Clinical Notes

scopically the urine showed blood cells, casts, bladder cells, and numerous ova of Bilharzia hematobia. This is a very interesting case, as the patient, according to his own statement, had never served in any country except England and India. In both countries this disease has not occurred except as imported cases. Lately many men have been found suffering from it in India who had served in South Africa during the war. If this parasite has found a suitable host in India there is great danger of this serious disease becoming endemic.

TWO CASES OF OVARIOTOMY AT THE LOUISE MARGARET HOSPITAL, ALDERSHOT.

By Lieut.-Col. W. Watson Pike, D.S.O., R.A.M.C.

Case I.—Mrs. Q. was admitted in February, 1903, with slight ascites and a small tumour in each ovarian region. She had twins on two previous occasions, once at the fourth month and once at full term. She suffered from very little discomfort, and though strongly recommended, would not agree to an operation. After a month's rest she was somewhat relieved and left hospital. In June last she was admitted in a state of collapse—she could not lie down on account of the fluid in abdominal cavity causing dyspnoea. I at once removed 280 ounces, and two days after 320 ounces more; this gave immediate relief. The tumours now were seen to be multiple on both sides. Owing to her weakness operation was then contraindicated; she took nourishment well and her general health improved. The fluid returned rapidly.

I pointed out to the patient and her friends that without operation there could only be one termination of the disease, and with operation there would be a chance, though a very slight one, of life. They then agreed and expressed regret at not having done so in February, when she was in first.

Two days prior to the operation I tapped the abdominal cavity and removed 400 ounces of clear fluid. On July 28 gas and ether was administered, and I opened the abdomen in the mesial line below umbilicus. The growths on the left side were found to be closely adherent to the adjacent parts, but more particularly to the sigmoid flexure and rectum. The largest cyst was tapped, and with as many others as possible removed, but portions of cyst wall had to be left where the adhesions were too firm for separation. About fifteen cysts were removed varying from the size of a walnut to an orange.

Five cysts were removed en masse from the right side, and as the patient was becoming weak I had to operate rapidly. The abdominal
Clinical Notes

cavity was washed out with boiled water, temperature 110°, which, acting as a stimulant, temporarily relieved shock. The incision was closed and a glass drainage tube placed in lower angle leading into Douglas' pouch. Patient was placed in bed with hot bottles, &c.; shock was very severe. An enema of brandy 1 oz., hot water 2 oz., was given, and later on an enemata of Valentine's Beef Juice, with hypodermic injections of strychnine, and also ether. However, she gradually sank and died fifteen and a half hours after operation.

A limited post-mortem examination was made, which showed all ligatures were intact and there had been very little oozing. Sections were made from the fibro-cystic tumours removed, which showed no signs of any malignant tendency, though the naked-eye appearances of those on the left side gave me that idea.

Case 2.—Mrs. B. was admitted on August 17, 1903, with large ovarian swelling. She had had four children, the last a year ago. She noticed the swelling about three months ago and stated it first appeared on the right side, but a few days before admission something gave way and it rose "suddenly up to the navel." She had great pain and was sent in from Pirbright in a cab.

On September 7, when her general health was improved, I opened the abdomen in mesial line below umbilicus and found a fibro-cystic tumour of left ovarian region, 12 in. by 15 in.; the pedicle was tightly twisted, and the tumour, which was of a livid red colour, had formed adhesions to the surrounding parts, most of them recent, and all readily gave way except that of the transverse colon, which was very dense. There was a good deal of oozing. The abdomen was washed out with boiled water, 200 parts to 1 of carbolic acid, at a temperature of 110°, till the solution returned clear; most of this was then pressed out. I closed the wound with two rows of interrupted silk sutures, first peritoneum and then the walls, and placed a glass drainage tube in Douglas' pouch. Boric acid and carbolic lotion was then rubbed into the skin of the abdomen, and gauze dressings applied and kept in position by an eight-tailed bandage. I removed the fluid from the tube every two hours for the first twenty-four, after which it was dry and I removed it. The temperature, which had ranged from 99° to 103° before operation, dropped to normal on the second day, and remained so throughout convalescence. I removed the sutures on the seventh day, when the wound was completely healed, and the patient made an uninterrupted and satisfactory recovery.

Remarks.—I think these cases point to the very great danger of delay in operation when once a tumour is detected in this region of the abdomen (ovarian). Delay not only allows the general health to become impaired, but favours the strengthening and occurrence of adhesions which are the recognised "bugbear" of abdominal operations.
The chances of recovery were rendered practically nil in the first case when operation was refused when first under treatment.

NOTES OF A CASE OF CEREBRAL EMBOLISM DUE TO MALARIA.

By Major J. B. Wilson, R.A.M.C.

Pte. A. S., 1st Hampshire Regiment, was admitted to the Station Hospital, Lucknow, on October 6, 1902, for ague. His health previous to that time had been good. He was brought before an Invaliding Board on January 26, 1903, at Lucknow, and was sent home to England in the "Sardinia," on April 10, 1903. Altogether he spent 169 days in Hospital at Lucknow. During this time he is stated to have had a rise of temperature almost every evening.

He arrived at the Royal Herbert Hospital, Woolwich, on May 5, 1903. There is a note on his invaliding documents to the effect that he improved on the voyage. On arrival at the Herbert Hospital, although he was very anaemic, he did not show any graver symptoms than the other invalids from tropical malarial disease.

After a day or two, however, he got an attack of fever, evidently of a serious nature, and on May 10, 1903, was handed over to my care. His condition at 10 a.m. on that date, when I first saw him, was as follows: temperature 100.8°, pulse 80, respiration 26. The patient was lying in bed in a semi-conscious condition. The peculiar earthy pallor of malarial cachexia was well marked. The pupils were dilated, but equal. The patient could be roused, and could evidently understand what was said to him, but soon relapsed into a vacant, semi-conscious condition. When roused, and when he tried to reply to questions, he was found to be partially aphasic, but not aphonic. He made sounds and used words which had obviously no relation to what he wished to say. There was marked deflection of the tongue to the right on protrusion. There was spastic irritation of certain groups of muscles in the right shoulder and arm. In the forearm the extensors were affected in this way. The hand would not shut easily, and when it was closed it opened again and the fingers came to the position of hyper-extension.

At this time there was no paralysis, except partially, that of speech. Later, paralysis of the muscles on the right side of the face came on and gave rise to the characteristic puffing out of the cheek on expiration on that side. The tongue was coated with yellow fur, the breath very offensive. The bowels were constipated. The liver on percussion was not enlarged. There was, however, a slight increase in the area of splenic dulness, showing enlargement of that organ. Careful examination revealed nothing abnormal in the heart and lungs, and there was no albumen...