On admission his temperature was 101° F. and his pulse was 116. His face was pinched and anxious-looking. The abdomen was rigid, the pain on pressure being very severe. I was called up at once and operated, finding on the anterior surface of the stomach towards the pyloric end a clean, punched-out perforation. The aperture was circular, it being as cleanly defined as the lace-hole in a boot before the ring is inserted and of the same size. The ulcer was excised by an elliptical incision an inch in length and the edges of the wound were closed by three rows of continuous suture as in gastro-enterostomy. There was a track of inflamed area from the vicinity of the ulcer leading backwards towards the junction of the liver and the right kidney. The area was visible by the white exudation due to the escape of part of the contents of the stomach. This was carefully wiped away with gauze sponges and then copiously washed out with salt solution. There appeared then so little contamination that it was deemed right to close the abdominal wound completely and to do without draining either there or in the flanks. A quantity of the saline solution was purposely left in the peritoneal cavity. After recovering consciousness the patient's pain had disappeared and at the first observation the temperature and pulse had both declined; his facial appearance was quite different, being free from the pinched and anxious look.

The patient's subsequent history was uneventful. His face for a time had a passively congested look, due doubtless to the manipulation of the parts in the near neighbourhood of the sympathetic plexus. He was dismissed well on Oct. 11th.

Glasgow.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF STRANGULATED HERNIA OPERATED ON UNDER LOCAL ANÆSTHESIA.

BY DAVID B. TODD, M.R.C.S. ENG., L.R.C.P. LOND.

THE interest of the following case lies in the complete success of the use of a local anæsthetic in an operation for strangulated hernia occurring in advanced life.

On the morning of Nov. 2nd last I was called to see a man who was said to be in great pain. On arrival at the house I found that the patient, who was a well-nourished man, aged 77 years, had a strangulated inguinal hernia of the right side. Some two hours previously he had been feeding pigs, when on lifting something heavy he suddenly felt a violent pain in the inguinal region. He had been ruptured for years and so at first thought that the old rupture was a little pinched and would go back, but as he had worked at it for two hours without success he thought it necessary to seek medical aid. Morphine was given hypodermically and gentle taxis was tried, but as it became clear that no good was likely to accrue operation was suggested. The patient was unable to make up his mind to undergo the ordeal until later in the day, when Mr. G. G. Parsons having very kindly come over from Westbury the operation was commenced at 8 P.M. On the ground of the patient's great age and the fact that he had a very weak heart it was decided not to give a general anæsthetic, but to use a local anæsthetic and the choice fell upon "anæsthunder," a mixture of beta-eucaine, suprarenal extract, and phenol. A line was taken from the pubic spine parallel to Poupart's ligament for three inches, and along this line the local anæsthetic was subcutaneously injected. 20 minims were used, and after an interval of three minutes the skin along the line was incised without pain. Until the gut was reached during the operation (which was not specially interesting except for the action of the local anæsthetic) only 60 minims of the anæsthetic were used. The tissues were carefully injected layer after layer; no pain was felt, and there was hardly any bleeding. When it became necessary to incise the internal ring, where in the circumstances of the operation it would have been dangerous to inject the anæsthetic, pain was severe but fortunately of short duration. The bowel was replaced without much difficulty, one deep stitch was inserted, and the incision in the skin was closed by four superficial sutures. Healing was by first intention, and the stitches were removed upon the eighth day after the operation. Throughout the course of the recovery no pain was felt. The patient is now quite out of danger and in addition has a good prospect of a radical cure.

Bratton, near Westbury, Wilts.

A CASE OF ECTOPIC GESTATION OCCURRING TWICE IN THE SAME PATIENT, IN BOTH INSTANCES THE UTERUS BEING RETROVERTED.

BY CLAUDIA A. P. ROWSE, M.B. DURH.

THE patient was married and aged 26 years; she had one child, four years old. Three years after the birth of the child she missed two periods. At the end of the second month irregular hæmorrhage set in, with severe pain in the right iliac region, the pain being especially noticed during walking. On examination the uterus was found to be retroverted and enlarged and a cystic swelling was felt behind and to the right of the uterus. A diagnosis of ruptured tubal pregnancy was made. Operation was performed. The right tube was ruptured and the ovum with about a pint of blood clot was found between the two layers of the right broad ligament. This was evacuated by the extraperitoneal method; the ovary and tube were not removed.

The patient did not become pregnant again until nine years after the operation. The history of the next gestation was as follows. On August 1st, 1906, I was called in to see the patient, who complained of pain in the left iliac region and over the lower part of the abdomen, with sickness after food; there was amenorrhœa of two months' duration. On physical examination the breasts were tender and slightly enlarged; no secretion could be obtained. The vulvæ were bluish in colour and the uterus was somewhat enlarged and retroverted. Owing to the extreme tenderness it was impossible to replace the uterus. Ichthyol plugs were applied per vaginam for seven days, the patient remaining in bed. On the 8th, while straining to pass a motion, severe pain was felt in the lower part of the abdomen, with shooting cramp-like pains in the legs. When seen the patient was in a state of collapse, the skin was cold and blanched, and the face was drawn and anxious. She lay on the left side with the knees bent and the thighs drawn up to the abdomen. Examination under an anæsthetic showed that the uterus was no longer retroverted, but drawn up high into the pelvis and pushed over to the right side. A cystic swelling was found behind and to the left of the uterus.

Operation was performed. The abdomen was opened. Behind and to the left of the uterus was found a large adventitious sac containing the ovum and about a quart of blood clot. The sac was formed by the posterior wall of the broad ligament in front, the ruptured tube above, and the intestines posteriorly. The clot and ovum were removed along with the tube and ovary on that side. The right tube and ovary were found to be bound down by adhesions and were not removed. The patient made a good recovery.

Watford.

AMYL NITRITE IN HÆMOPTYSIS AND IN OTHER HÆMORRHAGES: RECENT RESULTS.

BY FRANCIS HARE, M.D. DURH.,
LATE CONSULTING PHYSICIAN TO THE BRISBANE GENERAL HOSPITAL.

LAST year and at the commencement of the present year I published in THE LANCET and elsewhere nine cases in which the inhalation of amyl nitrite had been immediately successful in stopping hæmoptysis. (The first two of the series had been published in the *Australasian Medical Gazette* in October, 1903.) There was no complete failure, but in one case in which there had been three attacks one attack was moderated only, not immediately stopped. This was due to inadequacy of dose. Since then H. C. Colman[1] in Scotland and E. T. Smith[2] in Queensland have each published one case, both immediately successful. But it is in France that the method has been chiefly studied. M. J. Rouget[3] refers

[1] Scottish Medical and Surgical Journal, May, 1905.
[2] Australasian Medical Gazette, June, 1906.
[3] Bulletins et Mémoires de la Société Médicale des Hôpitaux de Paris, April 20th, 1905.

to ten cases of his own; and Georges Bourland[4] in a graduation thesis, describes 13 cases, four of his own, six by Pic, and one each by Leclerc, Lemoine, and Mouisset. Many of these cases had several attacks and in every instance the bleeding ceased immediately under amyl nitrite inhalation. The dose varied from three to nine minims. There are thus recorded 34 cases in which hæmoptysis occurred once or several times, and in which in every instance, save the one recorded by myself, the hæmorrhage immediately ceased under amyl nitrite inhalation.

Conformably with these clinical results Pic and Petitjean have demonstrated the action of the drug in the laboratory.[5] Dogs weighing from 15 to 20 kilogrammes were curarised, part of the chest wall removed, and artificial respiration was performed. Amyl nitrite was then injected into the femoral vein. Within a few seconds white patches commenced to form on the surface of the lung. These steadily extended, then coalesced, so that finally in from two to three minutes all, or nearly all, the lung parenchyma became exsanguine. This extreme effect lasted several minutes, but from seven to ten minutes elapsed before the normal rose colour returned. It would seem that the vaso-motor influence of the drug, at any rate, upon the pulmonary circulation, is more enduring than has been suspected The hæmostatic power of the vascular change was demonstrated by snipping the anæmic lung with scissors, when hardly a drop of blood exuded.[6]

Pic and Petitjean consider that the drug acts through an active vaso-constriction of the pulmonary system, not less than through vaso-dilation of the systemic periphery. They state that synchronously with the paling of the lung there is a rise of pressure in the pulmonary artery. Against this conclusion, however, must be placed the clinical fact that amyl nitrite is equally efficient in many hæmorrhages from the systemic vessels. Menorrhagia, apparently from any cause, may, as a rule, be effectually controlled by a single inhalation a day. Moss[7] found the drug successful in the reactionary hæmorrhage following the removal of parovarian cysts and in ruptured tubal gestation. And J. R. Keith[8] has recently recorded an immediately successful result in post-partum hæmorrhage.

Northumberland-avenue, W.C.

A Mirror
OF
HOSPITAL PRACTICE,
BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

MIDDLESEX HOSPITAL.

A CASE OF MULTIPLE PNEUMOCOCCAL EPIPHYSITIS; RECOVERY.

(Under the care of Dr. A. F. VOELCKER and Mr. W. S. HANDLEY.)

FOR the notes of the case we are indebted to Mr. H. J. Fardon, house surgeon.

The patient was an infant, aged 13 months, born of healthy parents and breast-fed until 12 months old. The child was perfectly healthy until five weeks before admission on August 1st last During these five weeks he had been under medical observation and was stated to have had pneumonia, from which he was apparently convalescing. On the morning of admission to the hospital the mother had noticed that the right shoulder was swollen and that the child would not move it. On admission the child was found to be well nourished; the temperature was 104° F., the pulse was 108, and the respirations were 60. The slight impairment of movement of the left side of the chest, together with impaired resonance and redux crepitations over the left lower lobe, confirmed the recent history of pneumonia. The right shoulder was markedly swollen, hot, painful, and tender, and its movements were limited. The swelling was chiefly in front of the joint and on its outer side. The skin was not reddened but distinct fluctuation could be felt beneath the deltoid. A needle was inserted and odourless pus was withdrawn. No growth was obtained on tubes inoculated with this pus, but films stained by Gram's method showed the presence of numerous diplococci indistinguishable from the pneumococcus. An incision was made between the deltoid and great pectoral muscles. About two ounces of pus escaped and an abscess cavity was found lying between the deltoid muscle and the outer side of the humerus and extending forwards over the front of the joint. The capsule was not distended and the shoulder-joint was therefore not opened. A counter opening was made into the abscess behind, the cavity was washed out, and drainage-tubes were inserted. The temperature fell immediately but began to rise again on August 8th and by the 10th had reached 103°. Two injections of anti-pneumococcal serum appeared to be entirely without effect. A small abscess developed at one of the costo-chondral junctions on the right side and was opened under local anæsthesia. Later a similar small abscess developed at one of the upper left costo-chondral junctions. On the 10th a swelling appeared just above the left knee. This was immediately incised on each side and pus was found about the epiphyseal line in front of the lower end of the femur and tracking up under the quadriceps muscle. The knee-joint was not at this time involved. The pus cavity was washed out and tubes were inserted. Further treatment consisted in hot fomentations and irrigation. On the 21st the left ankle swelled and the temperature again rose to 101·4°. The swelling subsided in two days without operative interference. The temperature, however, continued to rise until it reached 103°. On the 23rd the joint cavity of the left knee became distended. Incisions were made into it, turbid serum was evacuated, and the joint was washed out with weak perchloride of mercury solution. The temperature fell permanently to normal on the 28th. On Sept. 11th the discharge from the sinuses had ceased and the tubes were removed. The child became very emaciated whilst in the hospital and this was partly due to persistent but slight diarrhœa which resisted all ordinary treatment. During the latter part of September, however, the diarrhœa diminished and he put on weight and became appreciably fatter. The sinuses closed soon after the removal of the tubes. All signs in the chest completely disappeared and the child was sent to a convalescent home in the beginning of October. Although the movements in the affected joints are very limited the ankylosis is not complete.

Remarks by Mr. HANDLEY.—The case presents the rare clinical picture of an epiphyseal pyæmia. Its favourable result is owing mainly to careful dressing and nursing.

DERBYSHIRE ROYAL INFIRMARY.

A CASE OF SUBCUTANEOUS RUPTURE OF POUPART'S LIGAMENT AND LACERATION OF PERITONEUM.

(Under the care of Mr. R. H. LUCE.)

For the notes of the case we are indebted to Dr. F. A. Hepworth, house surgeon.

A young man, aged 20 years, while attending an evening class in a top-storey room at the technical school became faint and was sent out to recover. He went out on a parapet which runs round the roof and was forgotten. Apparently he fainted again and fell from the parapet into the area below, a distance of about 60 feet. When taken to hospital at about 11.30 P.M. he was extremely collapsed, and though able to give his name was unable to say what had happened to him. He complained of pain in the lower abdomen. The face was pale, the skin was cold, and the pulse was so weak that it was scarcely palpable. The abdomen was not distended but very hard and immoveable. There were evidently great pain and tenderness, especially in the lower part of the abdomen on the right side; nothing abnormal was found on percussion. The urine was drawn off by catheter and found to be normal. About an hour after admission a swelling was noticed in the right iliac fossa, immediately above Poupart's ligament; this enlarged slowly, became resonant on percussion, and slight bruising appeared on the surface. As it appeared probable that some part of the intestinal tract

[4] Traitement des Hémoptysies par le Nitrite d'Amyle, 1905.
[5] Comptes Rendus Hebdomadaires des Séances de la Société de Biologie, Jan. 26th, 1906, p. 131; also Lyon Médical, Feb. 18th, 1906, p. 309.
[6] Traitement des Hémoptysies par le Nitrite d'Amyle, 1905, p. 29.
[7] THE LANCET, Oct. 14th, 1905, p. 1107.
[8] Brit. Med. Jour., Oct. 27th, 1906, p. 1125.