again and was told to keep very quiet. The following day, however, she returned, as the haemorrhage recommenced, later becoming severe. On examination, the os would not admit one finger, but as unavoidable haemorrhage was strongly suspected, the vagina was tightly packed with pieces of gauze. These were left in for some ten hours and the patient carefully observed; at the end of this time the plugs were removed and the patient examined again. The os now admitted two fingers, the occiput was presenting and the margin of the placenta could distinctly be felt. The haemorrhage, on removal of the plugs, became very severe; therefore, determined to put her under chloroform and turn at once. The patient was put completely under the anaesthetic, and as soon as the uterus was sufficiently relaxed bipolar podalic version was performed, the haemorrhage at this stage being most alarming, for the blood was pouring out almost like a tap of water. The turning having been successfully performed, a foot was brought down with great difficulty, since the os would only admit two fingers and the parts were extremely slippery, due to the blood. As soon as the foot was brought well down so that the child's thigh plugged the os, the haemorrhage ceased entirely. The patient was left with the foot protruding at the vulva, with a cloth soaked in antiseptic wrapped round the child's foot to prevent it from slipping back, and carefully observed. A few hours afterwards uterine contraction began and a still-born child was delivered ten hours later as an ordinary breech case. The placenta was born within half an hour and it was then seen that a secondary placenta (placenta succinturiata) had probably been the cause of all the trouble. This secondary placenta, about 9 inches in circumference, was quite distinct from the primary, an interval of 2 inches separating them, with the membranes intact between. The child, which had been dead for some hours, showed a deep depression round its thigh, indicating how strongly it had been pressed upon by the os. An antiseptic intra-uterine douche at 120°F. was given. The puerperium was normal from beginning to end, and on the tenth day the patient left the hospital. It is interesting to note that there was no secretion of milk, and that the patient began normal menstruation two months later and is now in excellent health.

A CASE OF GENERAL PERITONITIS FOLLOWING ABBCESS OF THE LIVER.

BY LIEUTENANT T. J. WRIGHT.

Royal Army Medical Corps.

PRIVATE T., Manchester Regiment, was admitted to the Station Hospital, Wellington, on April 5th, 1906, with the following history:—During his fifteen months' service in India he has had dysentery on two occasions, neither of which, he states, was sufficiently severe to render him unfit for his duty. He has been a heavy beer drinker. His present illness began on March 27th, a week before admission, with dysentery,
which lasted three days. On April 2nd he began to suffer from headache, loss of appetite, and a feeling of weight and fulness in the right hypochondrium.

**Condition on Admission.**—Patient lies on his back, with face flushed, eyes bright, conjunctive somewhat bile-tinged, tongue dry and brown, bowels confined, temperature 101° F.; he says he feels comparatively well, with the exception of a dragging sensation in the right hypochondrium; urine normal, heart and lungs healthy. Liver is enlarged about an inch and a half below costal margin, but—there is no enlargement in an upward direction—pain is elicited on deep pressure, most marked at the costal margin in the nipple line. Patient was placed on plain milk, fomentations were applied over liver, and ten grains of ammonium chloridum given internally three times daily. During the next forty-eight hours his condition showed no improvement; the liver enlarged another inch below costal margin, and the pain and tenderness, although more localised, became more severe. On a blood count being made, a marked leucocytosis was found to exist, on account of which, together with the clinical aspect of the case, patient was given an anaesthetic, and on aspirating through the eighth intercostal space, mid-axillary line, a small abscess was discovered in the right lobe of the liver, which was opened, drained, and a tube inserted. Patient’s progress, after this operation, was satisfactory for eight days, at the end of which he began to complain of cramp-like pains in the abdomen, which were chiefly felt round the umbilicus. On examination, the abdomen was somewhat full and tympanitic, but there was no marked tenderness. During the next three days patient’s condition gradually became more grave, pulse increased in frequency, and all the symptoms of general peritonitis developed.

Operation was decided on, and as the rigidity and tenderness was most marked over the region of the caecum, Lieutenant-Colonel G. Cree, R.A.M.C., opened the abdomen by a vertical incision through the right rectus sheath, when a quantity of bile mixed with thin sero-pus escaped. The peritoneum was much congested, the large and small intestines were distended, and of a dark red colour, and the tissues very soft. On the fingers being passed to the back of the caecum a long gangrenous appendix was felt, and with difficulty freed from adhesions and brought to the surface; as patient’s condition at this stage of the operation became very weak, the appendix was hurriedly removed, and the abdomen, having been thoroughly flushed out with hot normal saline solution, two long strips of gauze were inserted, one reaching to the inferior border of the liver, and the other well into the right iliac fossa. The abdomen was then stitched up. The day after operation, under an anaesthetic, the gauze plugs were removed, the abdomen was again washed out with saline solution, and rubber drainage tubes were inserted. This washing out of the abdomen was continued daily for three days, at the end of which the returning fluid became quite clear; patient has made an uninterrupted recovery, and was discharged from hospital on June 8th, 1906.
Clinical and other Notes

Remarks.—The chief interest in this case, I think, lies in, What exactly was the cause of the general peritonitis?

I am inclined to think it was due to a fistulous communication between the liver abscess, which was quite superficial, and the peritoneal cavity, the condition of the appendix being probably part of the general peritoneal inflammation. The existence of leucocytosis I have found to be of the greatest value in helping to diagnose liver abscess in its earliest stage, more especially as our great pus indicator, the pulse rate, is usually masked by the presence of bile in the general circulation.

NOTES ON A CASE OF EXTENSIVE FRACTURE OF THE SKULL, FOLLOWED BY MIDDLE MENINGEAL HAEMORRHAGE.

By Captains A. H. Waring and W. C. Croly.
Royal Army Medical Corps.

This was a case of a sergeant, aged 29, who was thrown from his horse on September 23rd, 1904.

An onlooker gave the following account of the accident: "Sergeant L. was cantering on the grass when his horse swerved to the off side and the rider lost his balance, but clung with his right arm around the horse's neck, then fell just in front of the horse, striking the ground with his left shoulder and left side of head; the horse kicked him as he reached the ground." When I (W. C.) reached the patient, about ten minutes after the accident, I found him lying on the ground in a semi-conscious condition and breathing heavily, blood trickling from both nostrils and from mouth; slight bleeding also from right pinna. Patient was restless and trying to sit up, and his friends were restraining him. He could not be roused sufficiently to answer questions. It was noticed that in his attempts to rise his left arm and leg remained motionless, but right limbs were free. Pupils even, slightly contracted and fixed. A large, pulpy contusion was found extending from the right parietal eminence downwards and forwards towards the right ear; he also had ecchymosis of right eye. No escape of cerebro-spinal fluid. Pulse full and about 80 per minute. His friends stated that patient vomited blood once shortly after the accident.

On arrival at hospital patient was placed in bed, calomel administered, and bladder attended to. On examining his mouth blood was seen trickling down the sides of the pharynx. Breathing now was stertorous; pulse full and about 60 per minute. He had paralysis of left arm and leg; pupils equal, dilated and fixed. The case was seen by Captain A. H. Waring in consultation, and shortly afterwards by Lieutenant-Colonel T. Daly, Senior Medical Officer. It was decided to trephine over the anterior division of the right middle meningeal artery, so patient was placed on the operating table without further delay.