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.

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

By J. HARRY POLAND,

CHIEF MEDICAL OFFICER, SANDHURST HOSPITAL, VICTORIA.

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

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.

slight compared with the backward. The diagnosis is easily made, and the reduction and treatment similar to that employed in the foregoing case.

Sandhurst, Victoria.

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.

UNIVERSITY COLLEGE HOSPITAL.

A CASE OF TUBERCULAR PERITONITIS AND PLEURISY;
CYSTITIS; DIPHThERIA; NECROPSY; REMARKS.

(Under the care of Dr. F. ROBERTS.)

FOR the following interesting notes we are indebted to Mr. Thomas Wilson, M.B., B.S. Lond., late house-physician.

F. T—, aged fifteen, a "stripper" in a telegraph works, was admitted on Nov. 15th, 1883, complaining of pain in and swelling of the abdomen. At his work he had been exposed to draughts and damp, his diet had been deficient in meat, but his clothing had always been plentiful and warm. Until the present illness he had always enjoyed fairly good health, though he had never been robust. The family history was good. About Nov. 1st he experienced a chill, but did not feel unwell till two or three days after, when he became rather drowsy and apathetic. Two days later he complained of pain in the hypogastric and lumbar regions and of headache. Shortly afterwards his abdomen became distended and his appetite failed. The bowels were in a normal state. About this time the patient received a blow on the lower part of the abdomen, causing pain, which, however, soon passed away. About a week before admission he was, he stated, unable to pass urine for two or three days, and the quantity afterwards passed was diminished. On Nov. 9th the abdomen became painful and also more swollen. Since then the man had suffered much from thirst. During the fortnight previous to admission he had experienced much discomfort from external piles. There had been no constipation or diarrhoea.

On admission the patient was found to be a slightly-built, badly-nourished lad, with a sallow and anæmic complexion, and an anxious, fretful expression. He could lie without absolute discomfort in any position, but preferred lying on his right side, with his legs slightly flexed. Temperature 102° F. There was great thirst. Appetite fairly good; no nausea or vomiting. Bowels opened once or twice daily; stools semi-fluid, light in colour, consisting of curdy-yellowish material, with occasional light-green-coloured streaks. Lips dry and cracked; breath very offensive; tongue covered with thick, creamy fur, except at tip and edges, which were red with prominent papillæ. The abdomen was much distended, especially in the upper half; its walls were very tense, and not œdematous; the umbilicus protruded slightly; there was no marked bulging of the flanks. The lower margin of the thorax was somewhat everted. There was slight fulness of the superficial veins. The abdomen felt very tense, the resistance being greater in dependent parts. There was no marked tenderness on manipulation. There was dulness on percussion in the flanks, extending as far forwards as the anterior superior iliac spines when the patient was lying on his back. Each flank became resonant when the patient turned on the opposite side, the dulness then rising on the lower side. Distinct fluctuation was obtained between any two points in the area of dulness. The liver dulness reached as high as the fifth intercostal space in the right vertical nipple-line; the lower border could not be defined by palpation or percussion. The splenic dulness was not increased. Respiration 30, shallow, and thoracic. Slight cough with clear mucous expectoration. No abnormal pulmonary signs. Pulse full, regular, moderately compressible. Heart sounds weak, but otherwise normal. There was no pain, but some difficulty in micturition. Urine acid; it contained no sugar or albumen, but large deposit of amorphous urates on standing.

On Nov. 16th the patient complained of sharp, scalding pain in the abdomen, especially over the lower ribs. On the

17th the urine became alkaline, depositing a large sediment of phosphates. The bladder was very irritable. There was great thirst; no vomiting; slight diarrhoea, with light coloured stools; tongue thickly coated. The temperature varied from 101·4° to 103·2°. The urine continued alkaline till the 23rd, when it was again noted as being acid, and free from deposit and albumen. The abdomen was more tense, but less painful and tender. The thirst and diarrhoea continued. Temperature 101·2° to 103·4°, generally slightly higher in the evening. On the 26th the patient vomited twice. The diarrhoea and thirst continued, but to a less degree. The abdomen was more distended and tense, especially in the epigastric region. The man now began to suffer from troublesome cough and more difficult breathing. On the 28th the patient was stated to have been delirious during the night. There were signs of fluid in both pleuræ as high as the angles of the scapulæ. There was cough with expectoration of greenish glairy mucus, streaked with blood. The diarrhoea was worse. There had been no return of vomiting. Pulse 112, weak, irregular, and rather dicrotic. Temperature 101·6° to 103·6°.

On Dec. 3rd the patient remained in the same condition, except that the bowels were now rather confined. On the 7th the abdomen was distinctly larger and more tense; the signs of fluid at the base of the left lung were much less marked; the man slept better. On the 10th he vomited a little bitter yellowish fluid. On Dec. 14th the abdomen was aspirated, 212 ounces of clear yellowish serous fluid being withdrawn, a portion of which became solid on boiling. On the 17th the skin of the abdomen was hot and dry; there were still signs of a considerable quantity of fluid in the abdomen, and the signs at the bases of the lungs remained as before the tapping. The bowels were opened once daily, the motions being formed. There was catarrh of the nasal passages. On the 18th the urine contained a small quantity of albumen for the first time. On Dec. 19th the soft palate and fauces were found to be covered with thick greyish-white exudation, and the patient was isolated. His breathing was very laboured, on account of the obstruction in the throat and nose. The swelling of the abdomen was increasing. There was some œdema about the ankles. He slept fairly well. Temperature 100·6° to 102·8°; skin hot and dry. On the 20th there was more membrane about the throat; the lips and teeth were covered with sordes; the urine contained a large quantity of albumen. Temperature 101·2°; pulse 120, small and compressible. On the morning of the 21st the pulse was 148; the nasal passages and throat were covered with thick greyish-white exudation. The patient gradually sank, and died from asthenia in the evening.

Necropsy, sixteen hours after death.—The peritoneal cavity contained a large quantity of clear yellow serous fluid. The parietal layer of the peritoneum was from a quarter to a third of an inch in thickness, and adherent to the subjacent organs by a thick layer of reddish lymph. The intestines were firmly matted together; on separating them a large number of grey granulations were seen beneath the lymph. The liver and spleen were adherent to the surrounding parts by thick layers of lymph, beneath which the peritoneal coverings were found to be infiltrated with grey granulations. These organs were otherwise fairly healthy, as were also the heart, kidneys, and brain. The mucous membrane of the intestines showed no sign of ulceration or of tubercular deposit. The left pleural cavity contained ten ounces, and the right six ounces, of blood-stained fluid; no adhesions. Over the posterior aspect of the lower lobe of the left lung there was a fine coating of lymph. Over this surface and in the fissure numbers of grey granulations were scattered in the pleura. The right pleura was similarly affected. The lower lobes of both lungs were œdematous. No tubercles were observed in the substance of the lungs. There was an enlarged bronchial gland with caseous masses in its centre at the root of the right lung. Both tonsils, the soft palate, and the epiglottis were covered with a fawn-coloured, pultaceous, easily separable membrane. This extended down the pharynx as far as the cricoid cartilage, and was continued through the larynx and into the trachea for two inches. The glands about the angles of the jaw were enlarged.

Remarks.—This case is interesting from the localisation of tubercle in the pleura and peritoneum, no deposit being found in the substance of any of the organs. The diagnosis of the cause of the peritonitis on admission was somewhat obscure; the age of the patient, insufficient diet, and unhealthy occupation pointing to tubercle, while, on the other hand, difficulty in accepting this diagnosis was found in the