

possible that the occlusion by a thrombus of the second branch of the middle cerebral artery by affecting the middle part of the ascending frontal convolution of the left side might cause the conditions above described. This case shows the possibility of obtaining great improvement even after epileptoid convulsions, paralysis, wasting, and contraction of the muscles have continued unaltered for the long period of six years and ten months.

Belfast.

PENETRATING WOUND OF THE ABDOMEN: AN INTERESTING CASE.

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A STRONGLY built man, forty-three years of age, was riding on a bicycle behind his brother late on the night of Sunday, March 13th, when the machine of the latter capsized. As a collision could not be avoided the second rider ran into his brother's bicycle and was thrown to the ground, breaking his own handle-bar in falling. Both brothers seemed not much hurt at the time and were able to walk home, a distance of about three miles. The one whose machine had capsized complained about his knee and his brother and another relative took him to the German Hospital, where the house surgeon on duty, Dr. Krieg, diagnosed a slight contusion and allowed the patient to go home again. When leaving the room the elder brother, who up to that time had not complained about being injured, turned suddenly pale. On being asked whether he felt any pain he pointed to a slight abrasion on the chin and said that he thought his abdomen might also be slightly grazed. Dr. Krieg, however, insisted on examining him and found a penetrating wound of the abdomen with prolapse of the omentum. He at once had the patient undressed and he most carefully cleansed and disinfected the abdomen, finally covering the injured parts with hot sterile gauze compresses. In the meantime I had been sent for and arrived about an hour later. The patient, who was quite conscious and but slightly collapsed, consented to a thorough examination and was put under chloroform by Dr. Krieg. It was then found that the broken handle-bar had struck the ensiform process, but having been deflected by that bone had entered the abdominal cavity between it and the umbilicus. The wound was enlarged as far as the skin was undermined and the protruding omentum was ligatured close to the colon transversum and removed. It was now seen that the recti and their sheaths were severely lacerated and parts of these structures were missing. In the peritoneum there was a large irregular defect. The adjacent parts of the abdominal cavity and its contents were now carefully examined for further injuries or fragments of cloth, &c., but nothing was found except a few débris of fat and some coagula, which were, of course, removed and the parts cleansed with sterile gauze. As I felt pretty sure that the gut was not cut I closed the peritoneum with a continuous silk suture and then united as carefully as possible the torn recti and their fasciæ by separate rows of sutures. After paring the edges of the superficial wound and removing a large part of the much bruised and besmeared subcutaneous fat I closed the wound, only leaving the lowest part open, where a small strip of iodoform gauze was inserted as it was feared that some more of the fat might become necrotic. The patient bore the operation very well and was only sick once after it. The temperature was quite normal till the fourth night, when it suddenly rose to 102° F., the patient feeling, however, quite well. The dressing was then changed for the first time and on removing the gauze some bloodstained fluid escaped. From that time up to the 24th the temperature has been quite normal and the patient is progressing very favourably, his appetite and other functions being excellent.

The interesting points in this case are, in my opinion, the severe lacerations of the abdominal wall and the lucky escape of the gut and the very small constitutional effects these considerable injuries produced. I have, however, during the last nine months seen three other similar cases which all ended in recovery. All these patients walked to the hospital not knowing that they were so badly injured. One, a little

boy, suffered from a penetrating wound with prolapse of the omentum caused by falling on some broken glass. The second, a lad aged twenty years, had been stabbed and came to the hospital on foot; he also had a large penetrating wound with prolapse of omentum and a considerable part of the small intestine. The third patient, a woman, had been stabbed by her husband and she came to the hospital with a small puncture in the abdomen. I enlarged the opening and intended to follow the wound to the peritoneum to see whether the latter structure was penetrated or not. There was a small rent in the peritoneum and a part of the omentum was tightly gripped by it. On opening the abdomen further the penknife was found to have penetrated the small intestine and to have made a rather large incision into it. This was closed by Lembert's sutures and part of the omentum was removed. All these patients on admission to the hospital had little idea that they were dangerously ill and in no case was the collapse severe.

As regards treatment the lines to be followed were quite clear in the first three cases, as there was no doubt that the abdominal cavity was really opened. Resection of the protruding omentum and replacing of the stump and intestines were always followed by careful inspection of the adjacent parts. In the fourth case there was no evidence of the wound being a penetrating one. In such cases I think it the duty of the surgeon to enlarge the wound and follow the canal down to the peritoneum. In this way, much better and more safely than by probing, can a diagnosis be made. Should the surgeon be forced to wait owing to some unforeseen conditions then I would advise him not to use opium in any form, as it will probably do no good whatever but will often by masking the symptoms of a commencing peritonitis deceive the patient and his medical attendant.

Finsbury-square, E.C.

Clinical Notes: MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTE ON A CASE OF ETHER-PNEUMONIA.

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THE following notes of a case of ether-pneumonia may be of interest as illustrating a point in Dr. Frederic Hewitt's lectures on the administration of anæsthetics.¹

A man, aged twenty-five years, was admitted into the Cardiff Private Patients' Hospital on Feb. 23rd, 1898, suffering from varicosity of the left internal saphenous vein. At 11 A.M. on the 24th the vein was ligatured and divided in four places by Mr. J. Lynn Thomas, anæsthesia being produced by ether administered by myself by means of a Clover's apparatus. Very considerable cough was occasioned by inhaling the ether and there was much delay consequently in procuring insensibility, but it was remarked that the quantity of ether required to maintain full anæsthesia was less than usual. The patient was under the ether from first to last about half an hour. There had been some little cough on the day preceding the operation and during the night after the patient's admission to the hospital he awoke with a cough at 2 A.M. and did not sleep again, but this was attributed to nervous apprehension. He vomited repeatedly after the operation and at 9 P.M. his temperature was 102.5° F. At 2 A.M. he began to expectorate frothy mucous freely and he had very little sleep. On the following morning (Feb. 25th) there was some dulness at the base of the left lung. Expectoration was free and muco-purulent, with no rusty tinge. The temperature was 99°, rising again at night to 104.4°. The pulse was 120 and the respirations were 32. The expectoration was now slightly tinged with red. On the 26th the temperature had fallen to 100° and remained about this point until March 6th, when it fell to 99° and then speedily to normal. The muco-purulent expectoration continued for

¹ THE LANCET, Feb. 19th, p. 483; March 5th, p. 623; and March 19th, p. 772.

several days and the dulness cleared away about March 8th. The patient was discharged with very little cough on the 10th. Cardiff.

A CASE OF SCIRRHUS MAMMÆ BEGINNING IN THE AXILLA.

By C. E. M. KELLY, M.D., B.S. LOND., F.R.C.S. ENG.

IN connexion with the case reported by Dr. Herbert Snow in THE LANCET of March 12th, p. 717, the following may be of interest. The patient, who is still under observation, is a feeble old woman nearly eighty years of age. When she first sought advice it was found that there was a tumour as large as a pigeon's egg, of stony hardness, in the mid-axillary line on a level with the fourth rib. It was quite fixed, was adherent to the chest-wall, and had ulcerated through the skin; at this time it appeared to be quite unconnected with the breast itself. The age and general condition of the patient rendered operation inadvisable, so that the course of the growth has been watched. It extended during the following months along the lower border of the pectoralis major into the breast which became extensively involved. Retraction of the nipple took place and oedema of the skin, showing blocking of the lymphatics, and now the case has the appearance of a typical slow-growing scirrhous with the addition of the process extending into the axilla and the ulcer where the growth commenced. There is no glandular enlargement to be felt as yet. In this case the tumour apparently extends by continuity into the breast and does not start in an outlying and free nodule of glandular tissue.

Highbury, N.

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.

METROPOLITAN HOSPITAL.

A CASE OF RENAL CALCULUS; REMOVAL BY NEPHROTOMY; RECOVERY.

(Under the care of Dr. ARTHUR DAVIES and Mr. STEPHEN PAGET.)

AS Dr. Davies points out in his remarks the pain felt in the loin radiating round the abdomen in cases of renal calculus is often attributed to attempts made by the stone to pass into the ureter; but it is explicable rather as due to irritation of some of the nerves with which the kidney is so fully supplied. The pain of ureteral colic is different in character and different in its position for it passes definitely downwards towards the testis and thigh. The case illustrates the ease with which a stone can sometimes be found in a kidney by needling; yet numerous cases have been recorded in which stones quite as large as that found by Mr. Paget have entirely escaped discovery even after the very thorough use of an exploring needle.

A man, aged twenty-three years, was admitted into the Metropolitan Hospital on March 30th, 1896, complaining of great pain of a lancinating character in the left side. The first attack occurred two years previously and lasted for two hours; a year afterwards he experienced a similar attack which was of short duration only; and a month before admission to the hospital he had another attack which lasted for some hours. He described the attacks as coming on quite suddenly. The pain was intense, radiating round the loin to the middle line of the abdomen and not descending down the thigh or to the testis. The pain ceased as suddenly as it came on. The patient had not noticed any alteration in the colour of his urine during or after an attack. As regards the previous history of the case he had an attack of left pleurisy in 1887. He said that taking beer always increased the tendency to pain in the left

side. His father passed a stone two years previously. When the patient was admitted he was doubled up with pain which caused vomiting. There was less expansion on the left side of the chest than on the right and the note was impaired. No pain was felt over the left kidney on deep palpation. The urine was of specific gravity 1018 and contained a cloud of albumin. When the urine was examined under the microscope blood corpuscles, granular casts with oxalate of lime crystals, and pus cells were seen to be present in great number. As the symptoms continued Dr. Davies requested his surgical colleague, Mr. Stephen Paget, to explore the left kidney with a view to ascertain whether there was a calculus. This he did on April 16th. The kidney was exposed by a suitable incision and was found to be uniform in shape with no bulging. A harelip needle was passed into it and on the first occasion grated against some hard substance. An incision was made into the kidney following the course of the needle with a tenotome and on a finger being introduced it came immediately upon a calculus which was found lying in the pelvis of the kidney and was removed by a scoop. The calculus was composed of oxalate of lime and uric acid and weighed forty-nine grains. It was an irregular triangle in shape and was about an inch in its longest diameter. The patient made a perfect recovery.

Remarks by Dr. DAVIES.—It is noted in the above case that no pain was present on deep palpation. This is a point strongly emphasised by Sir Henry Thompson, who also insisted upon the fact that the majority of the cases of nephralgia are not calculous in origin. There was no pain radiating down to the inner side of the thigh or to the testicle. There seems to be no doubt but that the attacks of pain were due to the calculus irritating the renal pelvis and not to the passage of the stone into the ureter, though these attacks were formerly considered as a proof of such an occurrence. Similar attacks of pain are seen in cases of hepatic colic where the gallstones never leave the gall-bladder.

NORTH-EASTERN HOSPITAL FOR CHILDREN.

A CASE OF ENLARGEMENT OF THE THORACIC GLANDS AND BRONCHIECTASIS ACCOMPANIED BY A PECULIAR SPASMODIC COUGH; NECROPSY.

(Under the care of Dr. J. P. PARKINSON.)

IN the following case the much greater degree to which the left side of the chest was affected pointed to pressure on the left bronchus as the cause of the spasmodic cough, even though the spasms so closely resembled whooping-cough. The case is one of great interest.

A female child, aged six years, was admitted into the North-Eastern Hospital for Children under the care of Dr. J. P. Parkinson on Jan. 6th, 1898. The child had been healthy till she had an attack of whooping-cough when she was two years old, but had since suffered from a chronic cough. Fourteen days before admission shortness of breath came on, together with pains between the shoulders; a week later there occurred spasmodic attacks of coughing followed by vomiting, with occasionally slight traces of blood in the sputum. On admission the child was pale and thin and had clubbed fingers and toes; she was short of breath, breathing 40 to the minute. There were infrequent attacks of coughing resembling whooping-cough, with a definite whoop and causing much blueness and distress. The left side of the chest was smaller than the right and its movement was limited, the percussion note was dull both in front and at the back, and the breathing generally was obscured by numerous moist sounds, except about the lower angle of the scapula, where the breathing was cavernous in character. On the right side there was much impairment to percussion over the posterior base and there was also slight impairment at the apex and in the axilla. The breathing was harsh and numerous moist râles were heard all over. The pulse was 120 to the minute and compressible. The heart's apex beat was visible in the fifth space in the nipple line; the heart sounds were normal. The abdominal organs appeared to be normal and there was no albumin in the urine. The mucoid sputum was examined for tubercle bacilli but no bacilli were found. The temperature varied between 99° and 103° F. and the child got more dyspnoic and died on Jan. 12th.

Necropsy.—At the post-mortem examination the right lung