can only claim a palliative and not a curative influence, they were cases which, from their nature and degree, no other result could be expected. In less advanced cases, where the kidneys are capable of recovery, better results may be hoped for, and, indeed, have been obtained.

Cavendish-square, W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

REMARKABLE SUICIDE.

BY JOHN GRANT, M.B., C.M. EDIN.

At 8 A.M. on June 2nd I was called to see F. B—, a blacksmith, aged forty-eight. He was lying on his back in bed, dressed in a cotton shirt and flannel under-shirt, dead. He had come home the preceding evening at 6 P.M. partially intoxicated, having been drinking for two days. Of late he had been addicted to drink. He went to bed at once, but left his room in half an hour, coming downstairs. He was quarrelsome, but on persuasion returned to bed. At 11 P.M. his wife tried to rouse him, but, getting no answer, thought it best to let him alone. At 6 A.M. next morning she again tried, but failed. At 8 A.M. her son broke open the door, and found his father in a sitting posture with his back against it, preventing entrance. He did not go in, but ran for a police officer and medical man. The constable arrived first and forced open the door, finding the deceased as described. Round his neck was a common red cotton handkerchief twisted and tied to the door handle. He immediately cut him down and placed him in bed. On examination I found the body cold and rigid. Post-mortem lividity was well marked on the lower part of the back and legs. The pupils were equal, and moderately dilated. The jaws were firmly clenched and the lips blue, but the face as a whole was little altered, and there was no protrusion of the tongue or eyeballs. Round the front part of the neck immediately below the chin, extending upwards and backwards obliquely over the occiput, was a mark produced by the handkerchief; it was about an inch and a half broad, the skin being quite natural and pale; the texture of the cloth was clearly impressed, but there was no roughening or excoriation; at about an inch on either side of the middle line posteriorly the mark ceased. Turning the man on his face, I noticed the buttocks were flattened and white.

Remarks.—It is perhaps worthy of note that the post-mortem external appearances afforded some indication of the position in which death occurred. The presence of the lividity on the lower part of the back and legs, the flattened pale nates showed that the body had assumed a more or less vertical position, and the minute impress of the cloth on the anterior aspect of the throat pointed to its inclination forwards—in fact, indicated that the man had, so to speak, sat down and hanged himself. The handle of the door was only two feet nine inches from the floor. It is probable the deceased made a loop of his handkerchief, hitched it over the door handle, twisted it to fix it there, but leaving space to admit his head. He then sat down on the floor with his back to the door, put his head through the loop, and bent forward. The forward inclination of the body and the drooping of the head probably induced suffocation by pressure of the glottis against the back of the throat. One has only to try the position for a few seconds to become convinced of the congestion it causes in the head. The entire facts showed considerable method and determination on the part of the deceased.

Maidstone.

INSANITY FOLLOWING MUMPS.

BY R. PERCY SMITH, M.D., M.R.C.P.

INSANITY is well known to be associated with several of the infectious fevers as a complication or sequela, but I am not aware that cases following mumps have ever been recorded. Mumps is not mentioned in the ordinary textbooks on insanity under the heading of "Post-febrile

Insanity," and therefore the following cases have appeared to me to be worth recording.

CASE 1.—G. R. R. T—, a clerk, aged nineteen, was admitted to Bethlem Hospital on June 19th, 1888. He had enjoyed good health previously to this illness and had never suffered from insanity before, and there was no neurotic inheritance. A fortnight before admission he had suffered from mumps, there being other cases in the family and in the same village. His attack was associated with diarrhoea so severe as to be called "English cholera" by the doctor attending him. The patient was said to have been extremely exhausted and almost pulseless afterwards, and was described by his friends to have been "nearly gone." On recovering from this about five days before admission he became excited, sleepless, and rambling, and passed into a condition of acute mania, in which state he was admitted to hospital. There was no special feature about his insanity while in the hospital; he rather rapidly improved, and was discharged recovered in October last.

CASE 2.—This case occurred in a young medical man who had an attack of mumps complicated with severe orchitis, for which he was admitted to a general hospital, and as a result of which he became depressed and suspicious, thought he was guilty of imaginary crimes for which he dreaded punishment, and was suicidally inclined. He had a short attack of melancholia, which passed off with improvement in his physical health, and eventually he recovered perfectly without the necessity of being sent to an asylum.

It is worthy of note that in both cases there was a severe complication associated with the mumps, so that there was considerable physical exhaustion, this seeming to have more to do with the attack of insanity than and severe febrile process or metastasis.

Bethlem Royal Hospital.

NODULAR PERIOSTITIS IN CHILDREN'S RHEUMATISM AND HEART DISEASE.

BY ANGEL MONEY, M.D., F.R.C.P.

OF the occurrence of subcutaneous nodules we have many records enough and to spare. It is not so generally known that nodules are rheumatic manifestations in other tissues. Nodular pericarditis, pericarditis with fibrous nodules, nodular pleurisy, and nodular periostitis are, however, undoubted facts. I have notes of a few cases in which subcutaneous nodules were associated with nodules growing from the bone—exostoses—resembling subcutaneous nodules in every respect except that they are firmly fixed to the bone and cannot be dislodged. One case, a boy aged ten, died, and then I was able to prove post mortem that his olecranon had nodular exostoses growing therefrom. He had many nodules in the valves of the heart, chiefly the mitral valve. Rheumatism is a frequent producer of fibrous nodules, limited localised lumps of connective tissue; a nodular sclerosis, different from the nodules of tuberculosis and from the limited fibroid formations of syphilis, but nodules or limited fibrous formations all the same.

Harley-street, W.

CASE OF SUPRA-PUBIC OPERATION OF OPENING THE BLADDER FOR STONE.

BY CECIL A. CORKE, F.F.P.S., L.R.C.P., L.S.A.

W. B—, aged sixty-eight, consulted me about four years ago, when he suffered from chronic bronchitis, pain on micturition, and was passing gravel. About twelve months ago he passed some bloody urine, but this symptom has only appeared twice since. I sounded him for the first time in June, and discovered the presence of a stone; but from the symptoms then and in subsequent soundings I concluded that the stone was encysted, and from its position not easy to reach by the ordinary operation of lithotomy, so determined upon the supra-pubic operation.

On Wednesday, July 3rd, chloroform being administered by my coadjutor, Dr. Freeman, R.N., and in the presence of Dr. Sankey of Boreatton and Dr. Sandford of Baschurch, who kindly assisted me, I performed the operation, having first distended the rectum with an indiarubber ball of 10 oz. capacity. I injected ten to twelve ounces of boracic solution into the bladder, carefully dissecting and scratching my way

through the tissues. The knife was only used three times. I had no difficulty in reaching the bladder and in extracting the stone, which was, as I had supposed, encysted, and not to be easily discovered; in fact, I at first thought there was no stone, as only a very small surface could be felt, and requiring some little manipulation to free it from its cyst walls. A drainage-tube was passed from the external wound through the urethra, and left *in situ* about five days. The patient has made an uninterrupted recovery, and is now (July 26th) passing all his urine by the urethra, and the wound is nearly healed. The operation was attended by very little hæmorrhage, all veins being held aside, and was much easier to perform than the perineal operation. The stone is about an inch long, half an inch broad, and weighs one drachm five grains.

I place this case upon record as the high operation is only recommended for large calculi; but in all cases of encysted calculi I strongly advise it, and believe it the best resource.

Baschurch.

LARGE BURNS.

BY T. SOMERVILLE SMITH, M.D.

ON February 25th C. W.—, aged three years and six months, being left alone in the kitchen, played with the fire, burning himself in a dreadful manner. I saw him half an hour after the accident, and found him in a state of collapse, suffering from shock. The extent of the burns, subsequently ascertained, was as follows:—

All over the abdomen, width five inches, length seven; down the left thigh, width three inches, length four; on the back, nine inches long and four wide; round each arm, three inches long and four wide; round the neck, three inches long and three wide. The true skin was burnt through over the whole of the abdomen and a portion of the back. Linen rags steeped in linseed oil and lime water were applied to the burnt surfaces. Purgatives, at first administered, were discontinued, as peritonitis set in, accompanied for nearly a whole day with suppression of urine. The child lay on its back with its legs drawn up, the bowels not being relieved for eight days. There was delirium at night for the first five or six days. The treatment was as follows: Brandy during collapse, with bark and ammonia; bromide of potash for rest at night. Linseed oil and lime water were continued for about a week, at the end of which linseed poultices, with plenty of linseed oil in them, were applied to the abdomen and part of the back to remove the eschars. When the wounds were perfectly clean the whole of the raw surfaces were smeared with an ointment composed of lard, zinc, and glycerine, under which they slowly but surely healed. The child's strength was kept up by tonics. There is a very slight contraction in the left groin, where the thigh and abdomen wounds meet; in all other respects the child is now convalescent.

Sittingbourne.

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. THOMAS'S HOSPITAL.

CASES OF ORBITAL CELLULITIS AND ORBITAL ABSCESS; REMARKS.

(Under the care of Mr. J. B. LAWFORD, Assistant Ophthalmic Surgeon.)

THESE cases, which are examples of inflammation of the cellular tissue of the orbit, some of which terminated in abscess, illustrate the difficulty often met with in tracing a disease to a definite cause, as well as the successful treatment of a serious condition. In no case was any history of injury obtained, and in only one was disease of the bony

wall of the orbit found, making it probable that the suppuration in the orbit was secondary to a localised periostitis. There had been no recent attack of fever or erysipelas, but in Case 4 renal disease was present, the patients were apparently free from evidence of visceral disease. Mr. Lawson¹ speaks of an acute inflammatory exudation into the orbit of a syphilitic nature presenting the characters of a cancerous growth, and considers that some of the firm orbital tumours which had gradually subsided under treatment may have been of this nature. To show the remarkable resemblance, he cites a case in which he was himself misled by this close resemblance to malignant disease. When unable to account satisfactorily for the onset of an inflammation, it is not infrequent to find it ascribed to a chill, and this observation applies equally to orbital cellulitis as to inflammations in other parts of the body. Day² described a case of acute exophthalmos. After exposure to cold rain the eye protruded nearly three-quarters of an inch, the pupil being dilated. The protrusion of the eye subsided only after two months, without suppuration in the orbit, and vision continued unimpaired. The fundus was not examined. He ascribed the condition to congestion of the vessels, and perhaps infiltration of serum or blood in the post-orbital tissues. There was apparently nothing to cause the disease excepting the exposure to cold. The subjects of orbital cellulitis and abscess are so frequently depressed and feeble that it is quite possible sudden changes of temperature may lead to a localised venous thrombosis, with a secondary inflammation of the tissues around. The disease may be part of a pyæmic infection of the system, and is occasionally found accompanying the puerperal state. It may be secondary to abscess of the lacrymal gland. The disease may prove fatal by extension of the inflammation backwards to the cerebral membranes, but this is not a frequent sequence. Much more commonly the result of the disease is shown in more or less complete loss of vision in the eye of the affected side, by stretching of, or pressure on, the optic nerve; ulceration of the cornea may also occur from damage to the ciliary nerves behind the globe.³ As regards prognosis, much will depend upon the period in the course of the disease at which treatment is commenced and the way in which it is carried out, as well as upon the causation of the disease.

CASE 1. (From notes by Mr. Hinnell.)—Charles D—, aged thirteen, a schoolboy, was admitted on Aug 25th, 1886. The illness began on the 15th, when the boy awoke at night with severe pain in and about the right eye. The lids were then noticed to be swollen. The pain has continued since, and there has been frequent vomiting. There is no history of injury, or of recent illness. Family history unimportant.

On admission, there was marked proptosis of the right eye, the globe being protruded to the outer side of the middle line; almost fixed, but a little outward movement retained. There was slight bluish discolouration of the lids, with very little swelling. The cornea were clear, the pupil equalled the left in size and reaction. V = J.L. Under ophthalmoscopic examination the retinal veins were engorged; the margins of the disc hazy. On palpation there was a sense of resistance beneath the upper orbital margin, with doubtful deep fluctuation. There were no enlarged glands. The child was in pain, looked ill and thin, and was said to have lost flesh rapidly. The tongue was furred. Temperature 97·8°; pulse 66; urine 1032, acid, no albumen or sugar.

Aug. 27th.—The condition of the eye has scarcely altered, but there is more pain. No sickness since admission. The temperature has slowly risen, and remains about 100°. There is now a solid resistance to be felt at the lower and inner part of the orbit. Ether having been administered, an incision was made close to the lower orbital margin towards the nasal side. At a depth of an inch to an inch and a quarter thick fetid pus was discovered, and two to three drachms let out; a small area of rough bone was felt. A drainage-tube was inserted, and an iodoform dressing applied. Pus continued to drain away in small quantities for the next two days. The boy was much more comfortable. The temperature continued above normal.

30th.—More proptosis; discharge of pus continues.

Sept. 3rd.—Considerable chemosis of conjunctiva; eyeball greatly protruded. Ether again administered, and the

¹ Diseases and Injuries of the Eye.

² Medical News, April, 1888.

³ Nettleship.