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

is so easily damaged, and even a twist in the long tiny vas, feebly vascular, is sufficient to cause death of the organ. Special care is taken that there is absolutely no haemorrhage. The wound is closed in the usual way. Collodion dressing is applied, and over this a good pad of gauze, or sterilized swab. A plaster-of-paris spica is next applied, beginning below the knee.

The spica is of great advantage in preventing the child from wriggling about, and keeps the wound at rest. The spica is removed on the sixth day, when the wound will be quite healed. The important part of the operation is, however, the prevention of the wound and dressings getting soaked with urine.

The penis is inserted into a wide rubber tube. The tubing is attached round the skin of the base of the penis with four interrupted stitches, and the tube passes into a receptacle in the cot, or attached to a lead gas pipe, and allowed to drain into a receptacle on the floor. I am sure that the sooner the operation is performed the more chance there is of a perfect cure. The rubber tube acts splendidly, and apparently causes no discomfort to the infant, and the dressings and cot remain perfectly dry.

I have the greatest confidence in recommending this operation in early infancy in justifiable cases. In most hospital cases, at any rate, trusses are of little use.

ANTIQUACK LEGISLATION IN THE UNITED STATES.—A Bill has recently been enacted by the Virginia Legislature under which osteopaths, Christian Scientists, and "healers" of all sorts will be required to pass an examination before the State Board of Medical Examiners. A Bill granting many privileges to the sect of osteopaths, which was under consideration in the present session of the Alabama Legislature, has been thrown out after a long and hard-fought battle. If the Bill had passed all the osteopaths who had practised in the State before January 1st, 1903, would have been legalized practitioners by the Act.

A NOTE ON SOME RADIOGRAPHS ILLUSTRATING CONGENITAL DISLOCATION OF THE HIP.

(With Two Pages of Illustrations).

By DAVID MORGAN, M.B., C.M.
Liverpool.

Now that so much interest is taken in the reduction of congenital dislocations of hips by manipulation, it is most important that radiography should give the surgeon its best services. It should assist him in the selection of suitable cases, in confirming his clinical impressions as to reduction, and, in the necessarily prolonged after treatment, give him a knowledge of the position of the head more accurate than can be noted by the hand. For the proper interpretation of any given radiograph, the surgeon must know the position of the limbs during exposure and the relative position of plate and tube. On examining a number of radiographs of congenital hips, the surgeon must be struck with the great proportion which show either an absence of the neck or the presence of a very twisted short one. Now, these appearances are generally fallacious, and are wholly due to the position in which the limbs are held as regards in or out rotation. Furthermore, one must remember that the picture is shown most clearly of the structures in juxtaposition to the sensitized plate. For instance, if we rest the outer side of the forearm upon the plate, it is the radius which shows most clearly, while the ulna is less sharply defined.

For the purpose of showing the different appearances exhibited in the femoral head and neck dependent upon rotation of the limbs, Mr. Robert Jones allowed me to radiograph several of his patients before, during, and after reduction by the method of Lorenz. The accompanying pictures will show some of the results, and will prove, I hope, useful to surgeons. I have chosen one case only for illustration, but all the other cases confirm the appearances in detail.

The case depicted is that of a child aged 5 years and 3 months, with congenital dislocation of the right hip. In each picture the girl is lying on her back. The position of the tube is of importance. My custom is to place the centre of the anode over the symphysis pubis at a distance of 16 in. from the plate, and so tilted that it looks towards the umbilicus. By this means an even illumination of the whole pelvis is obtained and the acetabula are shown in better relief. I used a 10 in. coil, a mercury break and a moderately soft tube. I like to give a minute's exposure where possible.

DESCRIPTION OF FIGURES.

Fig. 1.—Case A depicts both femora rotated inwards until the sides of the feet almost rest on the couch. By this the neck is brought parallel with the plate, with the result that the shadow of the entire length of the neck is secured on the plate. The lesser trochanter disappears as a prominence upon the inner side of the shaft, and appears as a slight shadow on the femur.

Fig. 2 shows moderate eversion of the femora, the toes pointing directly upwards. It will be noted that the lesser trochanter begins to appear as a projection, the head points forwards, the necks appearing shortened, but still forming an angle with the shaft.

Fig. 3.—Here the femora are still further everted and the head looks forward, the necks are still further shortened, and on the dislocated side the head, neck, and shaft appear in line, while the greater and lesser trochanter are almost continuous.

Fig. 4.—The manipulations for the relaxation of all the structures around the joint having been completed, the limb is forcibly everted and abducted, the neck of the bone is brought into the same plane as the plate, and we thus obtain a shadow of its entire length. Here, however, the anterior aspect is necessarily nearest the plate.

Fig. 5.—The dislocation is here reduced, the limb still being maintained in complete abduction and eversion.

The remaining plates show other of Mr. Robert Jones's cases before and immediately after reduction.

OSIRIS PRIZE.—At the private quarterly meeting of the Institut de France, held on April 1st, the first award of the triennial prize of 100,000 francs, founded by M. Osiris to "recompense the most remarkable discovery or work in science, letters, art, industry, and generally in all that concerns the public interest," was made in favour of Dr. Emile Roux, the deputy chief of the Pasteur Institute.