pressed by the ease and comfort with which it may be used without any laceration of the cervix; it afforded a marked and favourable contrast with the discomfort and cramp which often attend manual dilatation. Another advantage appeared to me to be the absence of friction between the skin of the hand and the vaginal walls; the substitution of an efficient instrument, which can be rendered absolutely aseptic by boiling, for the hand seems to me a very welcome one.

In addition to these points, there are two questions which I had especially wished to bring before this Society:

1. The advisability of ending pregnancy when once convulsions have occurred. Is the existence of pregnancy a vital factor in the production of the eclamptic state? And, if so, is not the termination of that pregnancy a vital factor in the treatment? It is urged that the shock of delivery may intensify the seriousness of the case, and turn into a fatal case one which might have ended otherwise. But I fail to see why there should be this fatal shock; under the influence of chloroform, with gentle manual dilatation, or careful dilatation by means of such an instrument as Bossi's dilator, delivery should not be accompanied by such shock.

2. Another question is the wisdom of administering large doses of morphine by the hypodermic method. Formerly it was taught that in renal disease morphine should be withheld. Present-day practice seems to be to administer morphine in acute and recent forms of nephritis, where there is not much destruction of the renal epithelium, but to withhold it in more chronic forms when degeneration has advanced. Does the same apply in eclampsia?

Until we know something of the etiology and pathology of the disease our treatment must of necessity be "in the dark." The elucidation of the subject in its scientific aspects must be largely left to the "schools," and this will probably take years of work. Meanwhile, is there no way of finding the safest lines on which the practitioner may direct his treatment?

The Clinical Society of Manchester, of which Society I have the honour to be President, is commencing a "collective investigation" with this object in view. If a sufficient number of cases are recorded, it may be possible to draw conclusions as to what lines of treatment in general practice would seem to hold out the greatest prospect of success, and this would serve until our extended knowledge leads to a more complete and rational system.

CASE OF DYSTOCIA DUE TO UTERINE MYOMA: CAESAREAN SECTION.

By GILBERT KEMPE, M.D.,
Honorary Surgeon, Salisbury Infirmary.

WITH improved technique in abdominal operations the indications for Caesarean section are becoming more defined and the operation is attaining a larger scope. Formerly the results were so disastrous that it was only undertaken as a last resource when the mother was worn out from prolonged ineffectual efforts at expulsion and possibly other operative measures, and when the child was dead. With the present improved results Caesarean section becomes in many cases where the child is still living the operation of election. In the present case the pelvic canal was so blocked by the tumour that no alternative presented itself.

M. G., aged 34, was sent to the Salisbury Infirmary in December, 1901, on account of retention of urine, which was said to be due to a tumour of the pelvis. On examination it was found that the cavity of the pelvis was almost completely blocked by a large solid tumour springing from the posterior uterine wall. The external os lay apparently high up above the pubes, but could not be reached by the examining finger. The patient was also found to be about four months pregnant. The tumour, which was thought to be a uterine fibromyoma, could not be pushed out of the pelvis. The question of induction of premature labour was considered and dismissed partly at the wish of the patient and partly because it was thought that even a four-months fetus could not be delivered *per vias naturales*.

The patient's medical man was communicated with, and she went home to await results. Pregnancy proceeded normally until May 8th, 1902, when slight labour pains came on and the membranes seem to have ruptured, since a large quantity of "water" suddenly came away. The pains continued, and a constant flow of bloody fluid oozed from the vulva. The tumour presented an insurmountable obstruction

to delivery, so the patient was brought to the Salisbury Infirmary on May 9th, at 11 p.m. When seen her general condition was good, but the pulse was rather quick (98). Examination of the abdomen showed a pregnant full-term uterus containing a living fetus whose heart sounds were heard in the right iliac region. The head of the fetus could be distinctly palpated lying above the pubes. No placental *bruit* could be made out. Per vaginam there was a constant oozing of blood. The vaginal walls were relaxed, and the external os could be felt slightly dilated, almost out of reach behind and above the pubes. Behind the cervix and almost entirely blocking the pelvic cavity a firm tumour of the size of a fetal head could be felt. It was impossible to displace this upwards.

After as thorough a preparation as time would admit of the patient and her abdomen, she was anaesthetised and a 6-in. incision was carried through the abdominal wall in the middle line. The uterus was partially withdrawn and surrounded by hot sterilized towels. The supra-vaginal cervix and broad ligaments were grasped by the hands of an assistant in order to control haemorrhage if necessary. A 5-in. incision was then commenced at the fundus uteri, and carried downwards and into its cavity. The child was extracted alive by a foot and given to an assistant after the cord had been tied and cut. The placenta, which was situated posteriorly, and the membranes came away entire. The uterus contracted well, and the incision into it was closed with silk sutures, involving the peritoneal and muscular coats only. Some small, hard tumours, apparently subperitoneal fibroids, were seen on the surface of the uterus. A large, hard fibromyoma was found on the posterior surface of the uterus and cervix, bulging into, and quite incarcerated in, the pelvic cavity. This had formed the obstruction to delivery. The uterus was cleansed with boric lotion and returned to the abdomen. The abdominal wound was closed with silkworm-gut sutures and dressed with sterilized gauze. During the operation the patient became collapsed, but was rallied by strychnine $\frac{1}{4}$ gr. and sub-mammmary infusion of $\frac{3}{4}$ xv normal saline. The child was a full-time female, and breathed from the time of extraction.

On the following morning (May 10th) the patient had quite recovered from the operation. She had been sick but once, and there was some abdominal pain. There was also some distension, but no tenderness. There was a free lochial discharge. The temperature was 99.4°, and pulse 120. During the day she was sick several times, and in the evening her pulse had fallen to 110, and her temperature was 99.6.

On May 12th she had improved considerably, and had a free evacuation of the bowels after a soap and turpentine enema. Her pulse varied between 90 and 98, and her temperature was not raised above 100° (98.4° to 99.8°). The infant was put to the breast several times, with the result that a large clot was expelled from the uterus. After this steady improvement was made. The stitches were removed on May 17th, and the abdominal wound was found to be soundly healed. On June 1st she was allowed up, and on the 14th left the hospital wearing an abdominal belt.

She refused any further operation.

I have seen her in the town several times since, and she and the baby are quite well. Up to the present she has not again become pregnant.

I am indebted for the notes on this case to Dr. David Ferrier, late House Surgeon at the Salisbury Infirmary.

The post-operative course of this case was but little different from that of any severe abdominal operation, and this, in my opinion, is largely due to the promptness with which Dr. Blackmore (the patient's medical attendant) recognized that natural delivery was impossible, since for this reason the patient was brought to operation in good condition and without having had her strength wasted by delay involving ineffectual uterine contractions, and perhaps by futile attempts to extract a mutilated fetus.

PREGNANCY COMPLICATED BY SUPPURATING HYDATID CYST OF THE LIVER.

By RICHARD JONES, L.R.C.S., L.R.C.P.I.,
Honorary Physician to the Bendigo Hospital, Victoria.

THIS case well illustrates the dangers of such a complication in parous women, more especially when suppuration and rupture of the cyst is delayed to the first few days after parturition.

A lady, aged 36, a primipara, residing at some distance in

the country, was delivered by me of a healthy child at term. The case was normal and easy. All was reported to be doing fairly well until the third day, when she was "chilly," and experienced some pain in her right side. On the early morning of the fourth day she had a violent "shivering," together with very acute pain in the same situation, which was accompanied by vomiting. I saw the patient within a few hours afterwards. There was cough more frequent than severe; the respirations were 40, the pulse 120, and the temperature 102°. Through the period of gestation she had periodical spasmodic seizures of pain in her side, together with vomiting and jaundice. The attacks appeared suddenly, and as quickly disappeared. At the time of the attacks jaundice was always general and deeply marked. Through the intervals it for the most part disappeared, but never completely. Previous to her pregnancy she had no symptoms whatever, and her general health was good.

Upon examination her body appeared well nourished; slight traces of jaundice were visible. The abdominal organs appeared healthy with the exception of the liver, which was plainly enlarged. There was no sensation of anything suggestive of hydatid disease save the situation. Tenderness was marked in front and to a less degree at the side. The right side of the chest was greatly distended from base to apex. Movements of respiration were markedly impeded and greatly increased in frequency. There was apparent flattening on the left side, upon which side the movements of respiration were well performed. The upper half of the right side was highly tympanitic, the lower half markedly dull, together with absence of all sounds. The intercostal spaces corresponding to the dullness were bulging. With the hand extended flat upon the chest, the fingers covering the bulging intercostal spaces, I could make out distinctly the sensation corresponding to the hydatid fremitus. The left side of the chest was quite normal.

My diagnosis was suppurating hydatid of the liver bursting into the chest cavity. I operated accordingly through the chest in the usual manner. The patient, notwithstanding the unusual circumstances of her case, stood the operation well. The cyst, however, communicated with a large bile duct, so that the flow of bile was very profuse and continuous, and the patient speedily sank from exhaustion, expiring on the fourth day after the operation.

Through her period of pregnancy she had been seen by other medical men. A nurse had been in charge, and gall stones searched for but none found. I conclude that the pressure of a cyst explained the symptoms, which are so unusual with hydatid diseases except in active suppuration.

Mikucki reports a case operated upon by Vou Jordan of Cracow, the woman being in the fourth month of pregnancy. Abortion came on three hours afterwards, and the patient died on the third day. In her case the cyst had not burst.

It was unfortunate that a necropsy was not obtained in this case; an opportunity of going more fully into condition of liver was therefore not afforded.

PUERPERAL HYPERPYREXIA OF MALARIAL ORIGIN.

By PERCY B. SPURGIN, M.R.C.S., L.R.C.P.,
Wimbleton.

In the BRITISH MEDICAL JOURNAL of January 31st the report of a case of puerperal hyperpyrexia of malarial origin by Dr. T. W. Clay recalls to my mind a similar complication in a case of the same kind which was under my care in 1899. The following are the notes of the case:

Mrs. K., aged 34, a primipara, after being in labour for eight hours, was finally delivered while under the influence of chloroform of a full-term child. The delivery was most difficult owing to contracted pelvis, and after trying to introduce forceps without success the child, which was dead, was turned and partially delivered. However, the head was too large to pass the pelvis, so craniotomy on the after-coming head was performed.

The patient was under the anaesthetic for 1½ hour. Antiseptic douches were given. The patient, on recovering from the effects of the anaesthetic, stated that she felt very well. There was no laceration of the perineum, and she was left in a satisfactory condition. The temperature then, and for thirty-six hours afterwards, was normal, and the patient was doing well. On the evening of the second day she complained of intense headache and of dull aching in every limb. She had been douched twice daily since the confinement; one was now

given immediately. The temperature was 103°. Next day it was the same in the afternoon, but had risen to 103.2° in the evening. She complained of itching of the skin all over her body. No rash was visible. Next day the temperature had dropped to 99.4°, and a slight erythema was visible on the face, neck, and arms. The evening temperature was 98.6°. The rash had extended to the chest; there was now no itching.

After remaining at 98.6° the whole of the next day the temperature rose again to 102.8°. The skin was now covered with diffused well-raised squamous patches, the immediately surrounding portion being of a rose-red colour. It was not like an urticarial or scarlatinal rash. That evening the temperature was 102.4°, but the next day had dropped again to 99°. Remaining below that level for two days, it then rose to 102.6°, dropping next day to 98.6°. After two more days at 99°, a slight rise was noted; thereafter it dropped gradually, and in three days was normal, to remain so. The rash was less apparent daily, the skin desquamating freely. Some oedema remained below the eyelids for several days after all desquamation had ceased.

The case was treated medicinally at the initial hyperpyrexia by sodium salicylate; at the second rise the patient was put upon a mixture containing quinine sulphate gr. xxv every two hours for two days, then every four hours for the remainder of the illness.

Inquiry elicited the fact that the patient had been resident in India for some years prior to her marriage, but to her knowledge had never had any illness except a very slight and untreated attack of ague; on that occasion she "came out in a red rash all over."

The diagnosis made in the foregoing case was tertian ague, and I think the temperature chart bears this out. Owing to the very complicated labour, I was keenly alive to all points noted in the puerperium. It was only after three days that I was able to learn of her illness in India, which led me to form the conclusion as to the malarial origin of the present condition, which caused me much anxiety.

THE RADICAL CURE OF INGUINAL HERNIA IN EARLY INFANCY.

By B. H. NICHOLSON, M.B., C.M. EDIN.,
Surgeon to the Essex and Colchester Hospital.

No doubt the bugbear in surgeons' minds after this operation is the difficulty of keeping the wound aseptic. I fancy the operation would be performed more frequently in large hernias, with large dilated abdominal rings in infants, if asepsis could be promised. If the following method is carried out with ordinary surgical care, there is not much chance of the wound going wrong:

Bassini's operation is performed; the two points of chief importance in this operation being that the scrotum is not opened, and that the aponeurosis of the external oblique is cut through, thus exposing the whole length of the inguinal canal, and making it easy to ligature the sac flush with the general peritoneal cavity.

In congenital hernia the best plan is to isolate the vas at the neck of the sac only for a short distance, sufficient for the sac to be divided and tied or transfixed, or a preliminary twist if desired. It is much better not to meddle with the distal end of the sac in the scrotum, if possible, as the testicle