natural, being lined by the usual folded mucous membrane covered by columnar ciliated cells. There are no traces of placental villi or of anything that would indicate the former existence of a fetus.

The Left Fallopian Tube and Ovary.—In its outer two-thirds this tube is moderately distended, and the fimbriated end is closed, the fimbriae having, with the exception of remnants of two, quite disappeared. (See Fig. 2.) The wall is everywhere

Fig 2.—View of posterior surfaces of Fallopian tube and ovary (natural size).

thin and of a dark colour, as if intensely congested. The inner end of the tube is natural, both in size and structure. The tube contained a dark-coloured serous fluid, in which there were many red blood corpuscles. The wall is everywhere thin, and the mucous membrane is almost devoid of folds, which are stretched out. Under the microscope the mucous membrane is seen to be reduced to a very thin layer, with occasional and short simple folds projecting into the lumen. On the folds, which are very thin, the epithelium retains its columnar ciliated character, but elsewhere it is reduced to a layer of small flattened cells of irregular shape, devoid of cilia. The muscular wall is not structurally altered, being merely attenuated from the stretching. The left ovary is natural.

REMARKS.

In reviewing the clinical history of this case it is clear that in November, 1896, there occurred an abortion after three months' amenorrhœa; soon afterwards a tender swelling was detected in the right inguinal region. Recovery was slow, and the menses returned in due course. Nothing of any note occurred until July 2nd, 1896, when she was attacked while about by acute, stabbing pain in the lower part of the body, which was followed by profuse bleeding from the vagina; recovery from this was pretty rapid, although there was present, more or less constantly, some bloody vaginal discharge. Two similar attacks followed during July and August, and at the end of August she suffered from a considerable bloody vaginal discharge which was associated with a defined, movable, lobulated, and tender swelling in the anterior part of the right half of the true pelvis. During each attack there was great loss of blood through the vagina, accompanied by collapse. These symptoms could, so far as my knowledge went, only be explained by supposing the existence of an extrauterine pregnancy, with recurrent hæmorrhages and escape of blood from the tube into the uterine cavity, and thus through the vagina to the exterior. An alternative supposition was that the bleeding came from the uterus, and that the swelling was independent and playing only a secondary rôle in the case. On exploration it was soon seen that we had to deal with a bleeding cystic distension of the right Fallopian tube, the cyst being situated in the outer end and the fimbriae sealed together so as to close the abdominal opening. The tube nearer to the uterus was obviously free; it only contained recently clotted blood (see Fig. 1). The left Fallopian tube was also diseased, containing a dark blood-stained serous fluid, as above described.

In the absence of any trace of the structures of an ovum either in the sac of the right Fallopian tube or in its interior, it is but fair to conclude that the condition on the right side is only an advanced state of that on the left; and that the lining of the distended tube on the right side lost its epi-

thelium, and that this was replaced by a hæmorrhagic layer of granulation tissue. This change is indeed comparable to that which occasionally occurs during the development of simple hydrocele of the tunica vaginalis into a hæmatocele. It is of interest to note that there is no evidence that the right tube ever ruptured into the peritoneal cavity, and to all appearances the escaped blood made its way to the uterus and so to the exterior before the tube became overstretched. The attachment of the omentum to the distended tube may be fully explained by the chronic inflammatory state of the cyst wall.

PUERPERAL FEVER TREATED BY ANTISTREPTOCOCCIC SERUM, FOLLOWED IMMEDIATELY BY ENTERIC FEVER; RECOVERY.

By JAMES ADAM, M.A., M.B. GLASG.,
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A PRIMIPARA, aged 21, of spare build, was delivered of a large child on August 15th. Forceps were used. The perineum was torn into the rectum, but was not stitched. No douche was used. The patient was said to have been all right on the fourth day, but finding the temperature up on the sixth day a medical man gave a vaginal douche in the evening and next morning.

When I first saw the patient, on the evening of the seventh day, the temperature was 105°, and lochia fetid. A bichloride vaginal douche and biniodide was prescribed, alternated with nux vomica and quinine, but all these had to be stopped within twenty-four hours owing to diarrhœa. On the eighth day I gave an intrauterine douche, and applied iodised phenol to the interior of the uterus. Intrauterine douching was stopped on the eleventh day owing to tenderness of perineal wound; from that date a douche of boiled water and permanganate of potash was given twice daily, and an iodo-

the sphincter being torn and ultimately controlled by zinc oxide and nepenthe).

After much difficulty and delay, antistreptococcic serum was got, and 5 c.cm. injected on the evening of the eleventh day, the temperature being 104°. Further details of temperature and injections will be most readily understood from the accompanying chart (see p. 1825).

The condition of the patient during the third week looked hopeless. There was violent delirium, great emaciation, picking at bedclothes, glittering eyes, sleeplessness, constant fouling of the wound by slight discharge from bowel, baked tongue, pulse often over 120, and rhonchus in the chest, and the urine and faeces were sometimes passed involuntarily. The decline of temperature looked more like that of approaching death than that of recovery. Still, the pulse was of fair strength, and a good quantity of milk was taken. There was no peritonitis or sign of localised inflammation. For about forty-eight hours at the beginning of the fourth week the temperature remained below 100°, though it never fell to normal. Then it began to rise in such a characteristic fashion that one was made suspicious of enteric fever. This diagnosis was confirmed by the appearance of the characteristic rose spots on the twenty-eighth and succeeding days, that is, six or seven days after the enteric fever began, and by the appearance of "pea-soup" stools later on.

The patient's prospects of recovery seemed small, especially as the temperature was often 105°; but though reduced almost to a skeleton, she never looked so ill as during the "puerperal" fever, never had true diarrhoea, and ultimately recovered, thanks to the abundance of milk she took. The only other treatment was salol gr. xv, bis die, and bismuth and nepenthe one day when diarrhoea threatened. The temperature became normal first on September 21st, the sixteenth day of the enteric fever, or five weeks and three days after the confinement.

Diagnosis.—It is to be regretted that no bacteriological examination was made, for though the large tear into the bowel rendered a pyogenic infection highly probable, the appearance of enteric fever later on made one wonder whether the original fever might not have been enteric. If so, the interval between the primary fever and the relapse (two days) was unusually short, and the character of the temperature, 104° to 105° continuously till the injections were begun, seems to prove that a pyogenic infection was present as well. But the hypothesis of enteric fever was not needed to explain the patient's condition. There was no symptom of enteric fever except diarrhoea, which was largely explained by the tear of the sphincter, and which disappeared as the sphincter recovered. There was abundant cause for "puerperal" fever.

Injections.—Altogether 107 c.cm. were given; the smallest dose was 4 c.cm., the largest 17 c.cm. A larger dose was purposed, but some was lost. The first three or four injections were given between the scapulae, the rest in the flanks. Except slight tenderness after those between the scapulae there was no inconvenience or untoward result. The serum was that from the Pasteur Institute, Paris, except in the case of the four injections marked 1 in the chart, which were from the Bacteriological Institute, Lyons. The temperature never reached 104° after the injections were begun, but as even 17 c.cm. of the Paris serum failed to cause any improvement, the more expensive Lyons brand was tried, and it will be noticed that after each time it was used the temperature fell markedly, except when, the diagnosis of the new illness being uncertain, it was injected just after the onset of the enteric fever.

Antistreptococcic serum seems a safe remedy, but no certain inference as to its value can be drawn from this case. The impression given was that it kept the patient from losing ground; that the Lyons brand had a very decided effect on the temperature; and that in a future case it would be well to begin with 10 c.cm., and, if it were well borne, to give 20 c.cm. once or twice daily if the patient's condition seemed to demand it.

FRENCH HOSPITAL IN CONSTANTINOPLE.—The new French Hospital in Constantinople was formally inaugurated on December 12th. The ceremony was presided over by M. Cambon, the French Ambassador, and was very numerously attended.

PICRIC, OR CARBAZOTIC, ACID AS A THERAPEUTIC AGENT, ESPECIALLY IN THE TREATMENT OF CERTAIN INFLAMMATORY SKIN AFFECTIONS.

By WILLIAM MACLENNAN, M.B., M.C.,

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PICRIC, or carbazotic, acid, in watery and spirituous solutions, has for long been recognised, especially in France, as a useful application for superficial burns. Mr. D'Arcy Power¹ has recently recalled this fact, and has urged its more extensive employment in the treatment of burns and scalds. The admirable results which I have seen follow the free application of picric acid in solution to painful and extensive burns, led me to try its effect in the treatment of certain skin affections.

So far as I am aware, carbazotic acid has been little used, at least in this country, in the treatment of inflammatory skin diseases. In 1877 M. L. L. Grangé drew attention to the healing power of this remedy in some varieties of eczematous eruption. This therapeutic use of carbazotic acid seems to have been almost entirely overlooked, and is not mentioned in any of the larger works on dermatology that I have consulted. In a large number of cases in which I have employed picric acid locally I have found it more successful, by far, than any of the other remedial agents more commonly in use, and I think it well worth a more extensive trial.

I.—AS A LOCAL APPLICATION.

Acute eczema, associated as it usually is with burning, severe itching and profuse discharge, is rapidly relieved and cured under the influence of picric acid. Owing to the powerful astringent properties which this chemical possesses, it forms, when applied over a discharging or denuded surface, a protective layer of coagulated albumen and epithelial debris, under which healing rapidly proceeds; and as a potent antiseptic, by inhibiting the action of, or destroying the microbes on which the formation of pus depends, it completely prevents suppuration.

Applied as a pigment with a brush or piece of absorbent wool, even to an extensive surface, it is quite free from danger, and causes not the slightest pain, however vascular the surface may be. Almost immediately itching and smarting abate, and in a few days, when the protective crust is removed or separates, the underlying skin is found to be comparatively dry, free from redness, and covered with a young epidermis.

In that very troublesome form of acute eczema occurring in children (eczema capitis et faciale) which is usually so intractable to the ordinary methods of treatment, I have had most encouraging results from the use of picric acid. If the hair on the child's head happens to be long it should be cropped short, and all adherent crusts removed by means of poulticing. The raw surface should then be freely painted over, morning and evening, for three or four days in succession with a saturated watery solution. During this treatment the scalp and the face, when it is involved, should be protected by means of a calico mask. After the lapse of a few days, the pellicle which has been formed by the action of the picric acid can be removed by some emollient if it has not previously separated, and if any undue redness or moisture remain a fresh application may be made. The cessation of irritation permits the child to sleep, and its general health soon improves. When the disease becomes quiescent, the local treatment can be combined with, or followed by, the internal administration of alteratives like arsenic or grey powder.

Although picric acid is so specially valuable in acute discharging eczemas, it will be found an efficient remedy in almost any superficial inflammatory affection. Thus in 3 cases of erysipelas I have found a saturated solution of picric acid superior to any local remedy I have hitherto tried. It arrested the inflammation and prevented the disease from

¹ BRITISH MEDICAL JOURNAL, September 12th, 1896.