FATAL CASE OF ACUTE LOCAL ENTERITIS OF UNDETERMINED CAUSE.

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L. B—, a porter at the Royal Chest Hospital, aged forty-three, was suddenly seized with violent abdominal pain on the morning of April 21st. He was a married man with several children. He had always enjoyed robust health, but there was reason to believe that he was intemperate in the use of alcohol. On the morning above mentioned he was called for early at his own house, got up, opened the street door, and on returning to his room was attacked with colicky pains, soon succeeded by vomiting. Dr. Burgess, the resident medical officer of the hospital, was called to see him, and found him suffering from paroxysmal pain referred to a spot midway between the umbilicus and the pubes. I am indebted to Dr. Burgess for notes of the patient's condition at this time. From them I learn that the man complained of constant distress in the region described, aggravated every two or three minutes until it became so severe as to cause him to cry out and to double himself up with pain. The bladder was not distended; there had been no motion from the bowel on that day. He vomited whenever he took food. There was no history of previous constipation, and his last meal had been a simple one of meat for supper on the evening preceding his illness. He was given a draught containing castor oil and laudanum, which (according to his wife's statement) moved his bowels very slightly a short time after its administration. The symptoms continued unchanged during the day. He frequently vomited, and suffered from tenesmus. He passed a very restless night. On the following morning, April 22nd, I was asked by Dr. Burgess to see the patient. I found him lying on his back in bed, his knees not drawn up; his face rather pinched, and wearing an expression of anxiety; his pulse small and fast, about 110; his temperature 99.5°. His tongue was slightly dry, but not furred; he complained of thirst; and during my visit he retched ineffectually two or three times. The abdomen was moderately distended; there was no general tenderness, but pressure in the hypogastric region, a little to the right of the median line, caused pain. There had been no motion from the bowels since that mentioned above; the secretion of urine was very scanty. Two attacks of colicky pain occurred in my presence; they came on rather rapidly, the recti muscles contracted strongly, and the patient tried to bend himself forward, making exclamations indicative of distress. For many reasons it was considered advisable to remove him to the hospital; he did not seem to suffer from the journey, which was a short one. After his admission, the application of hot fomentations with laudanum seemed to give relief to the abdominal pain; the vomiting became less frequent, the vomit consisting of small quantities of green, bilious fluid. The urine was examined, and found to be highly concentrated and to contain a trace of albumen. It was considered probable that the case was one of acute intestinal obstruction. The seat of obstruction could not be ascertained; there was certainly no external hernia; there was no passage of blood from the bowel; digital examination of the rectum gave negative results. Enemas were given without any effect, but the patient asserted that he passed flatus after them and obtained some relief thereby. He was now ordered frequent doses of belladonna. I saw him again at 2 P.M., and found him certainly more comfortable, complaining but little of any pain, and vomiting very seldom; but he hiccupped occasionally, was thirsty, and his pulse was, if anything, worse than in the morning. He was able to swallow and retain concentrated nourishment. There had been no motion from the bowels, and no desire to evacuate on the part of the patient. Dr. Gilbert Smith was kind enough to see him with me at 5 P.M., and gave a very gloomy prognosis. At this time, although the man considered himself better, his pulse was exceedingly rapid and shaky, his breathing thoracic, and his abdomen more tumid than before. The previous treatment was continued by Dr. Gilbert Smith's advice—that is, nourishment and stimulants in small repeated doses, belladonna,

and opium if necessary, to relieve pain. I visited the patient for the last time that evening at 10. There was then no obvious change in his condition; he was perspiring freely, the temperature had never reached 100°; his mind was clear; he vomited a little bilious fluid at long intervals, and complained of some general abdominal pain, which was not at all severe. It was noted, however, as an unfavourable prognostic, that there was a tendency to jactitation, and that the pulse had by no means improved. I am informed by the resident medical officer that the patient was very restless during the night, that during the early hours of the morning he showed some signs of incipient delirium, and that at 7 A.M. he suddenly sat up, tried to get out of bed, and almost immediately fell back and died, brownish-yellow fluid pouring in large quantities from his mouth. Up to this the vomit had been throughout merely bilious. Death occurred forty-eight hours after the commencement of the illness.

The post-mortem examination was made by Dr. Burgess, assisted by Dr. Gilbert Smith and myself, twenty-six hours after death. On opening the abdomen we found evidences of general peritonitis; flakes of lymph covered the intestines, the coils of which were reddened, especially at their points of contact; and the abdominal cavity contained several ounces of turbid yellow fluid. Great care was taken to avoid disturbing the position of the viscera whilst a general inspection was being made. There was no band, twist, intussusception, or internal hernia. Attention was immediately attracted by the appearance of a piece of intestine, about three inches long, lying in the middle line of the hypogastric region; it was intensely congested, of a uniform deep-red colour, and contrasted strongly with the neighbouring coils. It was found to be a portion of the ileum, nearly two feet distant from the ileo-caecal valve. There was no such sharply defined line of demarcation either above or below the coil as is observed in cases of strangulation, but the deep-red colour shaded off very rapidly on both sides. The portion of mesentery belonging to the coil contained between its layers an oblong dark-purple mass. The ileum above this congested piece, the jejunum, duodenum, and stomach were all greatly distended, and filled with brownish-yellow liquid without faecal odour. No perforation was discovered. The last two feet of the ileum contained a thick pasty material; this part was neither much dilated nor contracted. The caecum and first part of the colon contained yellow faeces in considerable quantity; the sigmoid flexure and rectum were empty. Examination of the intestinal mucous membrane showed no evidence of diffuse enteritis; but in the intensely inflamed coil of ileum the mucous membrane was swollen and covered with sticky mucus. No part of the canal contained blood. The purple mass in the mesentery proved to consist of lymphatic glands with hæmorrhage in their substance and around them; other glands in the immediate neighbourhood were enlarged and so soft as to be absolutely diffident. The mass in the mesentery was about an inch and a half long, and communicated by means of a thin line of effused blood with a very small extravasation beneath the mucous membrane. A microscopic examination of parts of the glands and of the inflamed bowel revealed nothing further than had been ascertained by the naked eye. The mesenteric vessels appeared healthy, and there was no sign of embolism. The liver was soft and fatty. There was a small cyst in the left kidney. The heart was healthy; the left ventricle firmly contracted. There was acute diaphragmatic pleurisy on the right side. No other morbid appearances were observed.

Remarks.—It appears almost certain from a review of the clinical history and the post-mortem appearances that this was a case of local damage to the intestine, giving rise to local enteritis at first, then to obstruction from paralysis of the muscular coat, and finally to general peritonitis. It is difficult, if not impossible, to ascertain the nature of the original lesion. During life it was considered possible that there had been some accidental twist of the bowel, or that a knuckle had been suddenly constricted by a band or otherwise, or that an intussusception had occurred. Some such injury was supposed to have happened, because of the nature of the symptoms and their mode of onset after the patient had suddenly risen from bed. The theory of an intussusception was rendered to some extent improbable by the absence of physical signs and by the fact that no blood was passed per rectum; but that something of the nature of an accident did occur appeared, and still appears,

in the highest degree probable. What could this accident have been, regarding the matter in the light of the post-mortem appearances? If it was a twist or an intussusception, then the bowel must have recovered its original shape after the lesion had set up the inflammation which terminated in death. But even supposing the possibility of such recovery, would there not have been more definite appearances in the mucous and serous membranes to indicate the accident? On the whole, I feel unable to suggest any explanation of the phenomena; the only thing which at the time seemed to give a clue (and that by no means a satisfactory one) was the discovery of a hæmorrhage between the layers of the mesentery adjoining the inflamed piece of bowel. Whether this can have been the primary accident is a question which I cannot attempt to determine; but it is interesting to note that there have been recorded cases of mesenteric hæmorrhage discovered post mortem, in which no other cause was found for the fatal event. (See report of meeting of the Medical Society, December 5th, 1881, THE LANCET, December 31st.) The immediate cause for the somewhat remarkably sudden death in the present case was in all probability acute distension of the stomach by upward overflow of the contents of the small intestine. Up to the moment before death the vomit was simply bilious; at the moment of death, yellow fluid poured in quantities from the mouth; after death the stomach and upper part of the intestines were found uniformly distended with the same fluid.

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ON THE IMPORTANCE OF CONTINUOUS EXTENSION AFTER TENOTOMY IN CASES OF CON- GENITAL TALIPES, WITH TARSAL DEFORMITY.

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HAVING had "a run" of these cases of late in my hospital practice, a brief record of the line of treatment adopted will perhaps tend to elucidate some of the difficulties experienced in obtaining permanent good results after division of tendons. Not only is it necessary that the distorted limb be placed in its rightful position by the division of parts, whether tendon or fascia, that hinder by abnormal contraction the extension of the foot, but far more important is the maintenance of the limb by continuous extension in that exact position which it is intended ultimately to assume. By forcible manipulation under chloroform many of the fibrous bands and interosseal ligaments which had helped to keep the limb in a wrong position can be stretched or divided, and the astragalus brought up to its normal position under the articulating surface of the tibia. Care, of course, must be taken so to manipulate the bones as to preserve the double arch of the tarsus. I am not one of those who think we can effect much without the division of tendons, nor do I place much faith in Scarpa's shoe as a means for counter-extension. It is fortunate that with better educational advantages and improved means of transit, parents are finding their way to hospital at an earlier period than formerly. The district surgeons, too, though well able in many cases to perform these operations, are finding out the advantage of early treatment, and the benefit to be derived from sending their patients to hospital towns, where skilful and patient continuous nursing as an adjunct to special surgical treatment is now valued and appreciated. I cannot too strongly protest against the folly of depending upon complicated and expensive mechanical appliances which fail to keep up continuous extension, though designed for that purpose. By adding weight to the already impoverished limb they rather increase than diminish the deformity. To see the children parading the streets, their limbs encased in iron, with the idea that in some unexplained way the distorted limb will come straight, is only equalled by the credulity of the mother who, when told that iron was good for a rickety child, ordered its limbs to be encased like an ironclad, with a sailor suit to match. When the deformity has become so marked that the child is accustoming itself to walk upon the sides, instead of the soles, of the feet, the joint surfaces

have been so moulded by the altered position of the foot, and the tendons have become so rigidly contracted within their sheaths, that to rectify such malposition needs great care and assiduous treatment by continual pressure in the direction required to rectify the deformity. It cannot be supposed that any instrument maker, however large may be his experience, and however skilful he may be in the manufacture and adjustment of appliances, can be so acquainted with the physiological processes of repair and methods of accommodation during the period of growth as to be able to arrange for all the little niceties needful for keeping up continuous extension. As a fact, the parents too often live within a charmed circle of their own ignorance. Scarpa's shoe, with all its screws and straps, and purchased at a somewhat prohibitory price to many, presupposes to the uninitiated a guarantee of its hidden powers for self-adjustment.

As regards division of tendons, I find that the tendo Achillis requires division in the great majority of various deformities, simply because the gastrocnemius pulls the foot inwards as well as backwards during the flexion of the foot. The broad insertion of the tendon into the os calcis and the solid sheath encasing it permits of free division without absolute separation of all the attachments. By careful bandaging of the foot and leg the leverage obtained by the extensor muscles is to a great extent restored. As soon as all muscular impediment to the rectification of the foot is removed, there remains a considerable amount of distortion from the paralysed state of the extensor muscles. To obviate this I carefully apply a plaster-of-Paris bandage over a flannel "protective," bringing the foot up into its proper position by very firm manipulation, and keeping up this extension until the bandage has "set." By this means I succeed in procuring rigidity of appliance together with liberty for muscular effort. By galvanism and friction of the extensor muscles the tendons contract, and after three or four renewals of the plaster-of-Paris encasement the foot generally regains its normal position during the process of growth and development. Occasionally I fit a piece of webbing round the metatarsal bones and attach to the outside of it a length of solid elastic. The proximal end of this may be passed through a clip fixed to a garter below the knee. Continuous extension will in this way effect considerable rectification of the distorted parts. It will often be found useful with older children who are able to walk, and who have not such pliable and easily-moulded feet as young infants. I generally persevere for months with the treatment, and seldom require any mechanical appliance, not even in those extreme cases where the astragalus almost touches the ground.

Cranley-gardens, S.W.

FATAL CASE OF POISONING BY ERGOT OF RYE.

BY A. DAVIDSON, M.B., &c.

ON Saturday, June 3rd, about 4 P.M., I was called to see M. M.—, aged twenty-eight, lately a hospital nurse. She was said to have "burst" a bloodvessel. On entering her room I observed a basin of reddish-brown pultaceous matter, said to have been vomited by the patient about 8 A.M. I was informed she had vomited something like it a few days previously, and, complaining of lumbar and arthritic pains, had expressed a fear that she was going to have rheumatic fever. Late on the previous evening she had passed a very hard motion, and a quantity of urine which looked like blood. About the same time, also, she had vomited half a pint of blood. During the evening and morning she gradually became worse.

On my arrival the face, eyes, neck, and upper portion of chest were intensely jaundiced. The intensity of the jaundice diminished from above downwards, till at last it disappeared altogether. She had a pair of genuine "black eyes." The rest of the body had a natural appearance. The expression was anxious, and the general condition maudlin. Occasionally fits of stupor and of apathy ensued. There was no alcoholic odour, but during the evening a distinct etherish smell could be perceived. The lips were slightly swollen, and covered with dry black blood. The tongue was also slightly swollen, dry black blood covering