The preventive measures taken were exactly similar to those adopted in puerperal fever. They were effective. No further cases occurred. The midwife was at once suspended from work on April 20th. Thorough disinfection of the midwife's person, clothing, and appliances was carried out; the disinfection of her hands, appliances, and bag being personally supervised by me. She had a holiday in the country and resumed work on May 4th. The length of the suspension was in reality due to the fact that the midwife was unable to realize the serious nature of the disease, and to the probability that she had been the means of spreading it. She had failed to notify, as required, to the Local Supervising Authority, that she had advised medical aid to be called in to each of these cases, and thus had prevented early precautionary measures of disinfection being carried out.

It has been stated that pemphigus neonatorum occurs in the children of women who suffer from puerperal fever. In the last four and a half years I have only come across one such instance, although I have investigated all reported cases of puerperal fever in Manchester during that time.

I am indebted to the Midwives Supervising Committee and to the Medical Officer of Health for permission to publish the account of this outbreak, and to Dr. Mitchell for particulars of Cases II and III.

REFERENCES.
[1] Crocker, *Diseases of the Skin.* [2] Maguire, *British Journal of Dermatology*, 1903.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

THE BLOOD-TIGHT UTERUS.

IN his interesting paper on the Blood-tight Uterus, published in the JOURNAL on November 20th, 1909, p. 1459, speaking of Nature's method of haemostasis after delivery, Dr. Longridge suggests that, besides the two lines of defence against haemorrhage which he mentions, Nature "may have another card up her sleeve as a reserve."

Some time ago I was called to a case of retained placenta. I had no difficulty in introducing my hand, or in removing the afterbirth, which I found still attached to a loose and flabby uterus. The womb, however, did not contract after withdrawal of the placenta, and I expected every moment an appalling rush of blood, but there was no haemorrhage to speak of. My hand, which I had immediately reintroduced to stimulate contractions and to see that the uterus was clear, moved freely in what felt like a flabby leather bag. It was some time before the uterus assumed even a partially contracted condition in response to my efforts.

What struck me very forcibly afterwards, when washing, was that I had unusual difficulty in cleaning my hands, having to peel off thin strings of blood-clot which adhered firmly to them. It occurred to me then that, as there was no muscular contraction to close the blood vessels, the absence of haemorrhage must have been due to this sticky condition of the blood. Probably clots had already formed in the uterus before the placenta was detached.

Was this haemostatic power accounted for by the increase of leucocytes and fibrin, known to exist during pregnancy; or is there at term some blood constituent (produced at the placental site perhaps) which favours coagulation?

Hornchurch. GEO. H. PEAKE, F.R.C.S.Edin.

RUPTURE OF BOTH QUADRICEPS EXTENSOR CRURIS TENDONS.

I HAVE been much interested in the publication in the JOURNAL of November 6th, 1909, p. 1343, by Dr. Chichester, of Colchester, of notes of a case of rupture of both quadriceps extensors of the legs. A similar case came under my care in September, 1904.

A. M., aged about 57, slipped on entering a tramway car opposite my door and was helped into my house. He was placed on a sofa till I should return. He felt his left leg below the knee powerless in the movement of extension, and doubtless had, in his fall, ruptured the left quadriceps extensor cruris tendon. Feeling a little better, and being impatient in my absence, he endeavoured, with the support of the consulting room table, to get on his feet and to walk. Suddenly he collapsed on the floor, with severe pain in the right leg above the knee. He was again placed on the sofa, and when I arrived a little later I found that both the quadriceps tendons were ruptured, leaving considerable gaps above the patellae. Unlike Dr. Chichester's patient, my patient declined suture, and both legs were put in plaster for three weeks in the extended position. Subsequently the plaster was removed and massage and gentle passive movement adopted. The result now is good, though there was a great feeling of feebleness for about a year. This, apart from Dr. Chichester's case, is the only instance I have seen or heard of of this double rupture, and it is very curious that the conditions in his case and in mine should be so identical. I have not seen a case of it in hospital, though I have been associated in the surgical work of a large one for nine years.

J. WALLACE MILNE,
Aberdeen. M.B., C.M., M.R.C.S.Eng., L.R.C.P.Lond.,
Assistant Surgeon, Aberdeen Royal Infirmary.

GAS AND ETHER AS AN ANAESTHETIC.

No one will question Dr. Edward Phillips's belief (BRITISH MEDICAL JOURNAL, vol. ii, 1909, p. 1407) in the superiority of gas and ether over A.C.E. and chloroform.

I would, however, urge the decided advantages of ether administered by the open system over gas and ether. An almost daily experience during the last two years has convinced me that this is the best anaesthetic for routine work, particularly in dental cases where nitrous oxide alone is insufficient. From the point of view of:

1. *The Administrator*—open ether is easy to give and requires no expensive or cumbersome apparatus. I use Bellamy Gardner's wire frame with two layers of lint enclosing eight layers of gauze (thus obviating the superficial freezing apt to occur when gauze alone is used). Two ounces of ether is sufficient on an average to induce in ten minutes a condition of anaesthesia long enough for all dental operations.

2. *The Patient*—open ether is extremely pleasant to take (the testimony of doctors and nurses whom I have anaesthetized is definite on this point), and the after-effects are slight. It is very safe, the cleanliness of the apparatus affording a great contrast to the "to and fro" bag-breathing.

3. *The Operator*—the upright position, diminution of mucus, saliva, and haemorrhage, and rapid recovery, constitute open ether an ideal anaesthetic in dental surgery.

W. E. ALDERSON, M.D., M.S., D.P.H.,
Honorary Anaesthetist and Lecturer in Anaesthetics, Dental Hospital, Newcastle.

SUPPURATIVE PYLEPHLEBITIS FOLLOWING OESOPHAGEAL STRICTURE.

A SAILOR, aged 73, had suffered for nine months from the usual symptoms of cancerous stricture of the oesophagus. Though for some weeks unable to swallow solids, he retained the power to get down fluids slowly and in small quantity to the end of his life. He took to his bed a fortnight before death, and lost power then rapidly, at the same time developing an increasing swelling of the liver, which was readily palpated to 6 in. below the right costal margin. There was also great trouble with rectal tenesmus two days before death.

Post-mortem Examination.—There was septic peritonitis, the peritoneal cavity containing over a quart of dark-yellow serum. There were large flakes of lymph at the anterior margin of the liver and about the pylorus and omentum, as also on the intestines in the pelvis. The omentum was contracted to a width of about 3 in., and matted to the under surface of the liver and about the pylorus. The stomach lay empty and drawn up under the left lobe of the liver. The liver was much enlarged, especially the right lobe, which reached to 6 in. below the costal margin. The enlargement was quite regular, and no nodules of secondary growth were discovered. The capsule was smooth, and the whole surface of the liver was studded with fine yellow points, which on section proved to be tiny multiple abscesses. In addition there were two larger abscesses, containing some ounces of pus,

and in the quadrate lobe a large abscess which occupied the greater part of it. By opening the stomach and passing the finger for about 3 in. up the oesophagus, I came on a well-marked stricture through which the point of the finger was driven with a little force. On exposing this the malignant growth was fully seen in the form of an annular stricture with ulcerating edges. There was no fluid in either pleural cavity. The pericardium was not opened.

Remarks.

The condition found constitutes true suppurative pylephlebitis, and, as a sequela of an oesophageal condition, is, I believe, very unusual. I can find no reference to it in the textbooks to hand. Theoretically, it is quite possible on account of the free anastomosis of the gastric (or coronary) vein and lower oesophageal veins, which, in forming a connecting link between the portal vein on the one hand and the azygos veins on the other, play such an important part in the venous compensation in cases of cirrhosis of the liver.

In this case it would appear that the growth first obstructed and obliterated the upper venous route, and thus forced the blood to return by the downward or portal route—in the reverse direction, that is, to that taken in cirrhosis of the liver. Thus there was infection of the oesophageal veins through the growth, and carriage of the infection by way of the gastric vein to the liver, where the secondary abscesses formed. The peritonitis may have been due either to leakage from one of the bigger abscesses, or possibly to infection infiltrating directly through from the growth in the oesophagus, such as takes place in cases of suppurative pericarditis following on cancer of the oesophagus.

My warmest thanks are due to my friend, Dr. Stanley Barnes of the Birmingham General Hospital, for assistance given me in the above explanation of the condition found.

Penzance. E. C. EDWARDS.

AVULSION OF THE EYEBALL DURING INSTRUMENTAL DELIVERY.

IN the Memoranda of the BRITISH MEDICAL JOURNAL of November 27th, 1909, p. 1529, Dr. Turnbull mentions a case of "avulsion of right eyeball" in a newly-born female child. I suppose these cases are very rare, but about ten years ago I had an exactly similar experience in the Pleck, Walsall. The patient, a multipara, had good pains, but no progress was being made. I administered chloroform and applied forceps; when the baby was born (also a female) her left eye was lying on her cheek. I immediately took a towel, caught the eye, and replaced it. The mother's recovery was uninterrupted, but the baby's eye looked like a blood clot for about ten days, after which time it rapidly cleared up and became quite all right. I last saw the baby when it was 3 years old; it was then a strong, healthy child; her eye was apparently normal and the sight quite good.

One would naturally think the eye would be destroyed, but this case shows, I think, wonderful recuperative power in the tissues.

Senghenydd. JAMES DONALDSON, M.B., C.M.

IRIDO-DIALYSIS.

A GARDENER, aged 24, whilst chopping wood on October 17th, 1909, was injured by a piece striking the eye. Suffering much pain, he came at once to the surgery, about half a mile off, with a handkerchief over the eye.

A cleft was seen on the temporal side of the right iris, at about the junction of the outer with the inner two-thirds. The cleft was nearly vertical, and about ½ in. in length, and through it the red reflection of the fundus could be easily seen with the ophthalmoscope. There was no hyphaemia, and the lens was not dislocated, but the vision was much below normal (that is, as it was before the accident).

Drops of cocaine hydrochloride (grains v ad ʒj) and atropine sulphate (grains ii ad ʒj) were put into the eye, and after repeating the latter drug, the pupil dilated and the cleft in the iris disappeared, although the iris remained broader on the temporal side than elsewhere. A pill was given containing calomel, and the patient was kept in bed in a dark room for four days. The pupil was kept widely dilated for ten days, and the eye covered with a pad and bandage.

No trace of the cleft could be detected when last seen, even with a magnifying glass, and his sight has become normal.

T. H. MOLESWORTH, M.B., F.R.C.S.

St. Margaret's-at-Cliffe, Dover.

BLENORRHOEA OF THE LACRYMAL SAC.

REGARDING blenorrhoea of the lacrymal sac, whose etiology seems to be obscure, it may be of interest to recall a case treated by me in 1883.

The child, aged about 6 months, recovered from a rather severe attack of measles, with lung complication. There were only the usual eye troubles connected with the disease, which usually require no special treatment. One eye sac, which swelled up after obstruction, was opened by me under chloroform, and an eye probe passed once only. Recovery was complete.

London, E.C. J. REID, M.D.Aberd.

SPASMODIC CONTRACTION OF THE CERVIX IN ECLAMPSIA TREATED WITH COCAINE.

MRS. L. B., aged 38 years, a multipara, was seized at full term with violent eclamptic fits at about 10 a.m. on September 21st, 1909, before labour pains had set in.

At 4.30 p.m., when I arrived to see the patient in consultation with the family physician, she was in a fit, and had had six since morning. The uterus was felt to be tightly contracted on to the child. The os would hardly admit two fingers, and there was spastic rigidity. The pulse was feeble, quick, and intermittent.

The lower bowel was thoroughly cleaned out with copious enamata of soap and hot water, Barnes's hydrostatic dilator was introduced, and hot vaginal douches and hot packing ordered. I suggested morphine in preference to chloroform to control the fits, and injected ½ grain morphine and $\frac{1}{30}$ grain strychnine at 5 p.m. Again, at 7.30 p.m. I injected ¼ grain morphine and $\frac{1}{30}$ grain strychnine.

The convulsions ceased, but the os was as rigid as ever, and no regular labour pains were present. I then suggested cocaine, and applied ¾ grain of cocaine in cocoa butter to the inner surface of the cervix at about 10.30 p.m. At 11 p.m. the patient passed about 4 oz. of urine. The os quickly dilated, good labour pains set in, and in less than an hour after the application of cocaine the head of the child was well down in the pelvic cavity. A stillborn child was soon delivered by forceps.

The patient suffered from partial loss of vision, and consciousness for the two following days; otherwise she had an uninterrupted recovery.

Rangoon. LOUIS L. CARLOS, F.R.C.S.I., etc.

Reports

ON

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF THE BRITISH EMPIRE.

POOR LAW HOSPITAL, HALIFAX.

A CASE OF INTESTINAL ANASTOMOSIS.

By A. F. THEOBALDS, M.B., Ch.B.Edin., Resident Assistant Medical Officer.)

PROFESSOR EDINGTON'S article in the BRITISH MEDICAL JOURNAL of October 2nd, 1909, p. 970, on some cases of intestinal anastomosis, leads me to report the following case.

A woman, aged 22, pale, anaemic, and flabby, had been admitted two years previously suffering from tuberculous peritonitis. Two years before, exploratory laparotomy was performed, and the peritoneum found studded with tubercles. The wound healed and she was discharged.

On readmission in 1907 she was suffering from abdominal pain and vomiting, and a lump was felt in the right iliac region. Some months later the skin broke down over

by the French Government to inspect the French Schools at Beirut in Syria. In discharging this duty he conceived the idea of studying Egyptian antiquities. In Egypt during many years he conducted excavations which enabled him to fit up a museum at Cairo. He also created at Lyons a natural science museum of which he was director. In Egypt he made a large collection of mummies, birds, and other animals venerated by the Egyptians; his collection was particularly rich in serpents and saurians found at Komb-Bo, the city of crocodiles. Some years ago he exhumed some skulls of monkeys which he thought presented marks of syphilis. Only a week before his death M. Lortet received the intimation that the Egyptian Government had decided to make him a grant of £1,000 for next year. Dr. Lortet was the author of a number of contributions to scientific literature. Among his writings are monographs on researches as to the rapidity of the circulation of the blood in horses; the penetration of leucocytes through organic membranes; and palaeontological studies in the valley of the Rhone; and on modern Syria.

Universities and Colleges.

UNIVERSITY OF LONDON.

KING'S COLLEGE.

Special Lectures in Physiology.

A COURSE of lectures on recent progress in physiological chemistry will be delivered in the Physiological Laboratory during the present session. Five lectures on physiological chemistry of proteins, lipoids, and putrefaction will be given by Dr. O. Rosenheim on January 24th, 31st, February 7th, 14th, and 21st, at 4.30 p.m., and three lectures on metabolism of muscle and the energetic aspect of vital metabolism by Dr. F. S. Locke on February 28th, March 7th and 14th, at 4.30 p.m. The course is free to all students of medical schools in London and all internal students of the University of London, and to medical practitioners on presentation of their cards. The course is recognized as a B.Sc. Honours Course by the University of London.

UNIVERSITY OF LIVERPOOL.

Public Lectures.

A COURSE of public lectures to be given during the Lent term has been arranged; on January 27th, Dr. H. B. Forbes, Reader in Ethnography, will lecture on the golden age of the stone workers; on February 11th, Mr. K. W. Monsarrat, F.R.C.S., Lecturer in Clinical Surgery, on the conditions which determine predominance among individuals and species; on February 25th, Dr. A. T. de Mouilpied, Lecturer in Chemistry, on the imaginative use of science; and on March 11th, Mr. W. S. Abell, Professor of Naval Architecture, on naval architecture, the art and its application. The lectures are free to the public, and further particulars can be obtained from the registrar.

CONJOINT BOARD IN ENGLAND.

THE following candidates have been approved in the subjects indicated:

FIRST COLLEGE.—*Part I, Chemistry; Part II, Physics:* J. G. Ackland, *H. L. Addison, W. H. Alderton, C. P. S. Allingham, *O. Baier, A. Bishara, *H. Chorley, *C. T. J. Drobig, W. A. Easton, *C. L. Emmerson, †A. C. Freeth, †H. P. Gabb, C. de W. Gibb, O. Gleeson, *T. S. Greenway, †W. H. Harris, †C. O. Hudson, *A. M. Hughes, *J. Kinnear, V. E. Lloyd, J. Neal, *H. L. P. Peregrine, *G. W. Pool, S. J. S. Reid, S. Simons, *C. R. Smith, *W. B. R. Stower, *W. H. A. D. Sutton, †R. R. Sy Quia, J. R. N. Warburton, G. C. Wright.

Part III, Elementary Biology: C. P. S. Allingham, C. W. Armstrong, F. E. Bendix, R. O. Crawshay, T. H. Cresswell, A. C. Freeth, L. N. Glaisby, O. Gleeson, O. Hairsine, D. H. Hargrave, W. R. H. Heddy, A. H. Hilmy, L. Kahan, C. G. G. Keane, T. R. Kenworthy, S. H. Keys, L. A. Malik, W. E. Masters, H. P. Price, S. J. S. Reid, J. P. Shaw, E. M. Townsend, T. R. Trounce, J. R. N. Warburton, E. J. Wright.

* Part I only. † Part II only.

THE late Dr. George Joseph Cooper, who was member for Bermondsey in the last Parliament, left estate valued for probate at £433.

IT is announced that what is called a Radium Bank will shortly be established in London. The object of the bank is said to be to hire out radium to medical men who wish to use it in their practice. The bank will, it is stated, keep in stock £50,000 worth of radium, and will charge for the hire of 100 mg. of the substance £40, or 2½ per cent. of its value, for the first day, and ½ per cent. for subsequent days. The inception of the bank is said to be due to the General Development Trust, Limited. At present we are unable to give our readers any more definite information as to the scheme.

Letters, Notes, and Answers.

BRITISH MEDICAL ASSOCIATION AND BRITISH MEDICAL JOURNAL.

THE offices of the British Medical Association and of the BRITISH MEDICAL JOURNAL are at 429, Strand, London.

☞ *Queries, answers, and communications relating to subjects to which special departments of the* BRITISH MEDICAL JOURNAL *are devoted will be found under their respective headings.*

QUERIES.

DR. SHARP (Cavendish Road, Leeds) asks for information about L. Pappe, M.D., author of *Florae Capensis Medicae Prodromus.* (Capetown: W. Brittain. 1868.)

A COUNTRYMAN asks where he can obtain a pamphlet or card of directions suitable to give to a patient suffering from adolescent scoliosis, including a description or illustrations of suitable exercises.

*** We do not know of any such publication, and believe that most specialists draw up their own list of exercises. Our correspondent could probably compile one for himself, and for this purpose might consult Taylor's *Orthopaedic Surgery for Practitioners*, a review of which is published elsewhere in this issue.

PARENTAL ALCOHOLISM.

M. G. B. asks for literature of a scientific but popular nature dealing with the effects of parental alcoholism on the race.

*** *Infant Mortality*, by G. Newman (Methuen) (consult its index). *The Drink Problem*, edited by Kelynack (Methuen) (chap. ix, etc.). *Alcohol and the Human Body*, by Horsley and Sturge (Macmillan) (chap. xv.)

ANSWERS.

STATE-PROVIDED MEDICAL ATTENDANCE.

DR. PERCY ROSE (Canning Town) writes, in reply to "H." to state that Dr. Frederick Henry Alderson published in the *Provincial Medical Journal* for December, 1893, an article on "State Remuneration of Medical Men," which has been reprinted.

NEURALGIA IN EDENTULOUS GUMS.

MR. JAMES MONTEITH, M.B., C.M. (Oldham) writes, in reply to "G. D.": Be careful to examine for errors of refraction, and more especially for small amounts of astigmatism or apparent or spurious myopia or any irritation to the auriculo-temporal nerve or auditory apparatus. The local introduction of the salicylic acid ion by the application of pads soaked in a 1 per cent. to 2 per cent. solution of salicylate of soda, covered by a tin electrode attached to the negative flex; have the solution warm; apply to face, centre of brain, over scalp area, and not over the painful area; use 16 milliampères of current for at least thirty minutes. Then to positive flex attach a tin electrode of the same size as is attached to the negative flex, and compel patient to hold one hand in a warm solution of lithium citrate. On no account use a carbon electrode in a strong lithium solution. Pain will almost at once disappear, and keep away for good. Give internally ¼ gr. calomel every night for a week and a gr. x dose of salicylate of soda in half-cupful of hot water first thing in morning.

HOSPITAL DENTAL SURGEON writes: An *x* ray of the mandible at the site of pain should be taken, and if the result is negative, relief may be obtained by resection of the inferior dental nerve.

PRURITUS IN GLYCOSURIA.

DR. W. F. SOMERVILLE (Glasgow), in answer to "Nemo's" query regarding pruritus in glycosuria, advises the use of copper, a method recommended by Dr. Sam Sloan (Glasgow) and others. Introduce into the vagina a glass speculum of convenient size, perforate at its inner end. Fill the speculum with a saline solution and employ a rubber stopper, through which a thick spiral copper wire is passed, connected with the positive pole of a continuous current battery. The negative pole is connected with a carbon electrode placed on pad of twelve layers of lint, 6 in. square, which is soaked in warm saline solution and laid on the hypogastrium over the region of the uterus. The current is slowly applied till there passes 40 to 100 milliampères for ten to twenty minutes. The current should be slowly turned off. The treatment is repeated every third or fourth day. Selkirk and Co., 100, Bath Street, Glasgow, keep suitable specula.

THE TUBERCULIN TEST.

DR. DUNCAN LAWRIE (Oldham) writes: In the answer in the JOURNAL of January 15th, p. 180, "A. R. P." is recommended to use "Calmette" if he wishes to employ the tuberculin test. In *The Ophthalmoscope* of this month appears an abstract of a paper on the action of instillations of tuberculin into the conjunctival sac, by K. Stargardt