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CASE OF OVARIAN TUMOUR, WITH SPECIAL REFERENCE TO THE DIAGNOSIS OF ABDOMINAL SWELLINGS.

ARTHUR J. SHARP, M.D. Lond., F.R.C.S. Eng., etc.,
Whitby, Yorks.

[Original Article, specially written for MEDICAL REPRINTS.]

B., thirty-two, married fourteen years, was taken ill on April 1893, with sickness, swelling of the abdomen and constipation.

Menses very regular except during pregnancies, when they were stopped at once. The last two years periods have been more frequent, with much more pain preceding the menses, which has been scantier. The blood has been darker, and no shreds of membrane, debris or cysts have been seen. The periods continued till May 25th.

Pregnancies, six: all the children now living. Last conception seven years ago, nothing noteworthy.

Lactation.—Nursed all the children herself for nine months or so.

Micturition.—At the beginning of April could not empty bladder completely: this difficulty disappeared.

Defecation.—Bowels always costive: usually goes nine to twelve days without any action. A motion I saw was distinctly flattened.

General health, good. Four or five years ago was laid up for three weeks with severe abdominal pain and sickness, resembling morphia.

Present Illness.—When first seen on April 5th she was in a condition of obstruction and seriously ill. The abdomen was uniformly distended, dull all over and particularly tender at the cæcum and above the umbilicus. The symptoms were gradually relieved by frequent and copious enemata, aided by massage and starvation. They were attributed to accumulation of scybala with probably distension ulcers at the cæcum. The abdomen, however, continued dull except in the hypochondria, epigastrium, and upper part of the loins.

Some firm masses could be made out above the umbilicus, and the following possibilities were seriously considered:—

- Ovarian tumour.
- Ectopic pregnancy.
- Fæcal accumulations.
- Intestinal or omental growth.
- Ascites, etc.

The distension was still uniform and the umbilicus at first slightly bulged.

The uterus could not be recognized bimanually, but was separately movable. The sound passed 2½ inches with the cavity forwards.

Treatment with creasote, capsicum, salol, and cinnamon dispersed a quantity of wind, and made the motions

much less offensive. She was able to get up and attend to her duties.

By April 30th it was clear that the abdomen was full of ascitic fluid, and her friends pressed for her to be tapped. The legs also were dropsical. In the absence of cardiac, renal or hepatic disease, she was given diuretics. In this way the fluid present in the abdomen diminished so much that it was not difficult to recognize a median, partly cystic tumour reaching from the pelvis above the navel. The umbilicus was an inch nearer the symphysis pubis than the ensiform cartilage (in a simple ovarian tumour it should be nearer the sternum). The girth at the umbilicus was 38½ inches. The measurements from the navel to each iliac spine were practically identical. The tumour could be seen to influence the shape of the abdominal wall, when looked at from the side. The possible conditions considered were the following:—

1. *Distended Bladder*.—At once settled by the catheter, which did not affect the tumour at all. [I well remember in 1893 a patient sent up to a great London hospital for "ovarian tumour." Ever since her confinement six months previously she had had dribbling of urine, and a tumour had gradually developed in the lower abdomen. The first thing that struck one was the urinous odour about the case, the second was the foul nature of the specimen of the patient's urine, and the third was passing a catheter and drawing off some pints of water, by which time the tumour had vanished. Curiously enough the ward sister was most unwilling to have a catheter used, and with that fragmentary knowledge which is so dangerous, thought it was only boyish meddlesomeness that suggested such an unnecessary proceeding. No one ought ever to forget the aphorism of Sir Henry Thompson—*Incontinence means Retention*].

2. *Phantom tumour, pseudocyst, etc.*—Repeated careful examinations were sufficient to eliminate this without recourse to anaesthesia. The tumour could be definitely separated from the parietes.

3. *Pregnancy*.—This, the diagnosis of her first medical attendant, was made unlikely by the absence of amenorrhœa, sickness, quickening: no single positive sign of pregnancy could be found in the breasts, cervix, vagina, or vulva. No contractions, foetal movements, souffle or foetal heart have ever been elicited in the tumour. Sound passed 2½ to 3 inches only. The uterus was fairly movable with the sound, and had not the bulky inertia one would expect in a pregnancy of six months or more. An attempt was made to retrovert the uterus with the sound, and recognize its position from the rectum, but it was too tender and not sufficiently movable. There was a case some years ago of a lady whose chastity was impugned, and who vindicated her reputation by dying of an ovarian cyst, so that the diagnosis is by no means always easy.

4. *Pregnancy with excess of liquor amnii*.—This condition has more than once been mistaken for an ovarian cyst and tapped. In this case, the lower part of the womb was not expanded as in a four to six months' pregnancy. The cervix was not softened, shortened, nor drawn up.

5. *Ectopic Pregnancy*.—No single positive sign of pregnancy. No foetus can be felt with certainty, though the upper part of the tumour struck one as partly solid. The tumour was so large that it would be in an advanced stage, but such a pregnancy may continue for as long as ten months.

6. *Missed Abortion*.— } As No. 3. No uterine pains.

7. *Missed Miscarriage*.— } Ergot was given for a short time without any ebolic effect being produced.

8. *Hydatidiform Mole*.— } As No. 3. No evidence of cysts,

9. *Carneous Mole*.— } etc., in the discharges. Flow not constant; no pains nor amenorrhœa. Tumour not hard enough for No. 9.

10. *Pregnancy with placenta prævia*.—As No. 3. Os not readily dilatable.

11.—*Uterine Fibromyoma (hard or soft)*.—A tumour this size would almost certainly have caused very much more

bleeding, and the length and direction of the uterine canal would have been altered. In 1894 a patient of fifty was admitted into a London hospital with febrile symptoms pointing to the abdomen. On abdominal section a large tumour was exposed which the surgeon pronounced to be a fibroid which had become cystic, and was proceeding to close the abdomen again. The physician in charge of the case pressed him to puncture the swelling, which was done, liberating a quantity of pus. The tumour was a suppurating ovarian cyst, and was sewn to the abdominal wall and diligently irrigated and drained for some weeks, after which the patient recovered completely.

12. *Hydro, pyo, or hæmatosalpinx.*—Could hardly reach this size.

13. *Pelvic Hæmatocele.*—History too gradual: no bulging down of pouch of Douglas, nor fixation of uterus "as if set in plaster-of-Paris," nor history of ruptured tubal gestation.

14. *Ascites.*—There was abundant evidence of this, in addition to the tumour itself. Resonance could not be got in the flank by turning the patient over. This is not always readily distinguished from ovarian dropsy, and it is said that Sir Spencer Wells undertook an ovariectomy only to find ascites.

15. *Fæcal Accumulations.*—These were gradually dispersed and moved on.

16. *An Ovarian Tumour.*—Such are fibroma, myoma, sarcoma, carcinoma, dermoid and various kinds of cysts. The last was most likely, and the chief varieties of these are multilocular and paucilocular cysts of the ovary itself, papillary cysts starting in the hilum, ovarian hydroceles, and cysts of the broad ligament and contained rudiments.

17. *Ditto, with Pregnancy.*—Unlikely.

18. *Hydatid.*—The upper limits of the tumour felt too resistant for a simple hydatid cyst.

19. *Encysted serum or pus from chronic peritonitis.*—The causes are:

(a) Cancer, sometimes colloid, and usually secondary to visceral cancer of stomach, appendix, or ovary.

(b) Tuberculosis. A girl of fourteen was admitted to hospital in 1894 with what was believed to be tuberculous peritonitis. The gynaecologist who examined her pronounced the pelvis quite free, and suggested that the tumour felt was an enlarged spleen. The surgeon who examined the rectum also found the tumour unconnected with the pelvis. Ultimately, at the operation, it was an ordinary ovarian cyst with ascites, and she went to a convalescent home twenty-nine days after the operation.

(c) Alcoholism.

(d) Chronic Bright's disease.

(e) As the sequel of acute peritonitis, about the liver, spleen, etc., or as the result of tapping for ascites.

20. *Omental growth* (with matting of viscera and encysted fluid, as 19), and curiosities such as cancer of colon or rectum, tumour of the pelvic bones, postrectal dermoid, etc., which have been known to give rise to considerable tumours.

21. *Pancreatic and other Retroperitoneal Cysts.*

22, 23, 24, 25. *Other cystic abdominal tumours* arising in liver, gall-bladder, spleen, kidney, etc.

26. *Pelvic Inflammation.*—

28. *Malignant disease of body of Uterus.*—} No great
fixity or fever. } tenderness,

Putting everything together, a diagnosis was made of cystic ovarian tumour complicated by ascites and probably some adhesions.

She was admitted to the Leeds Infirmary on May 25th, and Dr. Braithwaite (with whose kind permission I publish the following particulars) operated on June 2nd. The tumour was a pedunculated multilocular cystic outgrowth from the right ovary with much ascites. The great omentum was adherent to the upper part of the tumour, but was separated without difficulty. The contained fluid was too viscid to flow through Wells' cannula, and was greenish or brown in colour in the different cystic spaces. The incision was prolonged upwards, and the tumour, which weighed about 6 lbs., was delivered whole through the opening. The left ovary contained two or three little follicles, which collapsed on pricking, and was replaced.

June 3rd.—A period lasting three days began.

June 24th.—She sat up for the first time, some of the sutures being removed.

June 26th.—Remaining sutures removed.

June 30th.—Returned home to Whitby, with a dressing and abdominal belt. Wound not quite healed.

July 9th.—Wound all closed. Attendance ceased.

MALIGNANT ADENOMA OF THE UTERUS.¹

By WILLIAM S. STONE, M.D., Alumni Fellow in Pathology, College of Physicians and Surgeons; Assistant in the Department of Diseases of Women, Vanderbilt Clinic, New York.

The class of new growths to which the term adenoma has been applied offers a field for study of much pathological and clinical interest. Some of these neoplasms present histological forms which differ but little from the more marked grades of glandular hypertrophy and hyperplasia. Other forms, although presenting certain anatomical distinctions, do not differ at all from other malignant new growths, either in their clinical history, their mode and rapidity of growth, or in their tendency to recurrence.

Adenomata, we know, occur in many different organs, as, for example, the thyroid gland, liver, kidney, intestine, mamma, ovary, and uterus. The uterus offers a good example of an organ in which they frequently display their malignant qualities. The uterine mucosa, too, is so frequently the seat of extensive glandular hyperplasia, that it is often from curettings hard to distinguish these anatomical changes from those of a tumour.

Waldeyer², writing in 1867, characterized adenoma as a reproduction of glands of the normal type, in which the epithelial cells were regularly arranged on a distinct membrana propria. We know now that this definition might apply to hyperplasia, and Waldeyer not having examined any adenomata of the uterus, the particular class which we call malignant adenomata was not included in his description.

In the latest times, Delafield and Prudden³ describe the adenomata in general as benign tumours, but mention the occurrence of malignant adenomata in certain organs, and place them on the border line between adenomata and carcinomata.

As most of the reported cases of adenoma of the uterus contain meagre descriptions of their anatomical structure, and as the exact nature of the tumours has been variously interpreted, there is much uncertainty as to the identity of some of these cases with the neoplasms now described as malignant adenoma.

Coe⁴ has written twice upon the subject, giving an historical résumé of cases reported, and adding three cases of his own. His conclusions are: "The term benign adenoma of the uterus is a misnomer; neither glandular hyperplasia nor adenoid polypus is adenoma; the only true adenoma of the uterus is essentially malignant adenoma, anatomically, because it invades deeper structures, and clinically, because it recurs after removal, and eventually assumes a more malignant character. Malignant adenoma at first is not identical with adenocarcinoma, but is an initial stage of it; endometritis glandularis hyperplastica is not adenoma, because the mucosa is generally hypertrophied without marked proliferation of pre-existing glands, and the process is confined to the mucous layer and proliferation is always typical." With regard to diagnosis and treatment, he states that rapid recurrence after recuretting should suggest malignant adenoma rather than glandular hyperplasia, although the disease may have existed for a long time and the curettings may not present the anatomical structure of a malignant neoplasm.

Ruge and Veit⁵ described malignant adenoma of the uterus, and, although they suggested that it might be a transitional form between glandular hyperplasia and cancer, never had seen cases which could prove this relation.

Pozzi⁶ says: "Lesions may begin as a slight glandular endometritis, may become, if inveterate, a glandular endometritis of the most pronounced type (typical benign adenoma); may then degenerate into an atypical malignant adenoma, and this is the first stage of cancer." He makes the difference between benign and malignant adenoma to depend upon the presence in the former of a single layer of epithelium, a certain amount of normal interglandular tissue, and a clear line between the glandular and muscular layers.

Schröder⁷ maintains that no sharp distinction between glandular hyperplasia and adenoma can be made; that there are extreme forms of the latter which suggest malignancy, and frequently go over into cancer.

¹ The writer has carried out this work in the Pathological Laboratory of the College of Physicians and Surgeons, and is indebted to Dr. G. C. Freeborn for many timely suggestions, and for the use of the slide from which Drawing 2 is made. For the specimens and clinical material the writer is also greatly indebted to Professor G. M. Tuttle and Dr. E. B. Crazin.

² *Entwicklung der Carcinoma.* Virchow's *Archiv*, 1867.

³ Delafield and Prudden. *Pathological Anatomy and Histology.*

⁴ *N. Y. Jour. of Obs. and Gyn.*, 1893, p. 599. *Jour. of the Amer. Med. Soc.*, vol. ii, 1891, p. 109.

⁵ *Zeitschrift f. Geburt. u. Gyn.*, Bd. vi, p. 302.

⁶ Pozzi. *Medical and Surgical Gynecology*, vol. i, p. 397.

⁷ Schröder. *Handbuch der Krankheiten der weibliche u. Geschlechtsorgane*, p. 235.

Fürst⁸ is very extreme in his suggestions for treatment. Although he regards glandular hyperplasia as benign, he does not think it is wise to be content with curetting, but "to strive for excision, as the new formation inclines to malignant degeneration."

C. Ruge⁹ uses the terms benign and malignant adenoma. By the former he understands simple glandular hyperplasia. "In malignant adenoma there are changes in the entire uterine tissue. Metastases occur in other organs. Solid cell processes invade the deeper parts to a greater extent than is common in cancer." These last changes are certainly those of true cancer.

Lander and Abel¹⁰ use the term simple adenoma, meaning glandular hyperplasia, in contradistinction to malignant adenoma. They consider the amount of relatively unchanged interglandular tissue as the best guide in distinguishing the two forms.

Ziegler¹¹ considers adenomata of mucous membrane in general as not sharply differing from cancer.

Williams¹² thinks adenoma in the uterus is probably always malignant.

J. Veit¹³ says: "There is a gradual transition from adenoma to cancer."

Cushing¹⁴ describes malignant adenoma of the uterus as "an adenomatous thickening of the mucous membrane of the body of the uterus in elderly women, which finally degenerates into carcinoma."

The majority of writers, then, classify the marked cases of chronic endometritis with glandular hyperplasia among the adenomata. So long as the reproduction of the glands conforms perfectly to the normal gland type, they speak of them as benign. When the numerical increase becomes excessive, and the epithelium tends to form in several layers; when the interglandular tissue becomes scanty, and the tissue consists almost entirely of new-formed glands, and inroads are made into neighbouring tissues, they are called malignant. Furthermore, the latter form of lesion is generally considered as the initial stage of cancer. In other words, simply hypertrophy and hyperplasia are not distinguished from the changes existing in a well-defined tumour. Many writers, too, wrongly speak of malignant degeneration of a tumour, using the term degeneration in the same way that it is used in speaking of fatty or amyloid degeneration.

Before taking up the four cases which the present writer has to offer as examples of malignant adenoma of the uterus, it was thought that it might be useful to give a general description of the curettings from nine cases of well-marked adenomatous hyperplasia.

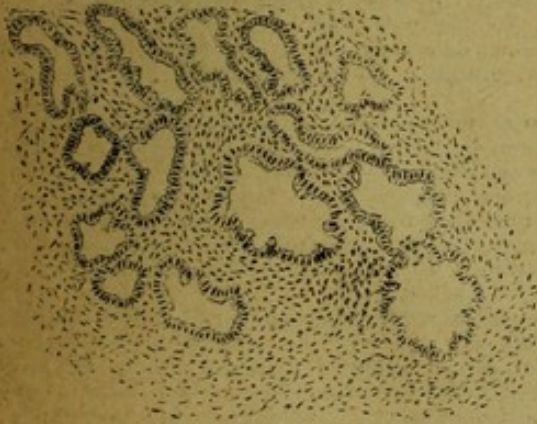


FIG. 1.

In these nine cases of adenomatous hyperplasia, the increase in the size and the number of the glands was very well marked. The epithelium, for the most part, consisted of one layer resting on a distinct membrana propria. The stroma was considerable in amount and showed in some cases the changes of a simple exudative inflammation, while in others there was the formation of new connective tissue. In other words, the glandular hyperplasia seemed to be simply a part of or a result of an ordinary chronic inflammation of the mucous membrane. Fig. 1 represents the condition in one of these cases.

The ages of these patients from which the curettings were taken range from twenty-eight to forty-seven. The most marked condition was in a patient of thirty-eight years. Five of the cases had been curetted before with relief for from six months to two years. Two of the cases were thought to be malignant clinically, because of their loss of flesh and poor general condition. This cachexia could readily be ascribed to the severe and protracted hemorrhages from which they had suffered. There were no appearances in these curettings which would warrant their classification among the neoplasms or suggest malignancy. The possibility of their future development into a malignant new growth can not be denied, but in the writer's experience thorough curetting and appropriate after-treatment cure most cases of chronic endometritis with glandular hyperplasia.

The curettings of two other cases, representing a more serious condition, have been very recently examined. In both of them the larger part of the curettings show simply a



FIG. 2.

glandular hyperplasia; but there are a few places in one case where there is an excessive numerical increase of glands and proliferation of the lining epithelium into several layers, with a very small amount of intervening stroma. In all parts a severe exudative inflammation is in progress, leucocytes almost filling the lumina of the glands. We have here, then, a beginning malignant adenoma. In a few places in the other case there are alveoli filled with regularly arranged epithelium, and with no trace of normal gland structure left. There is no exudative inflammation present, and glandular hyperplasia is not so well marked. In this case there is certainly a beginning carcinoma.

In both of these latter cases we have a simple benign process coexisting with a certain amount of excessive and lawless growth. We might interpret these changes as representing different steps of the same process if we knew certainly that they did not begin independently of each other.

Fig. 2 represents a section of some curettings showing coexistence of adenoma and carcinoma. On the left are seen the enlarged glands lying close together. The epithelium has proliferated into several layers, but the gland type is preserved. On the right the alveoli are completely filled with epithelium, and we have true cancer.

In contrast to the previous conditions, the writer wishes to describe four cases of well-marked malignant adenoma.

CASE 1.—Patient, forty-eight years of age, had had three children, the last one fourteen years ago. Her menstruation had always been regular until two years and a half before admission to the hospital. Since then she has flowed almost continuously, and has lost flesh rapidly for seven months, and during the last four months has suffered from severe pains in the lower part of abdomen and back.

Examination.—Patient is pale and thin. Palpation reveals a hard, smooth tumour in the median line of the lower part of abdomen, reaching to the umbilicus above. Bimanual examination shows the tumour to be an enlarged uterus. The cervix is short, soft, and the external os admits one finger. Behind and to the left of the uterus is a hard, immovable tumour, which with the uterus completely fills the pelvis and lower part of abdomen.

Patient was curetted, and a large amount of fleshy material having been scraped out, the entire uterus and tumour behind, with an indurated portion of the vaginal wall, were removed through the abdomen. The uterus externally resembles in its form one at full term of pregnancy, its cervix having almost disappeared. It measures from fundus to external os seven inches, and across the fundus between the tubal openings four

⁸ *Zeitschrift f. Geburts. u. Gyn.*, xiv, p. 332, 1887.

⁹ *Archiv für Gyn.*, xxxii, p. 487.

¹⁰ *Archiv für Gyn.*, xxxiv, p. 165.

¹¹ Ziegler, *Lehrbuch der speciellen pathologischen Anatomie*.

¹² Williams, *Cancer of the Uterus*.

¹³ *Zeitschrift f. Geburts. u. Gyn.*, vo. 4, 1887, p. 133.

¹⁴ *Annals of Gyn. and Paediatrics*, May, 1891, p. 458.

inches. The interior is completely lined by a soft irregular new growth, having elevations which project like polyp into the uterine cavity (see Fig. 3). One half of the uterine wall, which measures an inch and three quarters in thickness, consists of the new growth.

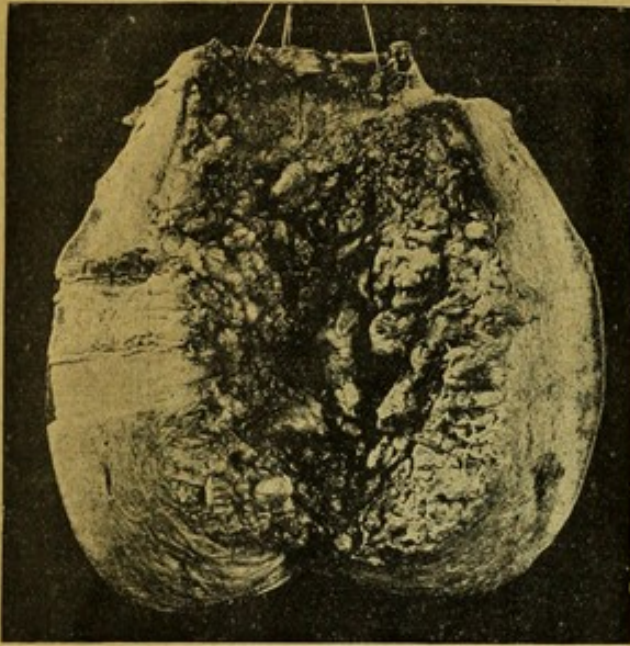


FIG. 3.

The other tumour, which apparently originated from the left ovary, is nearly circular in form, with a somewhat irregular surface, and measures four inches in diameter. It is solid throughout, its cut section being of a yellowish-white colour, not exactly homogeneous in structure, but traversed by numerous bands of slightly paler colour than the rest of the tissue. The apparently normal left tube runs over the tumour. The right ovary and tube are normal.

Sections were cut from different portions of the uterine wall, ovarian tumour, left tube, and broad ligament, and stained with hæmatoxylin and eosin and with picro-acid fuchsin.

The left tube and broad ligament show no invasion by the new growth. One half of the uterine wall consists of a mass of alveoli closely packed together, with a scanty supply of intervening stroma, resembling in structure the normal uterine

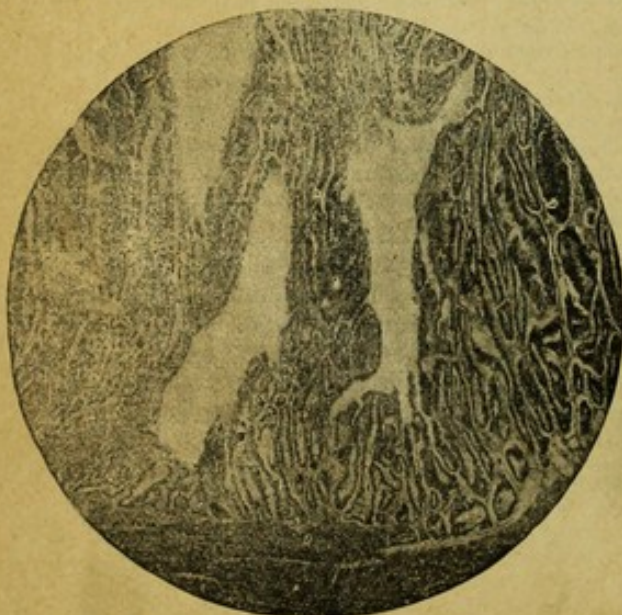


FIG. 4.

glands. The alveoli are generally lined with two or more layers of epithelium. A lumen is always present, although some of the alveoli contain a large number of leucocytes. The hypertrophied muscular layer is irregularly invaded by this adenomatous growth.

Fig. 4 is a photograph with a low power of a section of the

new growth. Fig. 5 is a drawing of the same with high power.

The excised portions of the vaginal wall also consist of this same adenomatous growth, the alveoli resembling normal glands and showing no true carcinomatous structure.

The ovarian tumour consists of a mass of alveoli, some of them having the epithelium regularly arranged like normal glands, others being filled with epithelial cells and leaving no trace of normal gland structure. Between the alveoli is a stroma consisting of irregularly branching trabeculae with a smooth, homogeneous appearance, resembling hyaline degeneration. A few connective-tissue cells are seen in the trabeculae, especially in the larger ones near the periphery of the tumour, and none of the chemical tests for hyaline degeneration give the proper reaction, so that these trabeculae, although closely resembling hyaline degeneration in many places, are thought to consist of very dense connective tissue.



FIG. 5.

Diagnosis of the uterine tumour is malignant adenoma; of the ovarian tumour, adeno-carcinoma.

CASE II.—A single woman, aged fifty-four, had suffered from irregular uterine hæmorrhages, increasing size of abdomen, loss of flesh, and poor general health for two years. Examination of abdomen shows a hard, irregular-shaped tumour completely filling the lower half of abdomen and pelvis.

Laparotomy revealed a large uterus filled with fibromyomata, attached to the left of which, by means of the tube and numerous adhesions, was a soft, friable mass about the size of an orange. The entire uterus and tumour were removed.

The large subperitoneal fibro-myomata, measuring about four inches in diameter, are situated at the fundus. Numerous small ones are situated in the uterine wall. One small pedunculated fibroid, attached to the fundus and having a shaggy covering, projects into the uterine canal. The uterine canal measures four inches and a half from fundus to external os and is lined by a soft, irregular growth, particularly at about the middle of the body.

The ovarian tumour consists of a rather firm central mass covered by a very soft papillomatous outgrowth. Microscopic examination of the subperitoneal fibroids shows the structure of an ordinary fibro-myoma. The pedunculated submucous tumour consists of a large number of well-formed glands with considerable intervening stroma. The entire body of the uterus is lined internally by an adenomatous growth, in all respects resembling the growths in the uterus in Case I, except that it is not so extensive. The growth in many places has superficially invaded the muscular coat.

Diagnosis is malignant adenoma occurring in a uterus the seat of multiple fibro-myomata.

The ovarian tumour consists of a papillary fibrous framework covered by a mass of alveoli, some of which preserve the normal gland structure, while others are simply masses of epithelial cells.

CASE III.—A married woman, aged sixty-nine, had been suffering from irregular uterine hæmorrhages for over a year, and had been curetted three times. The diagnosis of the first curettings had been simple adenoma; of the third, malignant adenoma.

Uterus was removed *per vaginam*. It measures four inches from fundus to external os and two inches and a half across the fundus between the tubal openings. The interior of the uterine body is covered by an irregular growth, not so exten-

sively as the first case, but much more so than the second. At the fundus the uterine wall is an inch in thickness and chiefly consists of this new growth. In one place only an eighth of an inch of muscular tissue remains. Near the internal os the growth has not encroached upon the muscular tissue so extensively, and the cervix is not at all invaded.

Microscopical examination of the growth shows it to have the same structure as in the other two cases. There are irregular invasions into the muscular tissue, and here and there, deep in the muscular coat, isolated patches of glands are found, conforming in general to normal utricular glands.

There are no evidences that the new growth has gone beyond the uterus, although in one place, at the fundus, it has very closely approached the peritoneal coat.

Diagnosis is malignant adenoma.

CASE IV.—A married woman, aged forty, had suffered from pain in the back and iliac regions for three years. During the six months previous to her admission to the hospital pain had become much worse and she had rapidly lost flesh, and for three months had had a foul discharge. Menstruation had been normal.

Examination under ether revealed an enlarged uterus, retroverted and adherent. Both appendages were prolapsed and adherent to the uterus. A hard mass was felt on each side of the uterus. Microscopic examination of the curettings removed at the time of the examination under ether show a great mass of glands lined by several layers of epithelium, but always preserving a general adenomatous structure.

On account of the infiltration on the sides of the uterus extirpation was not attempted. Patient died two months later. No post-mortem examination was made.

In this case, of course, it is impossible to be certain that there was no carcinomatous growth in or about the uterus, but a large amount of material was removed at the curettings which only showed the structure of malignant adenoma.

These four cases, as examples of malignant adenoma of the uterus, present some interesting points. The anatomical structure of the new growth in all of them is the same.

They all present more active and destructive changes than do cases of simple glandular hyperplasia, and they all differ anatomically from cases of cancer. Cases I and II are interesting because the adenomatous growth in the uterus is associated with carcinoma in the ovary.

Case II was interesting because of the association of the new growth with a uterus filled with fibro-myomata.

Cases I and III show well the encroachment of the new growth upon the neighbouring tissue and the preservation of the gland type in these invasions. Even in Case I, where the adenomatous growth has spread beyond the uterus, the invaded part of the vaginal wall consist of glands more nearly like normal uterine glands than those in the uterus. In all of the cases the cervical mucous membrane was not invaded.

Summary.—There occurs in the uterine mucous membrane a moderate glandular hypertrophy and hyperplasia, associated with chronic inflammation, which is entirely distinct from any tumours in the same region. The glands are simply more tortuous and more numerous, and the lumen is larger, but their general structure is the same as that of normal utricular glands.

More marked examples of glandular hyperplasia occur which often simulate clinically malignant neoplasms. They often occur near the menopause, may cause severe hæmorrhages, and impair the general health. Sometimes they have to be curetted several times before the condition disappears.

Anatomically these latter cases are characterized by an excessive number of glands, but the epithelium does not show any marked tendency toward proliferation, and there is still a large amount of stroma left in which inflammatory changes are going on. There is an increased number of stroma cells and an infiltration with leucocytes; there are new blood-vessels, and oftentimes interstitial hæmorrhages occur. The whole picture is one of inflammation, in which the glands are increasing in number simply as part of the general inflammation.

Some of these more marked cases probably do become malignant, and therefore a careful microscopical examination of all curettings should be made.

Although a positive diagnosis between adenomatous hyperplasia and adenoma may not always be made from the curettings, yet it is possible in the large majority of cases to form a conclusion of sufficient accuracy.

Adenomata occurring in the uterine mucosa are tumours consisting almost entirely of glands which conform in general to the normal gland type. There is very little interglandular tissue, and, while there may be an inflammation going on, it is entirely subsidiary to the main process—*i.e.*, growth of new

glands. The epithelium lining the alveoli shows a tendency to proliferate, but a lumen or the suggestion of a lumen exists.

Adenomata in the uterus are always malignant, because they invade neighbouring tissues and recur unless completely removed.

Adenoma in the uterus, although it may represent a transitional step between simple glandular hyperplasia and carcinoma, certainly often develops to a high degree without losing the anatomical characteristics of adenoma.

Adenoma usually, perhaps always, begins in the body of the uterus, and does not involve the cervical mucous membrane; and, while it invades the muscular layers and eventually goes beyond the uterus, it remains confined to the mucous membrane longer than carcinoma does. It might be described as spreading around in the mucous membrane rather than burrowing through the different layers, and thus quickly involving other parts.

Compared with carcinoma of the uterus clinically, we find that adenoma of the uterus usually occurs later in life than carcinoma, and lasts longer without causing cachexia. Frequently we get a history of irregular hæmorrhages for several years, during which time the patient has been curetted several times without permanent relief. Pain and discharge are not such prominent symptoms in adenoma as in carcinoma. The enlargement of the uterus is more marked in adenoma.

The prognosis in adenoma after removal is better than in carcinoma, because from its manner of growth complete extirpation of the growth is more certain.

The treatment for adenoma of the uterus should be the same as for carcinoma.

LACTOPEPTINE IN THE TREATMENT OF MALARIAL ENTERITIS.

By W. FORBES-LESLIE, M.B. and C.M. Aberd.

[An Original Article, specially written for MEDICAL REPRINTS.]

In an article which I wrote for *Medical Reprints* about a year ago I pointed out the efficacy of Lactopeptine in the treatment of malarial fever. Since then I have been able to extend my experience to its action in the course of malarial enteritis. This is a disease of the alimentary canal which stands midway between enteric fever and the enteritis of cholera. It has many symptoms in common with what we call summer diarrhoea in this country, but is distinguished by a number of well marked features, and in the slow recovery the patients make after the disease has expended itself.

It is very common in malarious districts, and is more or less epidemic. In this it resembles dysentery, to which it has a great affinity. I have seen cases described as dysentery which in my opinion could only have been subacute cases of malarial enteritis. Undoubtedly dysentery is a form of malaria; but it produces intense inflammation, followed by ulceration and destruction of the deeper tissues, while death takes place from perforation in most cases. The gastric mucous membrane is rarely affected. On the other hand in malarial enteritis there is a general superficial inflammation extending from the stomach to the lower bowel produced by irritation of the poison. It never concentrates itself upon certain points with the formation of ulcers, and pain is only the result of excessive peristaltic action. As I have said, it is more or less epidemic. Indeed some authorities consider malarial fever itself epidemic and recommend prophylactic measures. It is true that as civilization advances it recedes before it. It is true that when freshly broken up the ground reeks with the poison, but as the measure of cultivated land increases the fever diminishes, showing that treatment by such means is of undoubted value.

There are also some of its forms which generate a true epidemic power under certain conditions. Yellow fever, a low form of malaria, and cholera malarial, and indeed true cholera itself which seems to be affiliated to it, if not truly evolved from it, are highly epidemic.

Malarial enteritis is also infectious. Its type changes under the two-fold influences of climate and constitution. Sometimes it is so severe that death takes place in a few hours, in other cases a fatal termination is rare except in children or old persons. Death in the acute form takes place from shock in the early stages, in the subacute from exhaustion consequent upon the discharges from the bowel. These last consist at first of natural feces; later they become watery, frequent, contain blood corpuscles, epithelial cells, mucus, and small particles of undigested food. The most interesting epidemic in my experience was on board ship on my way to Africa. There were three hundred passengers struck down one after the other, together with nearly all the officers and crew, by

malarial enteritis. They blamed the water, the food, the cooking utensils—everything but the true cause, the malarial poison. There was no question, for the water and food were excellent, and the disease attacked us first off the coast of Senegambia. Moreover other ships passing through the same belt experienced a similar epidemic. I have no doubt that malarial germs floating in the atmosphere were inhaled into the alimentary canal and set up inflammatory changes, resulting in this form of enteritis. Once taken in they found suitable material for their development in the weak and unhealthy organs of some of the passengers, and extended the range of attack upon the others long after the malarial belt was passed, by virtue of generated epidemic powers.

The symptoms were very similar. Digestive disturbances were present early, and in most cases there was tenderness on pressure over the epigastric region, bilious vomiting, pointed tongue, red at tip and edges, but covered elsewhere with a yellow dirty fur. There was headache with purging and tenesmus, and sometimes stabbing pain in the anus, as if from spasmodic contraction of the hæmorrhoidal veins. The stools were dark, more or less natural at first, becoming watery with blood corpuscles, shed epithelial cells, triple phosphates and particles of undigested food. The evacuations were as many as forty per day, but small in quantity. The straining was very severe, and lent to the face a peculiar anxious expression. The temperature was always above normal; it was periodic in type, but in some cases presented considerable irregularity. It never rose above 104° F., generally keeping a low level and inclining upwards to the crisis. The urine was scanty and high coloured, and in a few cases contained albumen. The kidneys were tender to deep pressure, and evidently in a state of congestion. Rigors heralded the enteric symptoms, and always appeared again if the bowel took on increased inflammatory action. Sweating was seldom well marked. In one case, however, where there was little or no fever it was a prominent symptom, coinciding always with an improvement in the enteritis.

Collapse often occurred at the crisis, and had to be carefully guarded against; shock, too, appeared early in one or two cases, but these were in old people or those suffering from chronic diseases. In some epidemics the symptoms vary in prominence, but always heralding an attack and persisting long after it is the digestive disturbance. It is this which delays recovery, and which if not assisted will either destroy the patient, or lay the seeds of an atonic dyspepsia lasting for years if not for life. In treating the enteritis I aimed at producing an antiseptic effect upon the length of the bowel, at the same time endeavouring to control the excessive peristaltic action. I found that I best could obtain this result by the following:

R. Liq. hydrarg. perchloridi ℥ xv
Tinct. opii ℥ v
Fiat haust.

M. Sig.—Every two hours till the purging was stopped.

This it generally did within the first twelve or twenty-four hours. I never found this preparation rejected. The first two doses were sufficient to check the vomiting in most cases; if it continued equal parts of Bismuth Carb. and Bicarb. Soda was effectual. Complete rest was ordered; no food was permitted, except soda water and milk in small quantities frequently, and if collapse was feared champagne. In most cases the question of nourishment must be faced early. The gastric mucous membrane improves so slowly that if the exhaustion is great we must find a suitable method to introduce nourishment or lose our patient. The best preparation in my opinion after a long experience with various drugs is at first one which will digest and soothe. The following is what I prescribe:

R. Bismuth carb. gr. xv
Bicarb. soda gr. x
Lactopeptine gr. x
Fiat pulv.

M. Sig.—To be taken every four hours.

Custard puddings, chicken jelly and soup to be given in small quantities. Two days after this treatment has begun, cold chicken, game, pounded meat, fish or any light nourishment may be tried, discontinuing the soda and bismuth, and giving the Lactopeptine during the meal in weak whisky and water. At the same time it is well to act more directly upon the blood and nervous tissues. This may be done by ordering a mixture to contain iron with a mineral acid combined with strychnine or arsenic. Change of climate will complete the cure. This is, however, not always necessary, and a constitution built up in the pernicious influences which threatened to destroy it gains in the process, as it were, powers to resist fresh invasion.

ABSTRACT OF A PAPER ON THE USE AND ABUSE OF ERGOT IN OBSTETRICS.¹

By T. MORE MADDEN, M.D., F.R.C.S.E., M.A.O., *Honoris Causâ*, Royal University of Ireland, Obstetric Physician and Gynæcologist, Mater Misericordia Hospital, Dublin.

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THE reaction against the former abuse of ergot in obstetrics has apparently been now carried to an extreme and undue extent, and has led to its desuetude in many instances wherein this ebolic might be most advantageously employed. The writer therefore submits some observations with regard to the circumstances under which long clinical experience has convinced him that ergot, or its preparations, may and should be given in midwifery practice, and the methods of its administration, together with a summary of the results to mother and child in one hundred and fifty of the instances in which, in his practice, this drug was thus resorted to.

Circumstances under which Ergot may be employed in Midwifery Practice.—Judging from the recent literature of this subject, it may not be superfluous to premise that to use ergot or any of its preparations safely and effectively during parturition the presentation should, as a rule, be cranial; that there should be no disproportion between the fœtus and the maternal parts, nor any obstacle to deliverance in the genital tract; that the os uteri, if not previously fully dilated, should at least be sufficiently dilatible to allow speedy delivery by the forceps whenever that may become necessary; and that a preparation of ergot should be selected and a dose given calculated to produce the required ebolic effect.

Under such conditions ergot may be given with utility when required either before, during, or after the second stage of labour, viz.:—firstly, in some instances (*a*) of delay from inertia of the uterus before the full dilatation of a dilatible os, and in which there is any evident danger to either mother or child from protraction of labour; secondly, it may be administered during the second stage (*b*) in nearly every case of long delay from inertia wherein the presentation is natural and the delivery not otherwise impeded, or in which (*c*) there is then either reason to apprehend the probability of subsequent hæmorrhage, or any such complication as may call for its use; thirdly, during the last stage of labour this ebolic may be employed (*d*) to hasten the expulsion of the placenta when delayed by inertia, or (*e*) for the arrest of hæmorrhage; fourthly, after labour ergot may be resorted to either immediately (*f*) to prevent or check flooding, or subsequently (*g*) to produce such tonic or permanent contraction as will effectually seal up the uterine vessels, and so lessen the liability to subsequent septic invasion, or (*h*) to effect the expulsion of clots and so arrest after-pains; fifthly, and lastly (*i*), to stimulate such contraction as may quicken or secure the process of involution after parturition.

Method of employing Ergot.—In such cases this ebolic, if given at all—and whether ergot, ergotine, ergole, or any other of its preparations be selected—should be employed not in the repeated small and utterly insufficient quantities that have been recommended by some modern writers, but should be administered only once during labour, and then in such a bold, full, and effective dosage as may be likely to excite speedy and permanent or tonic uterine contractibility. With this view, in my own practice I therefore generally use the fresh liquid extract of ergot of the Pharmacopœia, of which I commonly give a couple of drachms, or some cases three drachms, by the mouth, together with a drachm by deep hypodermic injection in the gluteal region at the same time.

Abstract of 150 Obstetric Cases in which Ergot was employed.—In 70 of these cases the patients were primiparæ; in 80 they were multiparæ. In 148 instances the result was favourable to the mother. In 95 of the cases referred to the drug was given before the birth of the child—viz., in 15 for delay from inertia in the first stage of labour, the os being previously dilatible and the head presenting; and in 80 either for delay similarly occasioned in the second stage, or else then for the prevention of hæmorrhage, or for other complications. In 92 of these instances the children were delivered alive, either by uterine action or by the forceps. Of the 95 cases in which ergot was given before the birth of the child, in 86 the placenta was normally expelled, and in 9 its removal had to be assisted for morbid adhesions or other causes, one only of which was a case of hour-glass contraction. In 55 cases the ergot was given after the birth of the child—viz., in 25 during the third stage to hasten expulsion of placenta or to prevent hæmorrhage; and in 30 after delivery, for the arrest

¹ Read before Obstetric Section Royal Academy of Medicine, Ireland, April 24th, 1897.

of post-partum flooding, or for some other reasons to stimulate and secure tonic contraction of the uterus.

My experience on this subject, some of the results of which I have just summarised, points to the conclusion that the dangers which are now so commonly ascribed to the use of ergot in obstetrics, are probably largely attributable to its misuse, or administration in unsuitable cases, or in insufficient doses, and therefore furnish no argument whatever against its judicious and proper employment.

HEADACHE IN EPILEPSY.

By L. PIERCE CLARK, M.D., First Assistant Physician, Craig Colony, Sonyea, N.Y.; Member of the New York Neurological Society, etc.

AMONG the post-convulsive phenomena in epilepsy, one which is not of the least important symptoms is the headache. This symptom is almost invariably present, and is described by the sufferer in various ways, but is almost always consigned to the same region of the cranium—namely, the frontal. Of course, this symptom of headache in epilepsy is not meant to include those affections preceding, concomitant with, or following a fit, which are of a decided neuralgic or megrimous character. Such latter-named conditions have been frequently commented upon by such neurologists as Dana, Gray, Féré and Esquirol. They have been found to be associated with epileptic fits, and are a true part of the nervous discharge, the sensory phenomena of the attack.

When we come to consider the reason for this post-convulsive sequela of headache we find that many theories present themselves, but as yet they are all of such a distinctive theoretical and hypothetical nature that but little can be gained in detailing them at length here; therefore we will only make mention of the principal features of each theory.

Although headache in most affections is still a great mystery, yet it would seem that its occurrence would be more easily explainable when following an epileptic fit than it would be under most other conditions. The nerve fatigue or exhaustion resulting from such extreme discharge or liberation of energy in the cortex as is seen in an epileptic attack is a sufficient explanation for the condition, although we are aware that some physiologists state that no headache can be produced or have its origin in brain substance, and many psychologists state that all sensations must have their origin in the periphery. Against this first-named objection it can be said that we frequently see headache following simple brain fatigue from overwork, which must be due to the exhaustion of the nerve centres engaged in such excessive mental activity.

It is well known that the interdependence of the vascular supply to the face and the brain or meninges is no longer closely related, and that the congestion of the face does not necessarily imply a cerebral congestion. Again, it is hardly possible that the products of the nervous overaction may have served as an auto-intoxicant upon the individual nerve cell, which some writers state is incapable of receiving its normal blood supply and eliminating its excess waste products in the fit, although this may also act as a deterrent to the nerve cell's re-energising itself, and thus prolong the symptom, headache. It is interesting to note that those epileptics in whom little or no sleep stage is present after a seizure, are troubled to a greater extent by headache than those who have a prolonged sleep. Headache is also most noticeable and severe in those cases which have the greatest convulsive movement in the fit, and the condition is most easily relieved by those drugs, such as opium and morphine, which exert a very favourable influence upon fatigue induced in other parts of the body. However, the symptom is best treated without such drugs, but by milder remedies which induce sleep, and the sleep thus acts as a natural restorative. For this reason, as well as for many others, every epileptic should be earnestly persuaded to sleep after his attacks. Many post-convulsive phenomena, such as automatism, delirium and even epileptic insanities, are brought on or hastened by well-intentioned friends, who desire to arouse and awaken the patient before he has slept off the effect of his attack. A much more cautious prognosis should be made in any case of epilepsy in which the sleep stage is habitually omitted, and in which the patient is constantly afflicted with severe frontal headache.

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SOME CASES

IN WHICH I HAVE FOUND ANTIKAMNIA OF USE.

By J. P. MAGUIRE, M.B., B.Ch., B.A.O.

[An Original Article specially written for MEDICAL REPRINTS.]

TUBERCULAR MENINGITIS.

Miss B., aged 15 years, always a delicate child, came to my surgery on the 15th March, 1897. She suffered much from dyspnoea, even when at rest. She stated that the difficulty of breathing did not trouble her until the 10th March. She had neither pain nor cough. On examination I found the left pleural cavity full of fluid. I advised aspiration and performed it next day, drawing off four pints of clear fluid. Next day, 16th, breathing was much improved and temperature was normal, but a small quantity of fluid still remained in lower part of chest. I put her on Ol. Morrhuæ and Syr. Fer. Iod. and painted lower part of chest with Lin. Iod. About ten days after operation I blistered as fluid was slowly but steadily increasing. Blistering had no beneficial effect, and three weeks after operation the left pleural cavity was again almost completely filled with fluid. Temperature remained normal throughout. On 7th April, 1897, I again aspirated, drawing off three-and-a-half pints of fluid, a little still remaining in the lower part of the chest. There was no rise of temperature after the operation. On the 17th April there was still a little fluid in the lower part of the chest, not showing any tendency to increase or diminish; patient's general condition was fairly satisfactory. On the evening of the 21st April, that is fourteen days after aspirating the second time, she complained of severe headache; the bowels were regular and the cause of the headache was not very clear; there was a slight rise of temperature; suspected tubercular meningitis, shaved the scalp and tried the usual remedies with but little relief. The ice-cap proved useful but I had to give it up owing to the difficulty of procuring ice. I determined to give Antikamnia a trial: it frequently gave prompt relief to the headache in 10 gr. doses; of course the relief was temporary. Paralytic symptoms (strabismus, etc.) set in early in the second week after getting the headache, and she died in coma at the end of the second week. I think this case of interest as showing the power Antikamnia possesses of relieving pain in at least some cases of grave organic disease.

TYPHOID FEVER.

In some cases of typhoid fever the headache which occurs during the first week or ten days is slight and does not call for any special treatment, in others no headache is complained of, in others still the headache is very severe, especially during the first five or six days. Out of ten cases of typhoid fever which came under my treatment during the months of January and February last, headache was absent in one, very severe in three, and present but not very severe in the remaining six. All the cases made a good recovery; those with severe headache progressing as favourably as those with slight. How are we to relieve this headache? Cold applications to the head are undoubtedly useful, especially the ice-cap, when the headache is severe, but in most cases we have to try and get on without it. Evaporating lotions we can have, but they are very unsatisfactory. We are slow to use depressing remedies even in the early stages, so we are anxious to avoid leeches to the temples, etc. Antipyrin, antifibrin, etc., often give relief, but they also depress our patient very much. I have tried Antikamnia in the above cases and found it very satisfactory. It does not seem to have any depressing effect, and it certainly adds very much to the patient's comfort during the first week or so when the headache is severe. I find three 5 gr. doses administered at intervals of fifteen minutes to relieve the headache even when very severe.

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MEDICAL REPRINTS.

ILLUSTRATED. WITH ORIGINAL ESSAYS.

OCTOBER 15th, 1897.

We have received from the author a very interesting little pamphlet on the Hospital Question ("How to Help the Hospitals." By G. A. Hawkins-Ambler, F.R.C.S.E.; reprint from *The Practitioner*, September, 1897; pp. 12; no imprint). Dr. Hawkins-Ambler's remarks are valuable and to the point, and we are glad that he has brought the reprint to our notice.

Starting with the truism that all hospitals are needy, Dr. Hawkins-Ambler proceeds to the further deduction that these institutions also need very urgently a reform in their methods of management. "The great danger threatening hospitals" (he observes) "is that they will become eaten up by patients. No one for one moment imagines that we have not hospitals enough for all the present needs of the population, or that they are in any serious danger from the necessities of those for whose service they are primarily intended. If we have anything to fear, it is from the increasing mass of people who are well able to pay a reasonable sum for medical services, whose cases call neither for the extensive resources of a hospital nor the special skill of its staff. The bulk of all hospital cases could just as well be dealt with by any medical practitioner. The average doctor of to-day is highly trained, is equal to most of the emergencies of practice, and, having acquired his profession at considerable expense and great pains, he naturally wishes to see some pecuniary return for his labour; instead of which, he has the mortification of seeing people who might reasonably be expected to pay moderate fees pass his door in order to be treated at the nearest hospital. These good folk intrude on the time of men of more or less professional eminence, qualified by education and native talent to cope with the most serious difficulties that can present themselves to the practitioner. But this does not of necessity mean that the patient who is not in need of extraordinary assistance is likely to be better treated by them, or even served as well as by the regular general practitioner. General practice is a 'speciality' just as much as the most exclusive branch of practice, and the accomplished physician or specialist set down in the midst of an ordinary general practice would find himself very much astonished and oftentimes puzzled by cases which the experience and average intelligence of the medical man of everyday life enable him to manage with success and to the satisfaction of his clients. But if hospitals are used so largely by a class of people who are not entitled to their assistance, it is obvious that these institutions are being defrauded annually of immense sums of money, that they must always be running into debt, and that, as the public become alive to what has long been patent to the profession, funds will be subscribed with decreasing enthusiasm to charities that have long held a high place in the hearts of our countrymen. If the poor are being deprived of charity, of hospital service, by the diversion of funds to unworthy objects; if the medical profession is also being starved of necessary experience as well as of legitimate earnings, the question assumes very grave proportions from every point of view. Not the least danger of those incurred is that of diminishing public estimation of hospitals, as the recipients of eager and liberal support. Whatever be our views on these matters, we can hardly desire, for this country at least, the ~~transference of hospitals from the maintenance of the charitable~~ to the support and sole control of the State. It is rather matter for congratulation that their base of support is widening, that the voluntary sacrifices of the poorer classes of society are helping in the good work, and that the working

classes are accepting other duties to the State than those of voting and paying indirect taxation."

Another aspect of Hospital abuse, not always perceived by writers on the subject, is the position of the hospital and the consultant *vis à vis* the supply of medical service outside. "We are all," Dr. Hawkins-Ambler remarks, "apt to forget one still more important phase of the subject. Before the eminent practitioner is called upon to pronounce on the diagnosis or treatment of a case, the general practitioner is in charge of it, and it is much more important that he should be a man of ripe experience and judgment than that the consultant should have all the best things thrown in his way to the exclusion of his less esteemed but equally worthy brother. If we starve the general practitioner of fees, we exclude from general practice the best men, the ambitious men, and those who are best qualified to serve us in this important branch of practice. If, besides warning off good men from general practice, we starve the general practitioner of experience by depriving him of cases that will deepen it; if we throw him merely the dregs and trifles that are beneath the consideration of the 'specialist' (if any specialist be so crass a fool as to consider any phase of disease contemptible), we shall speedily find the average practitioner degenerate; he will cease to be the wise counsellor, the experienced friend, the large-minded physician, with whom we may safely advise on the ills that threaten us—the watch-dog who stands at the door and challenges on the threshold disease that too often can only be stayed there. It is the experience of all of us that success in treatment depends on the general practitioner much more than on the consultant. The latter too often sees the case only when disease has acquired such a hold on the life and constitution of the patient that no efforts of his can dislodge it. The insidious onset of consumption, the unobtrusive, early inroads of cancer, come before the general practitioner only. Then they are most difficult to recognise, but most easy to treat. They reach the specialist when a student could diagnose, but only a miracle cure them."

Dr. Ambler's remedy for Hospital abuse is summarised by himself as follows:—"The best suggestion, to my mind, is that we should take a lesson from the Charity Organisation Society. Why, it is asked, should we not have central bureaus at which all who need hospital relief must apply in the first instance? Here urgency notes could be obtained, or a liberal application of rules would permit urgent cases to be admitted without preliminary inquiry. But all cases must be submitted to inquiry at the earliest possible moment, and their claims investigated. Then proper applicants could be supplied with tickets on which the names, addresses, and hours of attendance of all local hospitals could be clearly printed, and this card would admit the patient to treatment at any of them. The cost of such a scheme need not be large; distributed over the hospitals of a district, it would be comparatively trifling compared with the benefits to be secured from it. The Poor Law Medical Service experience no difficulty with urgency cases, and none need seriously hamper the application of this scheme. The immediate result of its adoption would be an immense diminution of the casual, the undesirable, and otherwise improper cases which crowd our hospitals—at least in their out-patient departments." The ultimate result would be that hospitals would husband their resources, the public would subscribe cheerfully, with the certainty that their money would not be squandered, doctors would regain confidence in hospitals and give them moral support, which they are not so eager to afford as they were, and the sick-poor would not be defrauded of the kind intentions of the charitable. A wage limit would have to be adopted, and as time went on and experience grew, the acumen of the agents of the bureaus would develop most valuably and be a better safeguard still.

We have also received from the same author a reprint from the *Liverpool Medico-chirurgical Journal* of his article on the much-vexed Midwife Registration question.

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NEWS AND NOTES.

AMONG the oddly-intituled diseases that from time to time cause a mild sensation by transcending the limitations of purely medical discussion, surely "Theatre-Sickness" ought to take a high place. That staid and useful publication the *Progrès Médical*, of Lyons, appears to be the inventor of this somewhat farcical disorder, which it describes as "an affection often witnessed by physicians in theatres. It is manifested by loss of consciousness, faintness, and even syncope. It generally occurs in persons who have dined hastily in a restaurant and reached the theatre overheated. Pregnant young women are particularly disposed to it. The only treatment required is to loosen the clothing, lay the patient down, expose the face to fresh air, bathe the temples with a little cold water or cologne, and apply smelling-salts. The patient should not be allowed to stand or sit up until the attack is thoroughly over, that is, for ten or fifteen minutes, and then he had better not remain for the rest of the performance, but go home." It appears to us that ladies have fainted from time to time, and people have sprinkled them, and exhibited smelling-salts—but not for "Theatre-Sickness." As for those other young women, of a condition so bluntly specified by our contemporary—well, does it take a new ætiology to account for the faintings of a young woman who has been married (let us say) about four months and a half? Has the Editor of the erudite *Progrès* never met with that somewhat frequent incident in fiction, where the young wife suddenly faints, thereby revealing to an astonished husband a condition that he never so much as dreamed of? About ten years ago, no well-constructed novel of domestic life ventured from the press without this touching example of masculine inadvertence; but the incident has dropped out of recent fiction, though it cannot be said that the novel has in other respects grown more reticent about such matters.

Is a publication consisting of contributions from the Medical Faculty of the Imperial Japanese University in Tokio, Dr. K. Miura writes of a disease that prevails endemically in the northern provinces of Japan. The name *Kubisagari*, it seems, signifies one who lets his head hang down. The disease is known in European literature as paralytic vertigo (*vertige paralytique*), vertigo with ptosis (*vertige ptosique*), and Gerlier's disease. It is characterized by attacks, lasting from a few minutes to several hours, and occurring with varied frequency, of dimness of the eyes, ptosis, paresis of the muscles of the neck so that the head droops, and paresis of the muscles of the limbs and trunk, of the tongue, and more rarely of the muscles of the lips and of those concerned in mastication and deglutition. Less common symptoms are ill humour, increase of the nasal, the lachrymal, and perhaps also the salivary secretion, and exaggeration of the tendon reflexes. These attacks are brought on by bodily exertion, especially in a stooping posture, with the stomach empty, straining of the eyes, and scanty food, or food which is difficult of digestion. In the intervals the patient may be free from the symptoms, or there may be slight ptosis, great weakness of the muscles of the neck, and heightened tendon reflexes. The disease may last for many years, but it is never fatal. It is most prevalent in the warm season, from May to October, and attacks by preference persons who have the care of great herds of horses and cattle, and sleep under the same roof with the animals, so that they are exposed to the emanations from the stalls. It is to this that Miura attributes the disease, which he considers to be identical with that described by Gerlier, in 1886, as occurring in French Switzerland, especially in the Canton of Geneva, in Gerlier's cases, too, the ætiology seems to have been the same.

THE *Republican*, a lay newspaper, published at Denver, U.S., contains an interesting account of the Mud Baths of New Mexico. The hot springs which are accountable for these "baths" are on about six miles from Las Vegas, and they are situated in a basin about thirty acres in extent, surrounded on all sides by hills rising to a height of from three hundred to four hundred feet, shielding the place from wind and sand storms. The mud baths, which are famous for their curative effects, are to be had in only three places in the world, here, at Carlsbad, Germany, and in New Zealand, where they are often prescribed for the treatment of alcoholism. It has been shown that the mud found at the hot springs of New Mexico, and which is used in giving the baths, is of the same chemical composition as that of Carlsbad. It is very interesting to note the formation of this mud or peat. It is formed by the vegetation which has been washed down from the hills, probably a century ago, and which, settling among the rocks, has become decomposed and formed into a substance which is practically carbon impregnated with salts of magnesia, soda, lithia, and

various other bases. This peat is gathered from the rocks, dried, and put through a fine sieve in order to remove the silicates, and after this treatment it is as soft as flour. It is then taken to the mixing-room, where it is put in large tubs, and the water from the hot springs mixed with it until it is of about the consistency of mush. The mud is now ready for use, and it is taken into the bathing-room, where the patient is placed in a tub and covered, with the exception of the head, and allowed to remain in the mud for from ten to thirty-five minutes. The application of the mud has an effect similar to a mild poultice, and draws the impurities from the body through the pores of the skin. The patient is then removed from the bath, placed upon a slab, and submitted to a vigorous rubbing, the chemical composition of the mud being such that it can be rubbed from the body with a dry towel, leaving the flesh in a clean condition. A great many people come to this place to take the mud-bath treatment, and some remarkable cures are effected. The treatment is said to be especially beneficial to persons afflicted with neuralgia, rheumatism, and skin diseases.

A CONGRESS to arrest (not before such an arrest is needed) the spread of syphilis in Russia, was recently summoned by the government, and was attended by over five hundred physicians, teachers, professors, heads of penal and other institutions, inspectors of factories, and military and naval officers. Among the measures proposed were stricter supervision of the morals of the young and cultivation of out-door sports; education of the public to the dangers of syphilis, by popular illustrated lectures, pamphlets, etc.; the adoption of a uniform blank for recording all cases, and for annual reports to a central bureau; physical examination of prostitutes by female physicians, and also the examination of the men who visit them. Special measures for preventing the spread of syphilis among the innocent, which, as shown by Bulkley in his work on "Syphilis Insontium," is so common in Russia, were also recommended.

In the *Russkii Arkhiv*, Dr. Vievirovski presents an elaborate study of the blood changes occurring in patients with early syphilis, after receiving injections of serum taken from persons with tertiary manifestations. His investigations were made upon two patients with syphilitic roseola, who were first treated with serum from syphilitics with condylomata, and later, during a recrudescence of the disease, with serum from those with gummata. The difference in the effects of the serum taken from these two sources was a purely quantitative one, the gummata serum being the more active.

Immediately after the first injection of from twenty to fifty cubic centimetres of serum there was an increase in the number of red corpuscles and in the amount of hæmoglobin, and in most cases a diminution in the number of white cells. During the continuance of the injections, while the symptoms of the disease continued, the red cells and hæmoglobin remained at a fairly constant level, within nearly normal limits, or were slightly increased. But as soon as the syphilitic symptoms disappeared there occurred a new augmentation in the amount of hæmoglobin and number of red corpuscles. The white cells showed a tendency as at first to decrease. In one case, in which the injections of serum were without effect in preventing the development of the symptoms of the disease, there was always a diminution in the number of red cells the day on which the eruption appeared and also the day preceding it, although the number had been considerably above the average prior to this. The amount of hæmoglobin remained invariable. It was only after several injections, and upon the day the eruptions disappeared, that the number of red cells and the amount of hæmoglobin were increased.

Dr. Vievirovski believed that there occurred under the influence of the serum a rapid reparation of the blood which had been altered by the syphilitic toxin, this modification taking place very rapidly after the introduction of the serum, even before the injections had had time to influence in any way the symptoms of the disease. The effects of the serum were analogous to those of mercury, when the latter has simply caused a disappearance of the symptoms of syphilis, but has not been pushed so far as to exercise its hæmatolytic action. The difference between the treatment by serum and that by mercury consists chiefly, the author thinks, in that the serum acts more promptly, and occasions none of the destructive effects seen occasionally when mercury is employed in large doses or for a long period.

The experiments made by Dr. Vievirovski, of which we have been able to give only a bare outline, were most interesting and, except for their small number, quite conclusive. They at least incite to further trial, and justify the hope that we may find in hæmatotherapy a valuable aid in the prevention of the serious and destructive lesions of the so-called tertiary stage of syphilis.

THERAPEUTIC NOTES.

[Contributions to this column will be gladly welcomed at all times, and, when accepted, will be paid for at the rate of One Guinea a column, if original.—EDITOR MEDICAL REPRINTS.]

INDIGESTION IN INFANCY.—Indigestion in infants is too frequently ignored by parents, especially young mothers, until at last is engrafted gastro-intestinal catarrh, when at once they become alarmed, and justly too, and seek advice, either from the tradition burdened grandmother or the physician. It is the physician's luck to be called after all domestic means have failed. He is supposed to effect a cure forthwith, even though he first has to remove the trouble caused by the lotions, potions, etc., which have been administered by the mother. If the mother had watched the cause of the disturbance (faulty feeding) as vigorously as she applies home remedies, the chances are the child would have had no trouble. Infant feeding, then, should receive careful study by the mother and attention paid to the details of hygienic care. These measures would do much toward preventing indigestion and gastro-intestinal catarrh.

Treatment, too, of the diarrhoea, which becomes a factor in prognosis, should also receive attention. The use of mineral acids, bismuth and pepsin is well known, and also the use of Lactopeptine.

For several years we have used Lactopeptine in the indigestion of infants; in fact, it is much of a routine treatment, and the results have always been highly satisfactory. Infants need it when indigestion is more or less chronic, and it will do valiant service in correcting the difficulties of digestion here encountered. In addition to medical care, much attention must be given to the hygienic surroundings of the child, its bath, its outdoor life, its exercise, the water it drinks, and the quality and quantity of food taken.—F. P. NORBURY, M.D., *Medical Fortnightly*.

AMPUTATION OF OMENTUM IN HERNIA.—(1.) All irreducible hernias should be operated upon unless contra-indicated by age or condition of the patient. (2.) All omentum found outside the abdomen, or that will protrude under gentle traction, should be removed. (3.) Multiple, independent ligatures of good-sized silk, which surround the vessels alone, or small pieces of fatty tissue, are believed to be safer than other methods. (4.) The use of some film-forming substance, as aristol, on the stump is believed to protect in a measure from subsequent adhesions.—*De Garmo*.

ACNE.—

R Camphore	0·30 gm.
Acidi salicylici	0·50 ..
Sulphuris precipitat	10 ..
Zinci oxidi	2 ..
Saponis	1 ..
Ol. delphin	12 ..

M. Make one application each night, wash the face in the morning with soap and warm water. The camphor in this mixture is for the purpose of masking the disagreeable odour of the oil.

—*Jour. de Méd. et de Chirurgie*.

A PROMOTER OF PARTURITION.—Robert B. McCall, M.D., writes:—

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THE EDINBURGH MEDICAL JOURNAL

On ANTIKAMNIA.

"This is one of the many coal-tar products which have lately been introduced into medicine. . . . In doses of three to ten grains it appears to act as a speedy and effective antipyretic and analgesic."

THE QUARTERLY MEDICAL JOURNAL (of Yorkshire)

On ANTIKAMNIA & SALOL TABLETS.

"Have a specially beneficial effect in the treatment of acute rheumatism, and of the rheumatic pains that frequently persist after an attack of Influenza. Very handy for dispensing and for administration."

THE MEDICAL MAGAZINE

On ANTIKAMNIA.

"This is one of the latest discovered of the many very useful drugs derived from coal-tar, and from experiments we have made we are in a position to say that we consider it a most valuable addition to the list of new drugs."

"We have had opportunity of testing Antikamnia in three cases of facial neuralgia. In all of the three cases repeated doses of five grains gave relief, and in two cases the pain did not return. In no case was there any gastric disturbance. We also tried the drug in a case of acute rheumatic inflammation of the wrist and hand accompanied by considerable pyrexia. In this case its action was also satisfactory. The pain was at once relieved, and after three five-grain doses, repeated at intervals of forty minutes, the temperature was reduced from 103.4° to 99.2°. In one other case, one of hemicrania, we also got most satisfactory results."

Blaisdell SELF SHARPENING Pencils

are in use (in preference to cedar pencils) at

THE WAR OFFICE
BANK OF ENGLAND
NEW ZEALAND GOVERNMENT OFFICE
BANKER'S CLEARING HOUSE
UNITED STATES GOVERNMENT OFFICES
OXFORD UNIVERSITY
CAMBRIDGE UNIVERSITY
ETON COLLEGE
UNITED STATES ARSENAL
UNITED STATES NAVY
PENNSYLVANIA AND OTHER AMERICAN
RAILWAY COMPANIES
THE LONDON STOCK EXCHANGE
NORTH BRITISH AND MERCANTILE AND
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LONDON AND WESTMINSTER BANK,
CITY BANK, LONDON AND SOUTH-
WESTERN BANK, AND OTHER LONDON
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IN THE OFFICES OF THE LONDON AND
NORTH-WESTERN RAILWAY, MIDLAND
RAILWAY, GREAT NORTHERN RAIL-
WAY, GREAT EASTERN RAILWAY,
LONDON, BRIGHTON, AND SOUTH
COAST RAILWAY, SOUTH-EASTERN
RAILWAY, LONDON AND SOUTH-
WESTERN RAILWAY, LANCASHIRE
AND YORKSHIRE RAILWAY,
CALEDONIAN RAILWAY, AND OTHER
RAILWAY COMPANIES.

HOW USED.

Start the paper with a pin or any pointed instrument—a slight pull—off it comes, and the lead pencil is sharpened. **Thirty Fresh Points to every Pencil.** The only wear is from use, not from whittling away or breaking the lead.

No wood chips are left on the floor, nor any dirty marking-stuff on your fingers.

What the Newspapers say of the BLAISDELL SELF-SHARPENING PENCIL

Truth.

"There is no limit to the ingenuity of the Americans in improving upon the ordinary paraphernalia of daily life. The other day I found my office table provided with a set of new editorial pencils—red, blue, and black. Being struck by something unusual in their appearance, I made inquiries, and discovered that they represented the latest Yankee notion in lead pencils, the lead being mounted in a stick of tightly-packed paper instead of wood. The paper is laid on in layers, and the advantage of the arrangement is that when the point is broken or worn down, you tear off one layer of paper, and a new and perfectly symmetrical point is instantly produced without any further process of sharpening. This is called the 'Blaisdell' pencil, and if Blaisdell is the inventor, I hope he may make a fortune out of it."

The Queen.

"What an improvement this is upon the old laborious process of pencil sharpening, and how much less extravagant with regard to the consumption of the lead, which cannot snap off when thus treated!"

Westminster Gazette.

"It is decidedly an ingenious idea."

Black and White.

"The 'Blaisdell self-sharpening paper pencil' is a remarkably smart contrivance. The lead is encased in paper, which can easily be unrolled when a fresh point is required."

The Lady.

"A self-sharpening paper pencil does not sound a very promising invention, but anyone who becomes possessed of one of the Blaisdell variety will acknowledge at once that it is a very ingenious little article. These pencils need no knife to sharpen them, as, by simply tearing off a little roll of paper at the end, a new point appears. They are made in black, red, or blue, for office work, and are well worthy of a trial."

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"One of the latest inventions that tend to make literary life better worth living is the Blaisdell Paper Pencil. Penknives, blackened thumbs and unparliamentary language when the point snaps short at an important moment are now at a discount. All that the writer or reporter has to do is to insert a pin in a spot indicated on the pencil-stem, and, lo! a little roll of paper unfolds like a diminutive shaving, or a released curl, and a fresh, already sharpened point appears to gladden his eyes and stimulate his harassed brain."

HOW SOLD.

Ask for the BLAISDELL SELF-SHARPENING PENCIL at any stationer's. The BLACKLEAD PENCILS are made in 5 Grades: H.B; H; B; H.H; B.B; finest Bavarian Lead, equal to the highest quality of Artists' Pencils. COLOURED CRAYON PENCILS in Blue, Red, Yellow, Green, and Black, tough and smooth, rich in colour.

If your stationer does not sell them, send 1s. for set of sample Pencils to—

BLAISDELL PAPER PENCIL CO., LTD.,
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Fountain Pens and Stylographic Pens

*The objections to them
and how they have been met.*

Ceteris paribus everyone would rather use a fountain pen that carries its own ink, and can, therefore, be used anywhere and at any moment, in preference to an ordinary pen, which has to be dipped in the ink every minute or so.

But fountain pens have acquired a bad name from two or three general objections to them. "A fountain pen is all very well," people say, "but it has to be carried upright, otherwise the ink comes out in your pocket; in fact, the ink spills and makes a hideous mess on the smallest provocation. By way of compensation, when you want to write, the ink retires to the barrel (if it isn't all spilled into your pocket) and refuses to emerge until the pen has been shaken and thumped until it squirts out a blot on the carpet."

This used to be true; but the CAW PEN has met the difficulty. It does not have to be carried upright; it can be carried sideways, upside down, or in any position whatever. The ink cannot possibly spill, because it is in a hermetically closed chamber, screwed tight. There is *no air-hole*.

The pen can be jerked or thrown about as much as you please; it cannot spill. On the other hand, until the CAW PEN is opened for use the nib (which is a gold one of the finest quality) is immersed in the ink. Consequently it writes at once, without giving any trouble.

The CAW PEN is not merely the *only* fountain pen which anyone cares to use who has once seen it as a pocket pen, but it is so convenient for desk use that it supersedes all other pens whatever.

It is easily filled, and having a wide mouth does not clog with air bubbles during that operation. Prices from 12s. 6d.

"Caw pens have a repute beyond their neighbours."—*Westminster Budget*.

The objection to Stylographic Pens is that the point rarely suits the writer's hand, and cannot be adjusted.

The CAW STYLOGRAPHIC PEN can be adjusted in an instant. It has not all the advantages of the CAW FOUNTAIN PEN; but for people who prefer a stylo this is the best stylo on the market. Prices from 5s.

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