zygoma and around the neck of the jaw. The ascending ramus was then cleared with a raspatory three-quarters of an inch above the angle of the jaw and divided, and a wedge-shaped piece of bone with the base of the wedge (half an inch) posterior removed. This was effected with some difficulty partly by a keyhole saw and partly by cutting pliers as the bone was more than usually dense. There was no trouble with the inferior dental artery. The patient made an excellent recovery without constitutional disturbance and was able to masticate with very little pain on the third day. The mouth could be opened to the extent of seven-eighths of an inch, and very good lateral movement was obtained. The patient kept up passive movements very assiduously, and was given a graduated wooden wedge on which to measure the extent of the interval between the teeth. This has not tended to lessen during the last year, and the patient has at present perfect masticatory power, with free and painless movement, both vertically and laterally. This operation, the risk of which is small and the chief difficulty of which is the division of the bone without splintering or unnecessary damage, seems much more generally successful than excision of the condyle. The latter, as shown by Mr. Paul Swain some time back in THE LANCET,¹ has many risks, and often a result which is by no means satisfactory.

Nuneaton.

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.

WESTMINSTER HOSPITAL.

ADDISON'S DISEASE OF VERY RAPID COURSE; REMARKS.

(Under the care of Dr. DONKIN.)

THIS disease is one which has attracted the special attention of pathologists and physicians since it was first described by Dr. Addison. The communication by Drs. Alezais and Arnaud (summarised by Dr. Allen J. Smith¹) is one of the most interesting recently published as a contribution to its pathology. They consider the process to be essentially one of tuberculous infiltration, the presence of tubercle bacilli having been repeatedly demonstrated in the affected supra-renal capsules. The process may begin in the cortex or in the medulla, and less often in the fibro-vascular zone about the capsule. Changes may be found in the neighbouring tissues as the result of such processes in the supra-renal capsules, as alterations in the abdominal sympathetic nerve, changes in the mesenteric glands, tuberculous disease of the spine and lungs, and alterations in the kidneys and urogenital organs. They regard as being near the truth the view that ascribes the phenomena of the disease—especially the prominent nervous symptoms, such as the sudden and complete asthenia, the vomiting, the lumbos- abdominal pains, and often the sudden death—to alterations in the abdominal sympathetics. They think, however, that the pathological facts thus far established are insufficient to base any theory upon, as in a number of instances the abdominal sympathetic has been found quite normal. Of forty-nine cases met with, the abdominal sympathetics were quite healthy in twelve instances. They believe, however, that the nervous symptoms arise directly within the capsules themselves, and have found undoubted nerve ganglia in the periphery of the organ as a constant element, and state that these bodies are always implicated in the capsular lesion of Addison's disease although heretofore overlooked. They cite three cases in support of their view. In one there was marked tuberculous change all about these ganglia, which were, however, intact, and no symptoms of Addison's disease were present; in the second the pericapsular ganglia, as well as the left semilunar ganglion and branches of the solar plexus, were involved, the symptoms of Addison's disease being present; in a third the pericapsular ganglia were

alone involved, the rest of the abdominal sympathetic system being intact, Addison's disease being manifest.

A man aged forty-seven years was admitted into Westminster Hospital on Nov. 12th, 1894, complaining of very frequent vomiting and great prostration, and died on Nov. 24th. He had been perfectly well, according to his own and his relatives' accounts, until five weeks before admission. He had had no previous serious illness, had not had syphilis, and was in all respects a temperate man. This illness began quite suddenly one day with pain in the epigastrium and vomiting about three minutes after a meal, since which time he had vomited after every meal and become steadily weaker. Three weeks before admission his legs began to feel numb, and he suffered from pains in the back and shoulders. On admission he was thin; his skin was generally of a dark, bronzed colour, most marked in the face, dorsum of hands, and axillæ, least marked in the lower limbs. There were a few dark patches on the soft palate and on the inside of each cheek and of the lower lip. In answer to inquiry he said that his friends had told him about a week or so before his admission that he was getting darker in appearance. He was very feeble and walked with difficulty; but there was no discoverable alteration of sensibility over the trunk or limbs, and no muscular paralysis. The pulse was very small and compressible, and the first sound of the heart markedly indistinct. The breathing over the front of the right lung was harsh, but the thoracic signs were otherwise natural. Nothing abnormal was discovered on abdominal examination, nor in the urine, which was, however, of rather dark colour. After his admission the vomiting ceased, and the man seemed to improve. On Nov. 20th, his bowels being constipated, he had a dose of senna mixture. His bowels acted, but he started vomiting again. The temperature, hitherto normal or sub-normal, rose to 102° 6' F. Next day the vomiting continued, and the temperature, after falling to normal, rose again to 104°, at which point it remained during the day following. The patient, however, then felt better, the vomiting having ceased. He talked cheerfully and said that but for weakness he felt quite well. On the night of the 23rd he slept well. On the 24th, at 6 A.M., he complained of cold feet, and shortly afterwards sat up in bed and "became quite rigid, while his breath was very short." Recovering from this condition, he seemed to be fairly well until 8 A.M., when his breathing became short again, and he died in a few minutes. There was a cloud of albumen in the urine on the last day.

Necropsy on the afternoon of the day of death.—The body was fairly nourished, rigor mortis being present; the blood was fluid and dark-coloured, drying quickly. There was general bronzing of the surface, least marked over the lower extremities. The larynx was normal, and the thyroid gland small. There were a few old adhesions over the upper lobe of the right lung, but elsewhere the pleura was quite natural. In both lungs were several discrete, large, and pigmented fibroid tubercles, but there was no breaking down. In other respects the lungs were normal, as also were the mediastinal glands. The heart's muscle was firm and very dark; all its structures were apparently normal. The abdominal organs were natural, with the following exceptions. There were a few large pre-vertebral lymphatic glands, with no tubercles discoverable by the naked eye. The adrenals were very large, and quite converted into fibro-caseous masses in which all traces of normal tissue were lost, though the general shape was fairly well preserved. (The semilunar ganglia were normal.) The kidneys weighed ten ounces. There was cortical atrophy of the upper half of the right kidney, the capsule around this portion being very thick and adherent to the subjacent areolar tissue. In other respects the kidneys were normal. The bladder was healthy, but in the centre of the prostate were numerous small and yellow caseous foci, clearly tuberculous. The prostate was not enlarged. The vesiculæ seminales were normal. The epididymis on both sides, especially the left, was much enlarged from tuberculous deposit, and there were tubercles in the body of the right testicle.

Remarks by Dr. DONKIN.—The most important clinical points in this case are the very definite onset of the first symptoms and the extremely rapid course of the expressed disease. After searching inquiry it was established that the man felt and looked perfectly well until a little under seven weeks before he died. The pigmentation, as is most often the case in the more protracted instances of the disease, was not observed until after the important symptoms of vomiting and prostration had been established for some time. The

¹ THE LANCET, July 28th, 1894.

rise of temperature a few days before death must be noted as a symptom of infrequent occurrence. With this may perhaps be associated as a possible cause the advancing tuberculous affection of the prostate, epididymis, and testicle. The tubercles in the lungs were probably the earliest change of all those revealed at the necropsy.

CLAYTON HOSPITAL AND WAKEFIELD GENERAL DISPENSARY.

AN UNUSUAL CASE OF ADDISON'S DISEASE; SUDDEN DEATH; REMARKS.

(Under the care of Mr. PAUL STAR, senior house surgeon.)

TUBERCULOUS disease of the suprarenal bodies is an affection more common in men than in women, but the following case presents some other more important points of difference from the usual type, which mark it as especially interesting. The most characteristic symptom of Addison's disease is the gradual development of debility without appreciable loss of flesh, and a sudden cardiac failure ending fatally without previous complaint of weakness is fortunately very rare. "It is probably not possible in any case to ascertain the exact date of the commencement of the disease; there are good reasons, indeed, for believing that the process of suprarenal degeneration is always far advanced before the clinical signs of the affection reveal themselves. Counting then from this latter date, the malady is sometimes remarkably rapid in its progress—proving fatal in the course of two or three weeks,—while sometimes it is prolonged for several years."¹ Dr. Leva² has described a case the duration of which was supposed to have been eight years. This case exemplifies the advantages and advisability of holding a post-mortem examination in cases of sudden death.

A girl seventeen years of age was admitted to the Clayton Hospital on Jan. 27th, 1894. She had fallen in the street while on an errand, close to the hospital, and was brought to the institution on an ambulance. At the time of admission she was unconscious, motionless, and very pale; she was perspiring slightly about the face and neck, and the surface of the body was cold. There was no rigidity, and the sphincters were unrelaxed. The pupils were somewhat dilated, equal, and reacted to light. The conjunctival reflexes were present, but feeble. The tendon reflexes were normal, and there was no ankle-clonus. Respiration was shallow and the pulse was imperceptible. The cardiac impulse could just be felt and the sounds very indistinctly heard. The heart-beat was 65 to the minute. No injury to the head was apparent, and there was no distinct odour of the breath. Half a drachm of sulphuric ether was injected over the cardiac region, and a few minutes later the pulse could be distinctly felt at the wrist. The patient was put to bed and hot-water bottles applied to the legs and sides. She completely recovered consciousness in about half an hour. The pulse and respiration rapidly improved. She answered questions as to her name, previous health, &c., and said she felt quite well enough to go home. The heart and lungs were found to be quite healthy. The urine was normal. The patient was kept in bed and given some warm milk and about half an ounce of brandy. In about three hours the pulse again began to fail rapidly and became irregular in force and rhythm, the respiration at the same time becoming short and shallow. Sal volatile and brandy were exhibited, but there being no improvement in the pulse a drachm of ether was again injected over the heart. This had no effect, and the patient died a few minutes after the injection, the time between the commencement of the second attack and death being about ten minutes. The patient's mother said that her daughter had always been a healthy girl until about three months before the present attack, when she had to leave her situation owing to continued attacks of abdominal pain and vomiting. These symptoms were considered to be due to derangement of the digestive functions and had quite ceased about two months after their first onset, and she had again gone to work. Her family had always been healthy, and there was no history of any hereditary disease.

Necropsy.—A post-mortem examination was made fifteen

hours after death, when the body was found to be that of a well-nourished and finely developed girl. Rigor mortis was present in the lower limbs, but was passing off in the arms. There was no post-mortem staining, or pigmentation of skin, or mucous membrane, except below the umbilicus, where the skin of the abdomen was distinctly bronzed, forming a marked narrow line leading from the umbilicus to the pubes. The skin over the iliac regions was pigmented in a less marked degree. On opening the thorax the heart and lungs were found to be quite normal. The thymus gland was persistent and as large as that of a child twelve months old. It was normal in situation and weighed six drachms. The lobes were well marked. The abdominal viscera were normal. The stomach contained about half a pint of semi-digested food. The pelvic organs were normal. The adrenals were very large and tuberculated, hard to the touch, and on section showed no distinction between cortical and medullary substance. They cut like hard cheese and contained many cretaceous nodules, but no pus. Both the organs were surrounded by dense and tough connective tissue, and were bound down to the kidneys. The retro-peritoneal and mesenteric glands in their vicinity were enlarged and hard, but were normal in appearance on section. The semilunar ganglia and solar plexus were surrounded and compressed by fibrous tissue. The brain was normal. Microscopic examination of the adrenals showed the usual changes found in Addison's disease. Tuberculous growth was present in various stages; caseous centres were surrounded by small-celled infiltration with giant cells. A good deal of altered tissue was undergoing fibroid change. Sections of all other organs showed nothing abnormal. Unfortunately, the solar plexus and semilunar ganglia were not removed at the necropsy, so that a microscopic examination of their condition could not be made.

Remarks by Mr. PAUL STAR.—The chief points of interest about the case are—(1) the cessation of all symptoms for a month before death, the patient enjoying good health and following her occupation during that time; (2) the sudden death, this occurring about three hours from the time the patient fell in the street; (3) the presence of a large thymus; (4) the limited extent of the bronzing; and (5) there being no disease of other organs than the suprarenal capsules.

ROYAL INFIRMARY, NEWCASTLE-ON-TYNE.

A CASE OF CUT-THROAT INVOLVING THE LARYNX TREATED BY SUTURING; COMPLETE PRIMARY UNION; REMARKS.

(Under the care of Dr. ARNISON.)

THE ordinary rules of surgery as recently understood and expressed in our text-books left very little room for the exercising of the individual skill and discretion of the surgeon in charge of a case of cut-throat. If there was one thing about which there was unanimity it was the harm done by the insertion of sutures in such cases, and the great responsibility resting on the surgeon who ventured to use them. Dr. Arnison's treatment of his patient shows the excellent result which may be obtained by judicious suturing. The condition of these cases is often most unfavourable for the primary union of wounds: miserable, depressed, the subjects of chronic alcoholism, melancholia, renal disease, heart disease, or chronic phthisis—every injury, even the slightest, becomes of moment. Then, again the wounds vary very much in extent, depth, irregularity of surface and number of structures divided, and if there is any septic accumulation in a closed wound cellulitis of a spreading kind, only too frequently fatal, may ensue within a day or two. It is therefore necessary to exercise a careful selection before attempting primary union. For the notes of this case we are indebted to Dr. W. E. Harker, house surgeon.

A man aged forty years was admitted into the Royal Infirmary, Newcastle-on-Tyne, having cut his throat one hour previously. The skin incision began at the anterior edge of the left sterno-mastoid and tailed off a little beyond a corresponding point on the right side of his neck. Parts of the following muscles were cut: platysma, omo-hyoid (anterior belly), sterno-thyroid and thyro-hyoid, exposing on the left side the trunk of the vagus, which was lying internal to and on the same level as the vessels, which were uninjured. The thyroid cartilage was completely severed just below the pomum Adami, giving a good view of the interior of the larynx. The cut edges of the cartilage came accurately

¹ Pristowe: The Theory and Practice of Medicine.

² Virchow's Archiv für Pathologische Anatomie und Physiologie und für Klinische Medizin, Berlin, Band cxxv., 1891.