and lips—stomatitis and herpes; and in the other case involving the anus and setting up a herpetic eruption which one occasionally, but rarely, I admit, is found there. From the above, I think it will be seen that herpes on the lips and anus when occurring in connection with pneumonia is the result of extension of inflammation and not nervous in origin. As to its value in prognosis when present it may be of favourable import; but, on the other hand, if absent, one should not look on the case as being unfavourable as to recovery, at any rate as far as the Native of India is concerned. Osler, to quote a good authority once more, gives the hospital death-rate of pneumonia as 20—40%. In my 25 cases I had four deaths, or 16%, and that, when the very inferior nursing and comforts, which the sick sepoy gets when ill be taken into account is, I think, most satisfactory.

Hence, although herpes was not present in any of the above cases, still the mortality was, I think it may be said, very low. It would be interesting to know what is the general opinion concerning the frequency of the presence of this little symptom in pneumonia cases amongst the Native of India and also intrinsic value giving a prognosis.

[Herpes labialis, we have noted in cases of pneumonia, but it is also common after purely malarial attacks, and is the only skin rash that we have noted in a series of some 60 cases of cerebro-spinal fever, in which we have found it very common, but of no special prognostic significance.—ED., *I. M. G.*]

A Minor of Hospital Practice.

CASES IN S. STEPHEN'S MISSION HOSPITAL, DELHI.

BY MILDRED E. STALEY, M.B. (LOND.)
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Case I.—Porro's operation ("Puerperal Hysterectomy"). *Zagrâni*, Hindu, aged thirty-five. Four children, but none for the last ten years, during which she has been bedridden from osteomalacia.

The patient when first seen had been in labour for five days, and as the *dais* had fled some three days before, she had been without food or attention of any kind. Owing to the extreme distortion of the pelvis and general contraction, the finger could not reach the presenting part, and as the fœtus was dead, and from the odour decomposing, it was at once decided to do Porro's operation even though it was midnight, and the operator was quite alone.

With the help of the trained (native) nurses of the hospital, all was ready within half an hour of her admittance, and after a hypodermic injection of strychnine had been administered, the abdomen was opened by the usual incision in the mid-line, reaching down to within two inches of the pubis.

Immediately coil after coil of distended intestine was extruded, till several feet of it lay outside the patient, but as time was such an object, no attempt was made to deal with it, beyond covering it well over with several warm towels out of the sterilizer.

Next, a piece of strong rubber tubing (No. 14 E. catheter size) and about twenty inches long, was passed twice round the cervix as high up as possible, *i.e.*, immediately below the presenting head, tied once only, and clamped temporarily with a forceps.

The uterus was now packed well round with sponges and sterilized gauze so as to isolate it as far as possible, and an opening made in the fundus with a scalpel. This was at once enlarged downwards by cutting through the whole thickness of tissue with scissors the full length of the uterus when the putrid fœtus was extracted by the feet and separated.

Owing to the elastic ligature there was little bleeding, and the after-history proved that the abdomen and intestines remained free from infection of the putrid contents of the uterus.

The uterus, *with secundine intact*, was now easily delivered outside the abdomen, the clamp was removed, and the rubber tubing pulled thoroughly taut and doubly tied, the uterus being then cut off with scissors well above it.

The abdomen was explored with sponges on long handled forceps, but proved to be quite dry; the stump was carefully trimmed, and the mucous membrane left in its centre thoroughly scraped away (as it tends to decompose if left), and last of all the intestines were returned coil by coil into the abdominal cavity.

It only remained to fix the stump into the lower angle of the wound, pedicle pins being inserted above the elastic ligature.

As the contents of the uterus had been so offensive, a Keith's glass drainage tube was inserted at the lower angle of the wound, to be withdrawn in a day or two. The abdominal wound was closed by ten silkworm gut stitches passing through the whole thickness of the parietes; no attempt was made to sew the parietal peritoneum to the base of the stump as recommended in the books, as it practically appears to make no difference, and wastes much precious time.

The upper part of the wound was powdered with Boro-iodoform and dressed separately from the stump on which powdered boracic acid was freely dusted, and dry iodoform gauze and wool completed the whole dressing.

So feeble was the patient's condition on admission that only a few whiffs of chloroform

could be administered just at the beginning of the operation, while stimulants were given hypodermically throughout.

After-history.—There never was any appreciable rise of temperature, and the stump separated on the eighth day.

A few hours afterwards the dressings were found soaked with blood, which, on opening up the wound, was found to be welling up from the deep stump cavity. On plugging this up tightly with strips of dry iodoform gauze, hæmorrhage ceased and did not recur.

For the first day or two some very foul fluid was extracted with the syringe from the Keith's tube, showing the need of drainage in such a case.

The after-treatment consisted in careful feeding with tiny quantities of Brand's Essence, and of milk alternately every hour (rectal alimentation was found impossible in this case) with stimulants administered both by the mouth and hypodermically, as needed.

The bowels opened naturally on the third day, and the patient is now (fourth week) perfectly convalescent.

Case II.—Cæsarean Section. Pyari, Mahomedan, *pardah-nashin,* aged thirty. Her last child was delivered by high forceps four years before, since which time she had been bedridden with osteomalacia, and there was extreme lordosis of the spine, while the deformity of the pelvis made it difficult to even reach the os.

As the F. H. S. could be heard, and the anterior conjugate was under one and a half inches, Cæsarean Section was decided upon, and consent obtained.

The patient being anæsthetized, and the abdomen opened by the median incision reaching to within three inches of the pubis, the uterus was exposed and isolated by sponges inserted into the abdomen. The assistant grasped the sides of the abdomen, pressing them against the uterus, which was then rapidly opened by the same method as described above. The placenta was found lying in front of the fundus and had to be torn through in order to reach the legs of the child, which was extracted alive without difficulty.

The placenta and membranes were rapidly removed manually and the uterus massaged with hot sponges while the stitches (of medium Chinese twist sterilized) were being inserted.

As the uterus contracted well, there was no need for applying the elastic ligature to the cervix, as is sometimes found useful where there is hæmorrhage, while the sutures are being inserted by Sänger's method.

It was intended to remove the ovaries at this stage, but the patient's condition became so bad that the operation had to be concluded as rapidly as possible.

With stimulants, and hot rectal injection, the patient rallied well from the operation, and made an uninterrupted recovery.

Case III.— Anandie, Mahomedan *purdah nashin,* also one of Cæsarean Section, is mentioned to show the dangers of delay and previous interference where an abdominal operation is clearly indicated.

This patient had only been in labour three days; osteomalacia was far advanced, and there was extreme distortion and lateral contraction of the pelvic cavity, though it was possible to make out the presenting head with the writer's small hand in the vagina.

The friends at first absolutely refused to hear of Cæsarean Section, and as the poor woman was begging to be put out of her misery, craneotomy was quickly performed. But even then it was found to be impossible to extract the head or deliver the child, and on seeing this, the family at last consented to the abdominal method—fearing the disgrace of the patient dying undelivered. Thus it was not till after three precious hours had been wasted, that Cæsarean Section was performed by the usual method, as above described. In this case, as the child was dead, and the patient exhausted by all she had gone through, the rubber ligature was applied to the cervix before opening the uterus, and very little blood was thus lost.

The patient never rallied properly after the operation, and in spite of transfusion, stimulants, &c., sank quietly after some twenty hours, yet another victim to the ignorance and prejudice of (so-called) educated men of this country.

REMARKS.

1. *Delay* in either preparing for or performing Cæsarean Section and hysterectomy is to be avoided. Hence the need of keeping in perfect readiness every thing needed for these serious operations, e.g., *sterilizers* are a necessity, so that all towels, dressing, &c., can be ready in half an hour if need be—even in the middle of the night. One might mention too that sponges of sterilized absorbent wool sewn up in bazaar gauze sterilized, should be kept in readiness, while even the thorough cleansing out of the vagina can be left till after the operation is over.

2. The parietal incision for Porro's operation needs to be carried an inch lower than for Cæsarean Section, *i.e.*, to within two inches of the pubis, so as to fix the stumps more easily afterwards. One-third of it should lie above the umbilicus.

3. The cut in the uterine walls should not be carried too low down, lest the uterine arteries be endangered. The anterior reflection of the peritoneum off the uterus is a good guide.

It is unnecessary to waste time in trying to determine the seat of the placenta in order to avoid incising it; as in Case II, where it is lying

right in the line of incision, it can be plunged through and removed quickly after the extraction of the fœtus with the hand.

4. It seems also unnecessary to wait patiently for the placenta to detach itself spontaneously, as books recommend; the uterus contracts best, and the bleeding only ceases after it is empty, and delay is always dangerous. In Porro's, it need not be removed at all.

5. There is no need to apply the rubber ligature round the cervix, in a Cæsarean Section case, except when severe hæmorrhage occurs from the uterine wound when it can (if handy) be applied in three or four seconds.

6. The rubber ligature for the stump in Porro's operation is in my experience far a more satisfactory than a Kœberle's Serre-nœud, or any other. In five cases, I have used it four times, and they have invariably been satisfactory; also one has not the worry of taking care of the long metal handle, which often prevents one from turning the poor deformed patient on her sides, a great relief to those with lordosis, or congested lungs.

7. In Porros' operation it is quite unnecessary to spend precious time in carefully sewing the parietal peritoneum to that of the stump below the ligature, as I myself used to think important; now I merely see that the stump is well raised and fixed up in the lower angle of the wound, while the peritoneum is tucked down below the rubber ligature, in good contact with the peritoneal surface of the stump, to which it rapidly adheres.

8. There is also no need to deliver the uterus outside the abdominal walls in Cæsarean Section, even after delivery of the fœtus, as often done; sutures, &c., can be well applied while the uterus is still in the abdomen,—and provided a fairly intelligent assistant will keep the parietes pressed against the uterus, no evil results, and there is less danger of infecting and bruising its walls.

9. The method of suture mentioned above is as follows—

First, the peritoneal covering is detached for a slight distance (with the handle of the scalpel) along the margins of the uterine wound.

Next, deep sutures of silk are inserted through the muscular and serous (but not mucous) layers of the uterine wall, and *left loose* till the superficial ones have been put in. These are passed twice through the serous membrane on each side, so as to bring a good surface of it together, and are then tied, the deep sutures being last of all drawn tight and tied. This effectually closes the wound from the abdominal side; if all is trusted to deep sutures through the muscular wall, the retraction of the uterus will soon leave these loose and give a weak union as a result with perhaps escape of discharges into the peritoneal cavity.

10. Regarding after treatment, I can only say that these puerperal cases seem able (from our experience) to digest food by the mouth from the very beginning, and consequently food is given in small but increasing quantities every hour that way, as well as per rectum. But too often there is no chance of preparing the patient beforehand, and so rectal feeding is found to be difficult.

The recovery of the two cases mentioned above was, without doubt, due to the ceaseless watchfulness and devotion of the (Native) trained nurses of this hospital; it seems hardly fair to perform such operations unless one can be sure of properly caring for the patient afterwards.

SOME CASES OF MALIGNANT PUSTULE.

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Anthrax is endemic in Kashmir, and every year two or three cases of malignant pustule are seen at the Mission Hospital.

Wool is exported, and Dr. Bell, of Bradford, informed me that Kashmir wool is a frequent cause of 'Woolsorter's disease,' especially in its pneumonic form.

The cases briefly narrated below occurred during last winter, and are of interest on account of the history which is clearer and more connected than one is usually able to obtain in this country.

In the village of Kanda, 8 miles from Srinagar, last autumn (1900) there was much disease among animals, fowls as well as sheep, goats and cattle died. A woman was attacked by malignant œdema of the chest and neck and died within 48 hours. Her brother-in-law, Hasan, came to hospital on January 8th with a history of eight days' illness, fever and pain, and showed a typical pustule over the lower ribs on his right side. *Appearance*.—A patch of œdema with redness extending for two inches around an angry button shaped pustule, resembling an inflamed vaccination pustule about the 8th day.

General condition.—Not bad; temperature only 99·4.

Treatment.—I excised the pustule freely, and united the edges of the wound.

Progress.—The temperature dropped to normal, and remained so. On the 15th he complained of cough with pain in his side; but this passed off in two days, the wound healed by first intention, and he left cured on the 19th January. Four days later his brother Nura came in with a similar pustule on his right shoulder, and with œdema and erythema extending over his face and neck. The pustule was treated by actual cautery. On the fifth day of disease the temperature rose to 104° but five days later sank to normal and continued so. The erythema spread gradually over the body, but became