rather inarticulate. speech. His relatives volunteered the information that he was getting thin and weak, whereas he had previously been an unusually powerful man, and that his disposition had completely changed. He had been an exceptionally trustworthy, well-behaved, Government official of a very religious turn of mind. His disposition was said to be now quite the opposite. On examination speech was found to be tremulous and rather explosive. Although he used to be a lay reader, now when told to say the Lord's Prayer his articulation became quite unintelligible at the Fijian equivalent of "Hallowed be Thy name." The knee-jerks were very much increased; there was a tremor of the fingers which prevented the patient from picking up a pin. He was under my care for three months, during which time his mental condition got rapidly worse. Towards the end of this time his mental condition is shown by the fact that he told me that he was a harbour master (a high office in Fiji), and on another occasion that he was a big landowner and would give me certain very valuable lands which, as a matter of fact, are now owned and worked by Europeans. There was no basis of truth in his statement that he was a harbour master or a landowner. He then one day went to the house of a native medical practitioner during the absence of the latter, and exposed himself indecently to the native doctor's wife and made indecent suggestions to her. He was then sent to the Suva Lunatic Asylum, where he now remains. During the regrettable occurrence which led to his detention in the Suva Lunatic Asylum he was supposed to be in the charge of his brother, named Tiacoro, whose case will be next described.

CASE 678/16 (general paralysis of the insane).—Tiacoro, a middle-aged male Fijian of Nanukuloa town, Ra province, came to see me on August 5th, 1916, with the history that until four months previously he was quite well. At that time he went to see Taniela (the patient in the previous case) at the lunatic asylum. Whilst in Suva he had, he says, filarial fever (he is subject to attacks of filarial fever and has elephantiasis of arm, leg, and scrotum). He was in Suva only a week or two on this occasion, and on returning to Ra he was weak and depressed. This weakness increased, until on August 3rd he was discovered by a native medical practitioner, Tomasi Mawi, at 3 A.M. wandering away in the bush "looking for Taniela," as he said. On examination he was found to be very much thinner than he was last year when I examined him. His face was bloated and expressionless, a great change from his alert, vivacious expression of a year ago. Articulation was hesitating and difficult, but correct. He had a fine tremor of his fingers, which made him very clumsy. The knee-jerks were very much increased: the pupils were small, equal, and sluggish in their reaction to accommodation and there was absolutely no reaction to light. The sight was not affected.

It will follow from the above cases that there is a very high rate of such nervous disease amongst the Fijians, but it must be remembered that the whole Fijian population has been infected with yaws, and probably the case-rate following yaws might not greatly differ from the case-rate following syphilis.

Fiji.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

WOUND OF THE PORTAL VEIN; OPERATION; DEATH NINE DAYS LATER.

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THE following case of shell wound of the abdomen, which was treated in a casualty clearing station, may be of interest not only on account of the actual injuries caused but also as an instance of a shell fragment passing through the abdomen from front to back without injuring any portion of the intestinal canal.

An Australian soldier was wounded by high-explosive shell at 4 A.M. on July 5th, the fragment entering just below the left costal margin, one inch to the left of the ensiform cartilage. When first seen late the same evening the patient's condition was bad; he was pale and cold, with a thready pulse of 120, vomiting was marked and the abdomen was very rigid all over, tenderness being especially marked in the epigastric region. Under chloroform a laparotomy was performed through the left rectus at 3 A.M. on the 6th, 23 hours after the wound, and the abdomen was found to contain a large quantity of fresh

blood. A track was traced down and to the right through the left lobe of the liver, emerging on its under surface, passing through the lesser omentum and tearing a lateral hole about half an inch long in the portal vein, from which blood was gushing freely. A plug was placed in the liver wound and two artery forceps were clamped on the side of the vein in a longitudinal direction, thus controlling the hæmorrhage. The track of the missile was then seen to pass on just to the outer side of the second part of the duodenum and to pierce the peritoneum of the posterior abdominal wall here. Owing to the condition of the patient the fragment was followed no farther, and a rapid examination of the stomach, small intestine, and transverse colon discovered no perforation. The blood was then mopped out and the wound closed in three layers in the usual way, the plug and artery forceps being left *in situ* with their handles emerging from the upper end of the incision, half an inch of which was left unsutured for that purpose. Next day the patient was much better, with no vomiting, and he continued to improve for several days; the plug was removed on the second day and the artery forceps taken off on the third day without any difficulty. Improvement continued till the eighth day, when the patient was doing well and eating solid food, his bowels being opened naturally each day. On the evening of the eighth day, however, he suddenly complained of severe hypogastric pain, vomited twice, and passed some urine with much blood in it. His abdomen remained quite soft and mobile, but his pulse failed and he died in an hour.

Post mortem there was no peritonitis, no adhesions, and no perforation of the intestinal tract. The lumen of the portal vein was patent, the wound in it being represented by a sound scar, and the liver substance appeared quite normal. A large retroperitoneal hæmorrhage was present round the right kidney, and on dissecting out the right renal artery an ulcerated hole half an inch long was found on its posterior aspect, close to which there lay a small jagged piece of shell-case, a little larger than a green pea. The patient thus apparently died from secondary hæmorrhage from the renal artery on the eighth day.

Several other instances have been recorded in the present war of cases in which artery forceps have temporarily been left on the large veins of the abdomen, and the above case is only published as one of an uncommon class.

CASE OF TONSILLITIS WITH HÆMORRHAGIC ADENITIS.

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IN the following case of tonsillitis the unusual complication of hæmorrhagic adenitis occurred.

The patient, aged 22, of good physique, R.A.M.C. orderly, was admitted to the Connaught Hospital, Aldershot, on June 27th, 1916, with acute tonsillitis. He had had an attack of tonsillitis last year when at Malta, but never any other illness. His present attack, which commenced the day before admission, came on suddenly while on parade with shivering and chilliness, headache, and sore-throat. The headache was so severe as to prevent sleep. On admission he complained principally of sore-throat. On examination the pharynx was red and inflamed, but there was no swelling of the tonsil and no follicles. Temperature 102° to 103·6° F.

On June 29th our medical specialist, Captain A. Abrahams, asked me to see the patient with a view to surgical interference, as during the past two days a large swelling on the right side of the neck had appeared. I considered this advisable, and the patient was transferred to a surgical ward. Temperature 103°, pulse rapid, respiration not affected. The patient looked very ill indeed. A large glandular swelling occupied the whole of the anterior superior triangle of the neck on the right side, extending from the angle of the jaw to beyond the posterior border of the sterno-mastoid. The swelling was very painful and tender to the touch. There was no fluctuation nor pitting of the skin on pressure. The right tonsil was much enlarged, covered with follicles, red, and tender. He could only swallow liquid food with difficulty.

Operation on June 30th under general anæsthesia. An incision 2 inches long was made over the most prominent part of the swelling and a large gland (the size of a pigeon's egg) was exposed. The gland was steadied with forceps and an incision made through the whole of its substance. I had thought that perhaps there might be a gland commencing to break down with pus formation at the centre, but no pus was present. Countless minute hæmorrhages had taken place into all the substance of the gland and the enlargement was entirely due to these hæmorrhages. The gland was left alone. The lower part of the wound was closed with