $1\frac{1}{2}$ inch from side to side, and was elevated like the edge of an eggcup from the abdomen. On opening the cord a thin layer of healthy peritoneum, from which the cord could be raised, was seen to cover the umbilical opening. The cord was cut at its junction with the skin all round the umbilical edge (the vessels entering at the lower margin). The peritoneum was then opened, and the umbilical opening stitched with silkworm gut. The child, who was one hour old at the time of operation, did quite well.

In 10,000 births I only remember having seen one other case, and that being 3 days old the cord had sloughed, and the child died of peritonitis.

A. E. KENNEDY, Jun.,
Honorary Surgeon, Plaistow Maternity Charity.

SURGICAL EMPHYSEMA FROM A WOUND OF THE ARM.

THE following case seems to be worth recording in connection with the case reported by Dr. Stewart in the *BRITISH MEDICAL JOURNAL* of October 26th, page 1267:

E. T., aged 23, came to my rooms on October 14th. He had slipped while climbing over a fence. As he slipped he caught his arm on a projecting nail in the fence. He had a punctured wound of the left forearm, some 3 inches below the elbow; the hæmorrhage had been trifling; there was some bruising of the skin.

I found well-marked surgical emphysema extending upwards from the wound to half way up the arm. A few hot fomentations cured the pain, and the emphysema disappeared in three days.

Both this injury and that recorded by Dr. Stewart were punctured wounds into muscle. The explanation of the emphysema does not seem very obvious.

Hovingham. CHARLES W. SMEETON, M.R.C.S., L.R.C.P.

MOSQUITO LARVÆ IN MAIL STEAMERS.

WHILE travelling in a mail steamer from the Gold Coast to Sierra Leone I was surprised to find a full-grown larva of the mosquito of the variety debited with the odium of conveying yellow fever come through the tap into the wash-hand basin of my cabin. This larva hatched out into a fine stegomyia in

three days. As far as I could make out it must have come from the tanks below, through the pumps and from thence into the small tank over the basin. On mentioning the matter to the captain I was informed by him that he had seen them more than once in his basin. The ship had pumped in water from the Congo River four weeks before, and presumably the egg responsible for this larva came up at the same time. The small tank in the cabin did not appear to contain any more larvæ, and as it is open to the air only by a tiny opening in the top it is not likely that a mosquito laid eggs therein. The fact is interesting as showing how mysterious outbreaks of disease on ships may be accounted for, bearing in mind that sick people from the Coast are constantly to be found on the steamers.

FRED SMITH, D.P.H. Durham, Major, R.A.M.C.
Sierra Leone.

A CASE OF RÔTHELN.

It is probable that two distinct diseases are included under this term. One comes across cases very like measles, and others which mimic very mild scarlet fever—morbilliform and scarlatiniform rôtheln—(Ashby and Wright). The following is an example of the latter type: A child, aged 8, had scarlet fever a year ago for which he was in hospital twelve weeks. He had typical measles six months ago along with his brother and sister.

The first symptom noticed in the present attack was a rash all over the face and body. His brother had a similar attack a fortnight ago which his mother attributed to "indigestion," for which advice was not sought. The face, trunk, arms, and legs were covered with uniformly scattered rose-pink papules, very slightly raised above the skin, and each with a little areola of its own, exactly like what one sees in very mild scarlet fever, save that the spots were more raised, pointed, and were present on the face. The fauces were redder than normal, but there was no swelling or exudation. The eyes were somewhat suffused, but there was no coryza or coughing. The glands along the posterior border of the sternomastoid muscle on each side were enlarged and tender. There was no fever, and the child was otherwise in good health.

The diagnostic features of the case were: (1) History of previous scarlatina and measles; (2) history of similar attack in the case of his brother fourteen days earlier; (3) presence of the rash on the face, and uniform distribution over the body; (4) swollen and tender posterior cervical glands.

Southall, W.

J. D. WINDLE, M.D., B.Ch.Vict.

AN UNUSUAL CAUSE OF HÆMORRHAGE DURING PARTURITION.

ON October 9th I was called to attend a primipara, aged 43, whose labour had just commenced by rupture of the membranes, accompanied by hæmorrhage. The os admitted one finger, the vertex was presenting in the left occipito-anterior position, the vagina was filled with blood clot, and blood was slowly trickling from the cervix uteri.

Pains increased, and labour made steady progress until the birth of the stillborn child seven hours later; each pain was accompanied by a flow of blood. The patient's strength was well maintained, her pulse was good, and there appeared to me to be no urgent need of instrumental interference, but I was at a complete loss to account for the hæmorrhage, as there was no placental edge or laceration of the cervix to be felt, and, so far as the history of the case went, no reason to suspect so-called "accidental hæmorrhage." On delivery of the placenta the cause was at once obvious: the umbilical cord, instead of being directly attached to the placenta, was joined as nearly as possible to the most central point of the membranes; here it divided into two arteries and two veins, both of which coursed over the membranes to the placenta. It had so happened that on the rupture of the membranes, which occurred, as I have previously stated, at a very early stage of labour, one of these veins was torn. This undoubtedly accounted for the hæmorrhage, from which the child was suffering and not the mother. The patient made a complete and uninterrupted recovery.

LANCELOT M. BRETTON, L.R.C.P., M.R.C.S.
Portsmouth, Southampton.