character of the rash, I am inclined to believe that the case was one of abortive hæmorrhagic small-pox, the modification being due possibly to the primary vaccination. I shall be glad to know whether this condition is recognised, and if similar cases are recorded.

Liverpool.

A Mirror

OR

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.

SEAMEN'S HOSPITAL, GREENWICH.

TWO CASES OF HEPATIC ABSCESS; OPERATION; RECOVERY.

(Under the care of Dr. J. ANDERSON and Mr. W. JOHNSON SMITH.)

THESE cases are examples of some of the methods of treating hepatic abscess at the present day. The larger number of cases of this disease are met with at hospitals such as the Seamen's, which collect patients chiefly from foreign parts. Sometimes, however, a case of acute abscess with dysentery may be admitted into a general hospital in the summer time, although the patient has never visited the tropics. Two methods of treatment are shown, both of which proved successful: (1) free incision in Case 2, where the structures overlying the liver were adherent from extension of the inflammation to the abdominal parietes; and (2) operation in two stages across the pleural cavity in Case 1—viz., resection of rib and suture of the healthy layers of the pleura to each other in the first stage, and then, three days later, incision through the diaphragm into the abscess, with drainage. For the notes of these two cases we are indebted to Dr. C. W. Windsor.

CASE 1.—A native of Zanzibar aged twenty-seven years was admitted to the Seamen's Hospital, Greenwich, on Aug. 17th, 1895. He complained of pain in the right side of the abdomen and chest, from which he had suffered for one month. Four months before admission he had an attack of diarrhoea lasting one month, with very frequent small stools containing a good deal of mucus, but no blood. For three weeks previously to admission he had a similar attack of diarrhoea and tenesmus, but no blood was passed. He had never had malaria. He had not suffered from vomiting or jaundice, but he had lost flesh during the previous few months. On admission he was found to be a fairly nourished man suffering from pain in the right side. The abdomen was not distended; there was no marked prominence, œdema, or obliteration of the intercostal spaces. The liver dulness began at the sixth rib in the nipple line, at the eighth rib in the mid-axillary line, and at the ninth rib in the scapular line; it was continued downwards two inches below the costal margin. The edge of the liver could be felt mid-way between the costal margin and the umbilicus. Considerable tenderness was felt over the hepatic area, especially just below the ribs. The spleen was enlarged; its edge could be felt below the border of the ribs. Nothing else abnormal was detected in the abdomen. The patient had slight diarrhoea; the bowels were opened four times in the first twenty-four hours, the stools being clay-coloured, but without blood or mucus. The urine was of specific gravity 1026 and contained no albumin or sugar, but a quantity of bile pigment. The temperature was high and remittent, reaching 103° F. The lungs were clear, except at the right base behind, where there was some impairment of resonance; slight feebleness of the breath sounds was noted, and vocal resonance and vocal fremitus were diminished. No adventitious sounds were audible. There was no difference in the measurements of the two sides of the chest. The heart was normal. No nervous symptoms were observed. Two days after admission an exploring needle was inserted into the liver directly backwards through the eighth intercostal space; a small quantity of dark-red, rather offensive pus was withdrawn, showing under the microscope abundant blood and pus cells, degenerated liver tissue, and numerous streptococci, but no amœba coli was seen. In a few days the urine became free from bile, and the stools

regained their normal colour. Eleven days after admission Mr. Johnson Smith resected two inches of the eighth rib immediately in front of the anterior axillary line. The layers of the pleura were not adherent, and as the pus showed the presence of septic organisms, in addition to being offensive, these were stitched together to shut off the pleural cavity. Three days later an incision was made into the liver, and a considerable quantity (about one pint) of blood-stained pus was evacuated; it had a slightly faecal odour and was streaked with blood and bile. Repeated examinations failed to reveal any amœbæ. The abscess cavity was a large one and had a ragged wall. The cavity was washed out once daily with a 1 in 60 carbolic solution and very rapidly closed. In two days the temperature became normal. A fortnight after the operation an alarming gush of blood from the interior of the cavity occurred while the wound was being syringed, but the hæmorrhage was soon controlled by plugging with gauze. With this exception convalescence was uninterrupted, and the patient was discharged recovered.

CASE 2.—A man aged thirty-four was admitted to the Seamen's Hospital, Greenwich, on Oct. 21st, 1895. There was a slight family history of phthisis. He had had malaria and syphilis, but otherwise he had always been strong and healthy. There was a very inconclusive history of diarrhoea. The patient first noticed pain in his stomach one month before admission, while sailing home from Odessa; the pain was of a sharp, shooting character, radiating between the shoulders, and was so severe as to prevent him from sleeping at night. He first observed a swelling over the stomach seventeen days before admission, and it had slowly increased in size. No history of colic or of jaundice was elicited. The bowels were very constipated. He had lost 2st. in weight during the previous two months. On his admission the abdomen was found to be rather distended, particularly at its upper part. There was no œdema, and no enlarged veins were visible. There was a globular swelling lying very nearly in the middle line, immediately below the ensiform cartilage, its lower border being at the level of the umbilicus. Laterally the swelling approached close to the costal margin on each side, but especially to the right; but even here a finger could be laid between the margin of the swelling and the edge of the ribs when a deep inspiration was taken. The swelling measured eleven inches and a half transversely and six inches and a half from above downwards. It did not move perceptibly on respiration. It was rather fixed, and its right border either was connected with, or was in very close proximity to, the liver. There was no connexion with the right kidney. In consistence the mass was tense and elastic, fluctuation was obtainable, and the percussion note was dull. There was no fluid thrill, and there was no reddening of the skin. The liver dulness began at the sixth rib in the nipple line, and at the eighth rib in the mid-axillary line, and was continuous with that obtained over the swelling. The edge could not be felt in the axillary region, while anteriorly to this the swelling interfered with accurate palpation. There was no enlargement of the spleen. The bowels were constipated. The urine, which was normal in quantity and of specific gravity 1008, contained no albumin or sugar and no pus or blood. The patient's appetite was fair, but he was slightly emaciated. In regard to the lungs nothing abnormal could be detected save a little emphysema. As for the heart the area of dulness was obliterated, the apex was normally placed, and the sounds were healthy. The patient had an anæmic, sallow complexion and an anxious expression. There was no œdema, nor were there any obvious nervous symptoms. Three days after admission Mr. Johnson Smith incised the abdominal swelling, and a large quantity of pus escaped; the pus was of a dark-red colour, containing abundant pus and blood cells, but no amœbæ were found. The temperature, which had previously been slightly raised, fell to normal after the operation, and the patient made an uninterrupted recovery.

BRANCH SEAMEN'S HOSPITAL, ROYAL ALBERT DOCK.

TWO CASES OF HEPATIC ABSCESS; OPERATION; RECOVERY.

(Under the care of Dr. PATRICK MANSON and Mr. W. JOHNSON SMITH.)

WE bring before our readers in the account of two cases treated at the Seamen's Hospital two methods of operation for hepatic abscess. The following cases present two other