its tendency to bleed on even the gentlest manipulation. The growth removed was about the size of a small orange. It was tough, hard, and fibrous in consistency, of a yellowish-white, shining appearance on section, and, as was seen on microscopical examination, was composed of fibrous tissue with an admixture of spindle-shaped cells. On the 13th he passed a fair night. The evening temperature was 100°, but in the morning it was again normal. There was great pain in the head. The nose was ordered to be syringed out every two hours with weak Condy's lotion. On the 20th the sutures were removed from the palate. On the 22nd he was up for the first time, and on the 31st he was discharged from the hospital breathing freely through the right nostril, and well in every respect. The gland at the angle of the jaw was much smaller. On March 4th the patient was readmitted, as the gland had increased in size, and others had appeared. These were removed on March 6th, and the naso-pharynx was thoroughly examined whilst under chloroform. Some induration was felt at the former situation of the growth, but there were no definite signs of a return. The wound of the neck healed readily, and the patient left the hospital on March 20th.

Remarks.—The severe hæmorrhage which attended even the most gentle examination with the finger made it exceedingly difficult to define the exact attachments of the growth, and its size was such that the rhinoscope revealed little more than that there was a large mass blocking the right choana, and occupying the right half of the naso-pharynx. It became a question therefore what operation, if any, should be attempted for its removal. It was clear that, from its size and attachments, it could not be removed through either of the natural passages—i.e., anteriorly through the nostril or posteriorly through the mouth; and for the same reasons the operation of turning up the ala of the nose, or that of Rouge, did not commend themselves. The choice of operation was therefore narrowed to that of the partial or complete removal of the superior maxilla, or splitting the palate after the method of Nélaton. The last, as attended with the least danger, was finally decided on. A better view of the parts could not have been wished for, and although the removal of the growth was still difficult on account of its broad base of attachment, the whole of it was ultimately removed. The patient made an excellent recovery. The temperature, which never rose above 100·6°, fell to normal on the fourth day, and so remained for the rest of his stay in the hospital. The growth, though hard, firm, and apparently fibrous, was found on microscopical examination to be a spindle-celled sarcoma, and it is therefore interesting to note the secondary affection of the glands in the neck. The superiority of Nélaton's method of splitting the palate, over Langenbeck's operation of resection of the maxilla for the removal of such naso-pharyngeal polypi as do not allow of extirpation by simpler methods, cannot, I think, be too strongly insisted upon; and the more so as it does not appear to be generally admitted. I have seen both, and have no hesitation in preferring the former. The one is comparatively speaking a slight, the other a most serious, undertaking; in one there is but little shock, in the other it is severe; in one there is next to no hæmorrhage, in the other it is free, sometimes alarming. The latter, moreover, leaves an external scar, is necessarily attended with some injury to the lacrymal apparatus, and may be followed by unsightly œdema of the lower eyelid. In both an excellent exposure is obtained, but I do not think that that in Langenbeck's operation is any better for the purpose than that in Nélaton's. When the growth has invaded the anterior part of the nasal fossæ or the antrum, no doubt resection of the maxilla is the better operation; but when it is confined to the posterior third of the nasal fossa, Nélaton's in my opinion should be performed, and it is principally for the purpose of calling attention to this point that the case is published.

Weymouth-street, W.

A CASE OF CEREBRAL EMBOLISM WITH HYPERPYREXIA FOLLOWING CHILDBIRTH;

WITH POST-MORTEM APPEARANCES AND REMARKS.

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MRS. F—, aged about thirty-seven, multipara, consulted me on Feb. 20th, 1883, for considerable uterine hæmorrhage, from which she had suffered on the previous day. She was eight months pregnant. Palliative measures were adopted with success. On March 22nd hæmorrhage recurred, and continued in spite of treatment. Having diagnosed partial placenta prævia, I introduced a sponge tent. The hæmorrhage ceased, and she slept fairly well during the night. The following morning, however, on removing the tent, bleeding recommenced. I then ruptured the membranes, and with the aid of Barnes's bags dilated the os uteri to the size of an orange. Dr. Underhill, for whom I now sent, at once proceeded to perform bipolar version. The contractions of the uterus proving, however, a serious obstacle, the child did not survive.—24th: The patient had not slept at all. Great after-pains; weakness of both legs. Free lochial discharge; transverse colon greatly distended with flatus; pain in the hypogastric region. Temperature 98·4° F.; pulse 78, slightly dicrotic.—25th: Had passed a quiet night. Lochia had a slightly fetid smell. Pain and swelling of the lymphatic glands at the inside of the right thigh. Temperature 101°.—26th to 30th: Still complaining of weakness in both legs. The pain in the groin and hypogastric region less. Lochia diminished and with less odour; spirits better. A tendency to diarrhœa. Temperature never found to be above 100°.—April 1st: Depression of spirits; complaining of a slight cough, about which she was very nervous. Legs still weak, with pain in the groins on movement. Temperature 101°. During this time milk diet was adopted, with the addition of concentrated soups and small quantities of wine at regular intervals. For the pain and elevation of temperature Battley's solution, sulphate of quinine, and turpentine stupes were employed.—2nd: Patient nervous and anxious; cough more frequent. Slight cold sensations in the back; no physical evidence of pneumonia. Temperature 103·4°. I was sent for suddenly in the evening, and on arriving was told that as she was sitting up to take her medicine she fell back and became insensible. I found her quite unconscious, with paralysis of the left side of the body and clonic spasms of the right. The movement of the right arm was circumduction at the shoulder-joint forwards and from within outwards. The foot was alternately flexed and extended. Eyes open; pupils contracted and equal. Mouth open; tongue and lips dry; cheeks flapping slightly with the respiration, which was stertorous. Temperature 105·4°; pulse rapid, weak, and jerking (106). Sulphate of quinine in fifteen-grain doses was exhibited at frequent intervals. Sinapism over the chest, and the cold douche applied from a height above the head did not restore consciousness. The hair was cut and cold water compresses applied to the head during the night.—3rd: Both arms and legs motionless and flaccid. Right pupil much dilated; left pupil moderately contracted. Respiration stertorous (40); pulse 125; temperature (tested in both axillæ with two thermometers and observation repeated) 108°. Ice was applied to the head, and an enema of quinine administered. The patient died at 11 A.M.

Necropsy, twenty-five hours after death.—Gas was seen bubbling up from the nostrils and mouth. Pupil of right eye slightly dilated, and the cornea unusually bright. Rigidity well marked in lower extremities; lividity slight. Abdomen very greatly distended with gas. Brain: Superior longitudinal sinus contained a long decoloured post-mortem clot. The vessels of the vertex injected with dark fluid blood, and their terminations distended with gas. An excess of subarachnoid fluid, which was turbid; vessels of pia mater injected. The internal carotid artery of the right side, immediately below and at the origin of the posterior communicating branch, was completely closed by a firm pale ante-mortem clot. The basilar artery contained three small cream-coloured clots from $\frac{1}{4}$ to $\frac{1}{2}$ in. long, with rounded ends. These were not impacted, and may have been of post-mortem formation. The cere-

DEVONSHIRE HOSPITAL AND BUXTON BATH CHARITY.—At the meeting of the committee of management of this institution, held on the 5th inst., Dr. Robertson stated that during the half year ending June 30th, 1102 in-patients were admitted to the hospital. Of these, 684 were discharged as improved, 127 as no better, 6 at their own request, 3 were dismissed, 4 died, and 278 remained on the books at the end of the half year. The number of out-patients admitted was 91, and of these 26 remained on the books.

bral substance was injected. Both lateral ventricles contained a small quantity of blood-stained fluid. There was no evidence of anæmia of the right hemisphere. Brain tissue very soft. Heart: Flaccid; almost empty. Endocardium stained very darkly, valves being plum-coloured. The anterior internal aortic valve presented on the ventricular surface a small dark clot, which on removal disclosed a slight roughening of the endocardium. The inner surface of the left ventricle presented a marbled appearance. Spleen: Measured 7 in. by 4 in., very soft. Lungs: Pleural cavities contained no fluid. Both organs very soft, highly congested, with œdematous bases. No consolidation. Bronchial mucous membrane reddened and softened. Liver: Congested and fatty. Kidneys: Both very soft and greatly congested. Stomach and intestines greatly distended with gas; no evidence of peritonitis. Uterus measured 6 in. by 4 in. Ligaments thickened; no evidence of cellulitis. The interior, which had a fetid smell, presented a slate-grey appearance. At the placental site there were two depressed patches measuring respectively $\frac{1}{2}$ in. by $1\frac{1}{2}$ in., with rough granular floor of ash-grey colour; ovaries large and congested. Microscopically the clot from the internal carotid artery showed almost throughout the outlines of the individual corpuscles. It was adherent to the walls of the vessel by granular debris, fibrin, &c.; muscular fibres from the heart were cloudy and fatty. In the lungs some of the air vesicles showed evidence of croupous exudation. There was no thrombosis of the pulmonary veins. Kidneys: Epithelium of tubules greatly swollen, cloudy, and desquamating. Uterus (from the placental site): The inner surface presented the appearance of a false membrane composed of fibrin, leucocytes, compound granular corpuscles, and granular debris. In the kidneys and uterus there were some highly refractile bodies, giving no reaction with osmic acid solution, and not unlike micrococci.

Remarks.—References to the state of the body temperature after the occurrence of cerebral embolism are omitted in most text-books of medicine. According to the observations of early writers, especially Cohn, it was formerly believed that following embolic impaction there was both an initial and, for a time, a permanent general diminution of the temperature of the body. Bourneville's observations, on the other hand, have shown that there is a rise (reaching in some cases even 104°) on the second and third days and then a rapid fall.¹ Dr. Hamilton² quotes a case of Sokolowski's in which the temperature on the first day was 101.2° , and the next evening 104.8° . In this case, however, there was acute endocarditis. In a case of his own in which embolism occurred during the resolution stage of croupous pneumonia, the temperature was not high till the second day, when it reached 104° . I have, however, been unable to find any case on record in which there was hyperpyrexia. The pulse and respiration of Mrs. F—, contrary to the observations of M. Rosenthal,³ were found to be both of them unusually rapid. It is, I believe, rare for a case of cerebral embolism to prove fatal within twenty-four hours. It appears to me, therefore, highly probable that the hyperpyrexia was the cause of the anomalies in, and the rapidly fatal issue of, this case. The question next arises as to its origin. The clinical history, especially as regards the persistent elevation of temperature, its steady rise immediately before, at the time of, and after the embolic impaction occurred, and the presence of flatulence with diarrhœa, together with the pathological evidence—viz., the rapid decomposition, the congestion of all organs, the absence of pelvic cellulitis, and the condition of the uterus,—lead me, notwithstanding the fact that in many respects the case ran a very unusual course, to think that some form of puerperal septicæmia was present. The puerperal state of the blood, the morbid condition of the aortic valve, slight though this was, and the unusual strain upon the heart from the high temperature and sudden change of position of the patient, may account for the formation, point, in the absence of pulmonary thrombosis, to the source, and explain the departure of the travelling clot or clots.

¹ Ziemssen's Cyclopædia, vol. xii., p. 200.

² Nervous Diseases, 1878, p. 139.

³ Clinical Treatise on Diseases of the Nervous System, 1873, vol. i., p. 78.

At Exeter, on the 10th inst., the Mayor laid the foundation-stone of a new Asylum for Pauper Lunatics. The building will cost some £100,000.

DISLOCATION OF THE STERNAL END OF THE CLAVICLE, BACKWARDS AND UPWARDS.

By J. HARRY POLAND,

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R. G—, aged twenty, was admitted to hospital on Feb. 22nd, 1880. While wrestling with another man, both fell, the patient being underneath. He came at once to the hospital. On admission, the patient complained of pain in the right shoulder and inability to use the right arm; slight difficulty in breathing, and great difficulty and pain in swallowing. He was unable to say in what position he fell. On examination the right shoulder was slightly lower than the left, and projected more forwards; the arm was extended and kept at an angle of about 40° to the body, this being the least painful position. The head was inclined and turned slightly to the left side. There was a well-marked depression at the right sterno-clavicular articulation, and the sternal end of the clavicle could be felt beyond this, and at about three-quarters of an inch higher level than the corresponding articulation, the trachea apparently being pushed to the left side. The line of the clavicle could be felt throughout, and also the vacant sternal articulation. The patient was seated in a chair and reduction effected by placing the knee in the hollow between the two scapulae, taking firm hold of the upper part of the arm and shoulder, and bringing them backwards and a little upwards. The parts were retained in position by means of a large pad placed over the right scapula, and the right arm bandaged so as to keep it well backwards, the elbow a little upwards, and the forearm folded across the chest. There was some difficulty in keeping the parts in position, and the bandage had to be reapplied three or four times. The head of the clavicle did not completely resume its normal position, and at the end of four weeks, when the patient was discharged, a slight depression could be felt over the articulation. There was, however, not the slightest trace of any upward displacement. The patient has since resumed work, and experiences no inconvenience from the injury.

Beyond the comparative rarity of the lesion, the only point remarkable is the absence of dyspnœa, which in this case was almost complete. This seems to have been due to the head of the bone forcing the trachea to one side, instead of directly pressing upon it. Of all the authorities I have been able to consult I can only find one other case in which dysphagia was the prominent symptom and dyspnœa absent, or nearly so. The case referred to is that of Sir Astley Cooper, in which he removed about an inch of the sternal end of the clavicle to relieve the dysphagia, but in this case the cause of the luxation was spinal curvature. This case is given in both Fergusson's System of Practical Surgery and in Holmes' System of Surgery. Of the other cases quoted, Hamilton, in his treatise on Dislocations and Fractures, gives some thirteen cases, five of which were the result of direct violence, and the remainder by indirect violence; and from various other authors I have collected seven other cases, two of which were the result of direct and five of indirect violence, making a total of twenty cases, seven from direct and thirteen from indirect violence. In one case, Dr. Brown's, of Callington, the cause was a fall in wrestling; but there, as in the present case, it is doubtful whether there was direct or indirect violence, since, when wrestling, men are not likely to be able to say the exact position in which they fall. According to Dr. Brown's case it was indirect, but in the present one, if the man could be relied on as to the position, it was probably direct violence that caused the injury, the patient stating that he fell with his right shoulder against the kerb, while his opponent was immediately above him. In any case, however, this injury seems to be far more frequently the result of indirect violence. Further, it is generally accompanied by dyspnœa, rarely by dysphagia alone, and not unfrequently by both, the former, however, being the most urgent symptom. It is, according to all authorities, seldom completely reduced, and is not unlikely to give some trouble to retain the parts in position. In the majority of cases the displacement is backwards only, and in those in which it is backwards and upwards the upward displacement is