

CEREBRO-SPINAL MENINGITIS.

In the spring number of *Brain*, 1892, Trevelyan records thirteen cases of the non-epidemic disease with eleven necropsies. In no case was tubercle found after death, and in only one instance was there otorrhœa during life. The occasionally rapid course of the disease, and the ease with which it may be overlooked, are referred to. Under the morbid anatomy it is pointed out that the chief seat of the disease is in the subarachnoid tissue, and that the exudation is most plentiful in the dorsal and lumbar regions of the cord, because this tissue is most abundant there, whereas there may be none in the cervical region. The character and extent of this exudation in cases which recover are discussed, and the importance of a more systematic examination of the cord dwelt upon. Of the thirteen cases, six were examples of the primary disease, two complicated acute pneumonia, one was associated with proliferative endocarditis, and in another case these three diseases existed together. The relationship of these diseases is then discussed, and the probability of the same *materies morbi* (as, for instance, the pneumococcus infection) being able to produce them is referred to. No bacteriological investigation was made in these cases. In a most rapidly fatal case (ix) the disease supervened on diphtheria. The occurrence of cerebro-spinal meningitis after such infective diseases as enteric fever, measles, influenza, is next illustrated. In Case xii profuse otorrhœa occurred in the course of the meningitis, and at the necropsy no bone disease was found. The possible spread of the inflammation from the meninges to the middle ear is then alluded to, and the mode of origin of meningitis secondary to ear disease without any bone affection touched upon. Cerebro-spinal meningitis after head injuries, but without fracture, is next referred to. Case xiii was an example of the disease occurring after a comparatively trivial operation on the throat. Other such cases are cited, and an explanation of the connection, if any, between the events sought for.—*Med. Press*.

PROLAPSE OF THE EXTREMITIES IN HEAD PRESENTATIONS.

J. Kaeser (*Centralbl. f. Gynäk.*, No. 2, 1892), from a study of recorded cases, finds that prolapse of the extremities is far commoner in multiparæ than in primiparæ. The complication is favored by hydramnion, contracted pelvis with previous heavy labors and twin gestation, since in these conditions the inferior uterine segment does not press on the head with

firmness sufficient to prevent prolapse of the extremities. Prolapse of the arms is less serious than prolapse of the legs, but the cord often comes down as well in these cases, and that condition is very grave for the child. When the membranes are yet entire the obstetrician must wait till the os is completely dilated. Then the protruding extremity must be pushed up, and the head brought well down by external pressure. After rupture of the membranes, manual reposition of the prolapsed member must be effected; if this prove unavailing and the head is movable, it will in many cases be advisable to turn. When the head is firm, reduction of the extremity should be cautiously attempted in the intervals between the pains. If this should fail, then, according to the nature of the case in other respects, natural evolution may be awaited, or the forceps or perforator may be required.—*B. M. Journal*.

INJECTION OF SALINE SOLUTIONS.

Kortmann (*Deut. Med. Woch.*, April 21st, 1892) refers to over-distension of the venous system and other dangers from intravenous injections in cases of acute anæmia due to loss of blood, as well as to the want of success so often attending them. It is recommended to inject some 600 g. of a warm 6 per cent. sodic chloride (sterilized) solution into the outer side of the thigh, the needle being inserted well under the fascia ("parenchymatous injection"). A syringe holding 100 g. with a long needle provided with a stopcock, is made use of. It has been proved that absorption takes place rapidly from the subcutaneous tissue in the case of loss of fluids to the body. The circulation must, of course, be going on, but even in desperate cases with hardly any pulse such absorption will take place. In these cases it might be well to inject 100 g. into the veins at first, and then to proceed with the other method. The author gives the details of 11 cases, 6 of which were treated with intravenous injections, and the 5 remaining ones with these parenchymatous injections. Only one of the former recovered, whereas of the latter only one died. With one exception, they were all cases of hæmorrhages after very severe operations upon patients, many of whom had already lost much blood. The author is of opinion that, in all cases of acute anæmia consequent upon internal hæmorrhage, intravenous injections are contra-indicated on account of the danger of the rise of blood pressure producing further hæmorrhage, and that here subcutaneous or parenchymatous injections should alone be used. The latter methods are simple and without danger.—*B. M. Journal*.