extract were injected subcutaneously into the forearm. Two seconds after the injection the patient complained of a sudden spasmodic contraction of the muscles of the arm and fingers. On feeling the pulse at the radial immediately after injection I was alarmed to find that it almost disappeared for a few seconds. That this symptom was due to the local muscular spasm with which it was coincident is confirmed by the fact that the arterial pulse in the left radial was found to be full and vigorous. 12 minutes after injection the arterial pressure was found to be 150 millimetres of mercury and the pulse-rate was 85. Previously to injection the patient had complained of feeling uncomfortably hot and a couple of minutes afterwards he spontaneously remarked that "all the heat seemed to have gone inside." Two hours after the injection the pulse-rate was 89 and the pulse itself was much stronger and fuller. The patient still complained of feeling cold at the extremities. Three hours after injection the pulse-rate was 95 and the blood-pressure 135 millimetres of mercury. There were some pain and localised swelling at the site of the injection. There was marked diuresis during the 24 hours succeeding the injection; the urine was acid with a specific gravity of 1010. There was no glycosuria, an effect frequently noticed after suprarenal injection. I have taken considerable quantities of the pressor substance by the mouth but have never been able to record any result, although the substance is unaltered by peptic digestion and is dialysable. The pressor substance would appear to be proteid in nature. It is precipitated from salt solution by trichloroacetic acid, gives biuret, xanthoproteic and Millon's reactions. It is not precipitated by saturation with a neutral salt, it is unaffected by peptic but decomposed by prolonged tryptic digestion. The iodine found in the pituitary is not apparently in combination with the pressor substance. Its cardiac, vascular, and diuretic action would indicate that it may prove to be of service in cases of heart disease.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF RECOVERY AFTER VERY EXTENSIVE INJURIES.

BY MONTAGUE TENCH, M.D. BRUX.,
MEDICAL OFFICER TO GREAT DUNMOW INFIRMARY.

AS an example of extensive injuries followed by complete recovery the following case may prove of interest.

In the course of 1901 a man, aged 55 years, a farm labourer, was knocked down and run over by the barn works of a threshing machine, drawn by four horses which he had been leading and which had taken fright. Both wheels on the near side passed diagonally across his pelvis and chest while he lay on his left side. When picked up and admitted to Great Dunmow Infirmary he was collapsed and pulseless and appeared to be in a dying condition. He recovered consciousness within a couple of hours and the following injuries were recognised. Both iliac bones were broken off above the pelvic brim, being freely moveable with coarse crepitus. There was no injury to the bladder or the urethra, but the torn rectum was extruded through a rent reaching from the anus to the scrotum rather to the left of the middle line. Large hæmatomata extended from the buttocks down the outer side of both thighs to their middle. Several ribs on both sides were broken, so that the sternum was protruded and moveable with crepitus. Surgical emphysema developed the same evening on both sides of the trunk and on both arms to the wrist, though there was no external breach of surface and no hæmoptysis. The left clavicle was extensively comminuted, otherwise the limbs and head escaped.

Extensive sloughing of the back and buttocks occurred during the ensuing six to eight weeks, laying bare the sacrum, and the hæmatomata, which had suppurated, discharged through an area eight inches in diameter over and above the sacrum. Pus and sloughs were discharged for 10 weeks.

The patient left the infirmary six months after the accident

walking without limping, and is now contemplating resuming his work.

The temperature rose to 102° F. within the first week with the onset of suppuration, and assumed a hectic type while the discharge continued. Considerable wasting occurred during this time, but was rapidly made good afterwards. There was no indication of injury to internal organs other than that inferred from the general emphysema.

Great Dunmow.

QUININE AS A DRESSING.

BY J. REID, M.A., M.D., C.M. ABERD.

QUININE has been used in lotion for various diseases, but combined with cod-liver oil externally I do not know of any reference to the subject. I have used it with good results (one drachm to eight ounces in emulsion, to be shaken up before being used) in tertiary and rheumatic ulcers of the leg and for ordinary ulcers, in a case of gangrene of the skin, and after a burn, where a large surface (about a foot square) formed a slough and had to be removed as ulceration loosened the thick slough. All wounds took on a healthy and kindly action, and the pus from the sloughing derma smelled sweet and contained a limited number of cocci. I do not know that the dressing has anything to recommend it in the way of cheapness or of odour, but it has the advantage of supplying a weakened system with an oily food and a tonic drug. For intertrigo I have used it with good effects if not long required. For eczema it seemed to act well if stomach troubles were seen to.

Bristol.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

ST. MARY'S HOSPITAL.

A CASE OF TRAUMATIC RUPTURE OF THE PROSTATIC URETHRA; COMPOUND FRACTURE OF BOTH LEGS; OPERATION; RECOVERY.

(Under the care of Mr. EDMUND OWEN.)

In the following case the urethra was ruptured by external injury in an unusual situation. The most common site of rupture when occasioned by external violence is certainly the membranous portion of the urethra, but in this case the urethra was torn behind the posterior (superior) layer of the triangular ligament. This lesion is not very rarely produced by fracture of the pelvis, though in the case recorded below no signs of fractured pelvis were present. For the notes of the case we are indebted to Mr. W. J. Finlayson, dresser.

On the afternoon of Oct. 21st, 1901, some children were playing in the timber-yard of an undertaker, when they upset a pile of coffin-lids which fell upon them, killing one of them. As a result of this accident, a boy, aged seven years, was brought into St. Mary's Hospital with compound fracture of each tibia, and in a state of serious collapse. The house surgeon, Mr. V. Nesfield, at once took him into the theatre, and, under the influence of chloroform, cut down on to the right tibia, clearing dirt and blood-clot from the wound; then, having sutured the periosteum which had been extensively stripped up, he inserted a drainage-tube and dressed and fixed the limb. He treated the left tibia in the same way (this fracture was comminuted as well as compound, and the fibula was also broken and exposed). Marks of severe bruising were noticed over the lower part of the abdomen.

When the house surgeon saw the boy at night he found that some blood had escaped from the urethra, but that no urine had been passed. He, therefore, tried to introduce a catheter, but though he could not make it enter the bladder,