and happy, and is equal to a walk of two miles. From November, 1911, to February, 1912, each menstrual period brought on a severe crisis of vomiting and weakness, and Dr. Speirs had been summoned each time. Since operation last March the menstrual periods have come and gone without any trouble whatever. The pigmentation is distinctly less, and the patient has gained in weight to the extent of about one stone since leaving hospital. The blood-pressure on June 19th, when the case was shown at a clinical meeting of the British Medical Association, was 104.

Knowing the transient nature of the improvement in cases in which the other ductless gland—the thyroid—has been transplanted, no claim is made at the present moment that the case should be ranked as a cure. Time alone will show whether sufficient functional activity will take place in the transplanted organ to continue to supply the needs of the body. Cases of this kind are so rare in literature that the publication of this case, in which, three months after the transplantation, the patient is in a condition of good health, good spirits and activity, with the characteristic signs and symptoms of the disease fast diminishing, must be of interest and profit. The future history of the case, whether for good or ill, will be recorded for similar reasons.

To Dr. Speirs I owe this interesting case as well as the suggestion of transplantation. To my lot fell the doing of the work and the exercise of discrimination in determining the nature of the graft.

NOTES ON A CASE OF COMPLETE RUPTURE OF GRAVID UTERUS.

ROBERT SCOTT, M.D., C.M.
(Hon. Surg. Ballarat Hospital).
WILLIAM SLOSS, M.B., F.R.C.S., Edin.

(Read before the Ballarat Division.)

Mrs. R., aged 32, was quite healthy until she was married at 19 years of age. One year later her first child was born without any special trouble—this child, now 12 years old, is apparently quite healthy. 2½ years after this, when she was 7½ months pregnant, she slipped on a brick and "fell on her stomach." This caused her great pain; she vomited blood several times in large quantities, besides passing blood per vaginam. Six weeks later she gave birth to a dead foetus, and was attended by a nurse only. Her third and fourth pregnancies came away at the sixth month; her fifth at the third month; her sixth at the fifth month; her seventh at the sixth month. Her eighth was full time, but had probably been dead in utero several days. In this case the after-birth had to be removed manually, which apparently was accomplished with great difficulty by a doctor who had been called in several hours after. She contracted next day what she termed "blood poisoning," and said that she was curetted three times. She was very ill, and did not recover for at least three months. The placenta on the sixth, seventh and eighth occasions was abnormally large, particularly so on the eighth. For several months after this she was under treatment, and again became pregnant towards the end of February, 1911. Having now removed to Ballarat, she engaged me to attend her about the end of November. On Saturday, December 9th, when examining her abdomen, I could not detect any foetal heart, and the peculiar feeling of the uterus gave me the impression that the foetus was dead. She herself had not felt "life" for several days. I advised her removal to the "Nursing Home." The following day she was getting rather anxious, and, mainly as a placebo I ordered 4 grains of sulphate of quinine to be given. Next morning, after telephone message about 9 o'clock, I called, and was told that slight pains started about 4.30, and a couple of "good ones" about 7. She also had a slight "show." I examined and found cervix dilated to admit one finger, but could make out no definite presentation. She complained of pain on my palpating the abdomen. On the presumption that these pains were partly due to the medicine taken, I gave ⅛ of a grain of morphia hypodermically. At 12 o'clock she said that her stomach was a little sore, but that the pains had practically disappeared. I called again at 5.30, and the dilatation just admitted two fingers. Temperature was then 100deg. F., and pulse 120 per minute. Patient was somewhat drowsy and had an anxious look. The conformation of the abdomen was rather peculiar—somewhat barrel-shaped. I decided not to delay, and got Dr. McGowan to give an anaesthetic. When she was under, I found on vaginal examination two fingers easily passed into the cervix, which seemed only partially taken up. Beyond the internal os a rent could be felt, through which the finger entered the cavity of the abdomen, touching what appeared to be the peritoneum, and a little at the side, a substance which felt like the placenta. I told Dr. McGowan, and he took the pulse and found it was under 90. I again examined, and found my finger went into the empty contracted uterus. The diagnosis could only be a rupture of the uterus, with the escape of the foetus and after-birth into the peritoneal cavity. Dr. Robert Scott, who was telephoned for to bring the necessary instruments, was soon on the spot, and performed, under very adverse conditions, a laparotomy. As rapidly as possible, a long incision was made from above the umbilicus to within two inches of the symphysis, and the abdomen opened. The peritoneal cavity contained a large amount of blood, the foetus—macerated—the placenta and membranes were lying in the left hypochondrium. The peritoneal cavity contained the liquor amnii, and probably some meconium and vernix caseosa. The uterus was firmly contracted. During the delivery of the child, Dr. McGowan, who was giving the anaesthetic, remarked that the patient was suffering markedly from shock, even though both it and the placenta had been free in the abdominal cavity. A hypodermic of 1 c.c. of 20% pituitary extract was given. The uterus was examined, and the laceration extended from just above the internal os

along the right side to well above the attachment of the round ligament. The edges were very irregular, and separated in a V shaped manner, owing to the contraction of the uterus. The uterus was removed supra-vaginally as rapidly as possible, and with some difficulty on the right side, owing to the extensive laceration. A Mikulicz gauze drain was inserted owing to the amount of blood, the amniotic fluid, etc., which were in the abdomen, and also because the peritoneal toilet had to be performed with the greatest rapidity. Before inserting the drain a large amount of normal hot saline was literally poured into the abdomen, and certainly helped to rally the patient, who was now suffering profoundly from shock. After being put back into bed, another 1 c.c. of pituitary extract was given, and the usual measures taken to overcome surgical shock. The after-treatment requires little to be said. The gauze drain was removed on the third day, and she was able to be moved to her own home on the eighteenth day. A vaginal discharge persisted for about three weeks, which required a lysol douche once or twice daily. She then made a gradual and uneventful recovery, and is to-day—nearly five months after—without any complaint, except an occasional headache, from which, by the way, she has suffered from, more or less, all her life.

I have read this paper to-night, gentlemen, because, firstly, although somewhat rare—one in four thousand cases—it is a possibility for any man in general practice to meet with. Secondly, because we were taught "that the occurrence of a case of rupture of the uterus in the hands of an obstetrician was, in the majority of cases, a reproach to him and a slight on his art," but cases arise under apparently normal conditions and without any premonitory sign whatever. Thirdly, one can understand the excessive retraction caused by a contracted pelvis, a hydrocephalus, a shoulder presentation, obliquity of the uterus, undilatable cervix, impaction of the cervical lip, or by compression between head and pelvis, or by manual interference such as turning, or by disease of uterus. One can also understand the predisposing tendency associated with a "Caesarian section," but in this case the rupture doubtless occurred at the beginning of labour in a uterus of normal conformation, and in which there was no gross complication, such as cancer, fibroid, or a bicornuous state. Cases of this kind have been reported by Ingerslev, by Hofmeier, by Professor A. R. Simpson, by Milne Murray, and others. Fourthly the absence of shock—at any rate, to any marked extent—the symptoms of haemorrhage, and the feeling of something having given way were not present. Fifthly, this shows that one's confidence in the peritoneum to deal with foreign substances is not lessened. The peritoneum is in no way incommoded by the presence of considerable quantities of blood and other non-septic material. Sixthly, the undoubted value of pituitary extract in shock. Of course, other things, such as strychnine, brandy, hot coffee, etc., were used. Seventhly, sometimes the gods that control microbic invasion are very kind, because this operation had to be done on an ordinary table in the living room of a cottage without time for carrying out more than a perfunctory asepsis. Our best thanks are due to Dr. McGowan for the way he gave the anaesthetic, which was ether throughout.

A CASE OF TRIPLE PNEUMONIA.

With Some Remarks on Variations Met with in Course of this Disease.

F. J. OWEN, M.D.

(Read before the Bendigo Division.)

F.H., æt 17, female. Admitted to Heathcote Hospital on March 4th, 1912. Illness commenced on previous day. Had physical signs of commencing pneumonia at left base. Temperature ranged between 102 deg. and 103.8 deg. until the evening of the 6th, fell to 99.4 deg. next morning, and normal same evening. Fall unattended by perspiration. The symptoms were mild, with obstinate constipation, and absence of rusty sputum. Then a fresh attack started in the left lung, the temperature reaching 101.4 deg. on the evening of the 8th and 103.8 deg. next evening. The range of temperature was not quite so high as in the first attack, and it came down rather gradually to 99.2 deg. on the evening of the 14th, and 99 deg. next morning. The fall this time was accompanied by free perspiration. Rusty sputum still absent, and general symptoms mild. The tongue at this stage was perfectly clean and moist, and patient looked and felt quite well. Lower half of lung consolidated, upper part clear.

On the evening of the 15th (13th day of illness) temperature rose to 100.8 deg., next morning 103.4 deg., and by evening 104.8 deg. Signs of pneumonia were apparent at the right base. From this time on until patient's death on the 24th day of illness, there was apparently a steady spread of the disease until only the upper part of the lung anteriorly remained unaffected. The temperature throughout was unusually high, the highest shown on a morning and evening chart being 105 deg. on evening of 22nd, and 105.2 deg. shortly before death. A four-hour chart, however, recorded a temperature of 105.8 deg. on two occasions. There was no delirium until the 21st (19th day of illness). On two or three occasions the sputum was slightly discoloured, but by no means pathognomonic. For the last four or five days it was so scanty that I was unable to collect sufficient for a bacteriological examination. The tongue was moist and clean almost throughout the illness. Perspiration was frequent and free in the middle stage of the third attack, but absent in the last. On the 23rd the temperature fell to 102 deg., with some diarrhoea, but next day rose again, and continued high. There was no dyspnoea throughout, and not until two or three days before death took place did the case appear to be quite hopeless.

An interesting feature is the different aspect given to the temperature by comparing a morning and evening with a four-hour chart, and still more by comparing a four-hourly temperature taken at 7, 11,