

heart was normal; no albumen in the urine, of which he passed about a pint and a half a day; but feet and ankles were slightly swollen. The bowels acted daily, motions formed, no blood. Tongue furred; mouth not aphthous. The abdomen was slightly prominent, but soft, not tender, and was resonant down the left side. He did not complain of pain or discomfort after food, or any other signs of dyspepsia. Mucous membranes of eyelids and lips were pale. The patient said he took his food well and enjoyed his meals. His habits appeared to be to have a cup of tea and a piece of toast about 6 A.M., a couple of fried eggs or some fish at 11, and to dine at 6 P.M. off a chop or steak. He did not like milk and did not take much of it. Sometimes he would take a glass or two of port. The friends thought there was very little hope for the patient, and, to use their own expression, wanted to know if we could "patch him up for a few weeks." Considering that the patient was so anæmic, but still had a considerable amount of vitality in him that he could take his food so well and was not being exhausted by night sweats, I suggested transfusion. The patient was willing to try anything, and his wife offered to give the blood.

The next day (May 15th), having procured an Aveling, with the assistance of Mr. De Gruyther and a sister of the patient I transfused about two ounces directly from a vein in the wife's arm to a vein in the patient's arm. During the process the patient exclaimed, "I feel so hot; open the door." The wife rather complicated matters by vomiting during the transfusion, and was rather faint afterwards; but the patient was in no way worse, and said he should be ready for his dinner at the usual time. On the 16th Mr. De Gruyther reported: "Patient is better to-day; his pulse seems to me to be improved, and is 120; he himself feels better." On the 19th I saw the patient, and found his pulse 128, but much less easily stopped than on the 14th. He had taken his food as usual, and said he felt stronger. He further said that on the 17th he had got out of bed and had walked across the room to an arm-chair without assistance, a thing he had not been able to do for a fortnight. The wounds in both cases looked well, and there were no signs of inflammation or tenderness over the course of the veins. On the 21st Mr. De Gruyther again reported: "Our patient is progressing very favourably; his pulse was about 120 to-day and firm; he walks without aid." On the 22nd, one week after transfusion, I saw the patient. I found him sitting in an arm-chair, having moved into the next room. He had walked from one room to the other without assistance. He looked much happier; the pulse was stronger and 128. He said he felt stronger, and that he was sure he should be better if he could only get some sleep, that he had hardly had any sleep from 9 P.M. till 5 A.M. the previous night on account of his cough. The patient's wound was almost well, the one in the wife's arm showed a small slough. On the 25th Mr. De Gruyther wrote: "Our patient had a weak pulse of 116 yesterday, and he himself felt weaker. He says he had a better night on Friday (May 23rd) after inhaling five minims of eucalyptus oil in a metal respirator. The slough from the wife's arm has not come away." On the 26th Mr. De Gruyther wrote: "Our patient is not so well to-day."

May 28th.—Thirteen days after transfusion I saw the patient. I found him sitting on a couch in a room next his bedroom; he had walked there with difficulty, and with assistance. His expression was much more anxious; his pulse was 130, and very easily stopped; his appetite was very bad, and he could only take liquid nourishment, such as egg and milk or beef-tea. He had lately discovered that he could take milk. His ankles were swollen. I found that on Friday, the 23rd, he had walked by himself with ease down the passage of his house out into a small garden or yard at the back and had sat in the sun for some hours, and had thoroughly enjoyed it, and that he had slept better that night. On Saturday, the 24th, he had done the same thing again, but had walked with even greater ease, and had felt still stronger. Sunday, the 25th, was a cold day, and he did not go out. On Monday, the 26th, he had not felt so well; on Tuesday, the 27th, he had felt worse, and on Wednesday, the 28th, he had gone back considerably. The cough was still the great trouble, it prevented his resting; but the amount of sputum was considerably less than when first seen, and there had been no sign of blood in it since the transfusion. The wife complained of pain in her arm, the slough had come away, the wound was healthy and healing,

but there was tenderness along the course of the median vein, and the vein was thickened and cordlike. On May 30th Mr. De Gruyther wrote: "Yesterday our patient was a good deal weaker; he took a fair amount of nourishment, and had better rest at night."

June 3rd.—I saw the patient, and found him on the couch; pulse stronger, 120. He would take no medicine of any kind; he looked happier again; his appetite was better, and he fully intended to go out into the garden again as soon as practicable.

June 12th.—The patient had been out in the garden several times since June 3rd, but he had gone back. Pulse 120, weak and small. Both legs were much swollen and cedematous. The abdomen measured thirty-one inches and a half; it was tense and full of fluid. Very little albumen in urine, but some dyspnoea at times. A day or two after this date the patient was taken in a cab to the German Hospital, where he remained until July 27th, when he died. I have not been able to hear whether there was a post-mortem or not, but I think it is most probable that it was not allowed.

Westbourne-street, W.

## A Mirror

OF

## HOSPITAL PRACTICE, BRITISH AND FOREIGN.

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

### ST. GEORGE'S HOSPITAL.

#### A CASE OF RUPTURE OF THE GLUTEAL ARTERY AND ONE OF AMPUTATION AT THE HIP-JOINT ILLUSTRATING MORE RECENT METHODS OF ARTERIAL COMPRESSION.

(Under the care of Mr. HAWARD.)

FOR the following notes we are indebted to Mr. R. Mar-gerison, surgical registrar.

John D—, aged twenty-four, received in May last a blow on the right buttock from the buffer of a locomotive. When admitted soon afterwards into St. George's Hospital, the buttock presented near its most prominent part a contused and lacerated wound large enough to admit a finger. Out of the wound dark blood oozed very freely. The soft parts were very extensively undermined, and beneath them was a large and increasing collection of blood. This blood collection did not pulsate and no bruit was audible. A pad was firmly bandaged over the buttock for three hours. In this interval the collection of blood had greatly increased, and when the pad was removed large quantities escaped. Ether was then administered and the right iliac artery compressed with Davy's lever. When once introduced far enough, this instrument acted perfectly. Mr. Haward enlarged the wound to a length of some six inches. The gluteal muscles were found to be torn across, and beneath them existed a large cavity full of blood. This was quickly turned out, bringing into view the sciatic notch and the open mouth of the gluteal artery. This and a great many other muscular vessels were secured with catgut ligatures. No blood was lost during the operation and the man's recovery was uninterrupted.

The case shows well the value of the lever, and in connexion with this subject of compression of the large vessels of the abdomen it seems well to mention a case of amputation at the hip-joint for sarcomatous disease, which also occurred in Mr. Haward's practice. Here the abdominal aorta was very effectually controlled by a contrivance more or less like that suggested by Sir Joseph Lister. The blunted apex of a pyramidal piece of wood was fixed over the abdominal aorta by an elastic bandage. The apex of the pyramid was about one inch square and covered with felt. The base measured about three inches square and presented instead of a plane surface a broad and shallow groove. The elastic bandage passed round the pelvis and along this groove. When fixed it was placed in the charge of an assistant, who, grasping the wood with both hands, could very easily and

nicely direct and regulate the pressure. This contrivance caused no dyspnoea and completely checked all bleeding.

### HOSPITAL FOR EPILEPSY AND PARALYSIS, REGENTS-PARK.

SEQUEL TO THE CASE OF EXCISION OF A TUMOUR FROM  
THE BRAIN.

(Under the care of Dr. HUGHES BENNETT and Mr. RICKMAN  
J. GODLEE.)

IN our issue of Dec. 20th we supplied our readers with some notes of a case in which a tumour had been excised from the substance of the brain on Nov. 25th, with the condition of the patient up to the 15th ult.; to which date the progress of the case had been entirely satisfactory. We are now enabled to give the sequel, which has unfortunately terminated in the death of the patient. On the morning of Dec. 16th the man was suddenly seized with a rigor, followed by fever, sickness, and pain in the head. A hernia cerebri of large dimensions supervened. The pyrexia increased and continued, the patient emaciated, gradually sank, and died on Dec. 23rd, the intelligence remaining intact to the last.

On post-mortem examination meningitis was found at the lower border of the wound, spreading downwards towards the base of the brain on the same side, the whole of which was inflamed and covered with plastic lymph. With the exception of the loss of cerebral tissue, caused by the operation, the brain was otherwise practically normal. We understand that the details of this interesting case will be brought before the profession in due course.

### DUNDEE ROYAL INFIRMARY.

ACUTE CEREBRAL MENINGITIS; RECOVERY.

(Under the care of Dr. SINCLAIR.)

For the following notes we are indebted to Dr. A. M. Stalker, pathologist, late house-surgeon:—

J. R.—, aged eleven, mill-worker, was admitted on March 31st, 1882, suffering from an illness which had commenced five days before. There was no history of illness or injury previous to this. The symptoms were pain and stiffness in the neck, especially on the right side, with general malaise and weakness. The boy's friends said he had been carrying unusually heavy loads on his shoulders two or three days before he began to complain.

*State on admission.*—Patient has a feverish look; lips dry and cracked; tongue dry, furred on dorsum, and glazed at tip and edges; appetite gone; bowels constipated, motions natural in colour; some abdominal pain; heart and lungs normal. Pulse 108; respiration 28; evening temperature 103.4°. Pupils contracted and equal. Tache cérébrale brought out on abdomen and arms. Patient has tendency to delirium; never lifts his head, complains of frontal headache, cries out suddenly, the cry having a cerebral character. There are diffuse stiffness and pain in the neck, most marked on the right side. For some days the patient continued in much the same state, being generally delirious at night and quieter during the day. Bromide of potassium and opiates were given when necessary, cold lotions were applied continuously to the head, and a blister raised on the nape of the neck. Temperature in the morning 101° to 102°, in the evening 103° to 103.8°; respiration normal; pulse 112 to 120, regular. From April 9th to 17th there was some improvement, the pulse and temperature being nearer the normal, and the patient being quieter. The pupils were now unequal in size, the right being larger than the left. At this time the temperature rose on two successive nights to above 104°. Croton oil was effectually applied to the back of the head. The symptoms showed general improvement, though slow, till the end of April, when the temperature fell to normal, and the other symptoms disappeared. Bowels remained normal all through. Dismissed on June 10th, quite well.

*Remarks by Dr. SINCLAIR.*—That the possibility of enteric fever was never seriously entertained will excite no surprise after a perusal of the clinical history of this case. Was it tubercular meningitis? Was it an instance of that malady which I am not alone in believing to be extremely rare—viz., acute simple idiopathic meningitis? Or was it a case of meningitis due to an obvious external cause? I must say that tubercular meningitis has never come forcibly

before my mental vision in a case of this description, least of all, perhaps, in the earlier stages of its course. That the patient did not die does not by any means exclude the possibility of a tubercular origin; but the age was rather against such an explanation, because, although the disease sometimes occurs beyond the age of ten, it is much commoner before that age, and commoner still between the ages of two and five. It will be observed also that there was no prodromal stage, with its wasting of the adipose and muscular tissues, its languor, mental torpor, unstable emotions, and irritable temper. The pulse was never slow and irregular in the stage immediately succeeding the stage of invasion. The temperature at the time the patient came under observation and subsequently was nearly always too high for this explanation. The idiopathic theory seems to me untenable, so long as any other agency can account for the morbid condition. We had here to deal with a previously healthy boy eleven years old. A sudden invasion, a well-marked attack of cerebral meningitis, probably an effusion of lymph, and a complete mental and physical recovery. We had a history of an unusually heavy load having been carried on the shoulders a few days before the onset of the attack; and this I am convinced gives us the solution of the difficulty. The unusual exertion caused, I believe, a determination of blood to the head, and initiated a sequence of events very similar to those which follow closely upon that vaso-motor paralysis which is apt to be induced by exposure to the direct rays of the sun or artificial heat. The recovery was complete, although slow. How much of the result was due to good nursing and careful feeding and how much to the local treatment I am not prepared to say.

CEREBRAL ABSCESS DUE TO CHRONIC SUPPURATION OF THE  
MIDDLE EAR; DEATH; AUTOPSY.

(Under the care of Dr. SINCLAIR.)

For the following notes we are indebted to Dr. D. J. Reid, late house-surgeon:—

J. Y.—, aged twenty-two, carter, admitted on August 17th, 1883, with the following history:—The patient had a rigor three days ago and another last night. Since then he has complained of pain in his head, especially on the left side.

On admission he was so sick that he had to lie down at once. Tongue covered with a creamy fur, and the papillæ enlarged. There was no eruption on the body. His aspect was heavy; pupils natural. He had slight photophobia. Temperature 102°; pulse 144; urine acid, sp. gr. 1024, with slight albumen.

August 18th.—Temperature 103.6°; pulse 84. Ordered dry cupping to the nape of the neck; hair cut short; ice-bag to head. Ordered twenty grains of bromide of potassium every six hours. Had a rigor at 1.45 p.m., and was livid. Morning temperature 103.4°; evening, 101.6°, and at mid-night 103.4°.

19th.—Temperature 101.2°; pulse 108; slept fairly well; headache gone. Evening temperature 99.8°; had a rigor at 7.35 p.m., when the temperature rose to 103°.

20th.—2 A.M., temperature 105.6°; 9 A.M., 103°; has had diarrhoea since last night; stools of a "pea-soup" character; 6 p.m., temperature 98.4°.

21st.—9 A.M., temperature 98.4°; 6 p.m., temperature 101°; bowels opened twice to-day.

22nd.—9 A.M., temperature 99.2°; 6 p.m., 100.4°; bowels opened twice; severe headache.

23rd.—Morning temperature 102°; spleen enlarged; slight cough; lungs normal. Ordered a diaphoretic mixture twice daily. Evening temperature 104.4°; bowels opened once to-day.

24th.—Morning temperature 100°; evening, 100°; rigor this forenoon.

25th.—Died this morning at 6.15.

*Autopsy.*—Abdomen: No peritonitis; omentum injected; intestines filled with loose dark yellow stools; considerable injection of upper half of large and lower two feet of small intestine; some enlargement of solitary glands; no ulceration; spleen large and congested; liver and kidneys normal. Thorax: Heart and lungs normal. Head: Dura mater slightly adherent posteriorly. On removing the brain a small collection of ill-smelling pus was found over the upper surface of the petrous portion of the left temporal bone, between the bone and the dura mater. There was some inflammation and very superficial softening of the temporo-sphenoidal convolutions in the immediate vicinity of the abscess. On sawing through the petrous portion of