COMPOUND FRACTURE OF THE NECK OF THE
SCAPULA AND SIMPLE FRACTURE OF THE
SHAFT OF THE HUMERUS BELOW THE
INSERTION OF THE DELTOID.

By F. A. A. HOLMDEN, M.D., M.S. EDIN.,
SURGEON-CAPTAIN, BECHUANALAND BORDER POLICE.

ON June 27th, 1895, a trooper was riding on the front of a regimental transport in N'gamiland, and when trying to step off slipped to the ground, falling on his back, the front wheel passing over the shaft of the right humerus and shoulder. I examined him a few minutes after the accident occurred, and found there was marked projection of the acromion, and a considerable interval between it and the head of the humerus. The deltoid was flattened, the limb had sunk into the axilla, and the coracoid process was movable and at a lower level than that of the opposite side. Crepitus could be produced. There was also a wound on the back opposite the shoulder-joint, which was caused by a stone in the sand. When the probe was used the injured part was found to communicate with the fractured neck of the scapula. The humerus was also fractured below the insertion of the deltoid. The following was the treatment adopted. The wound at the back of the shoulder was syringed with an antiseptic and dressed with iodoform. I applied an angular internal splint from the axilla to the wrist, fashioned so as to project a little below the elbow. The axillary end of the splint was shaped and padded so that it would principally support the anterior and posterior axillary borders, thus avoiding pressure on the vessels. Three short splints were placed on the other sides of the limb. The angular splint was now pushed well up into the axilla, and the four splints were bandaged to the limb; and then, after binding the arm to the side with a broad bandage, a sling was applied well supporting the projection of the angular splint at the elbow, as well as the forearm, which was kept midway between supination and pronation. When seen on Sept. 28th the patient had made an excellent recovery without deformity and had returned to duty.

Bechuanaland Border Police Camp, Kgontsa, N'gamiland.

NOTES ON A CASE OF LYMPHADENOMA; EFFUSION
INTO THE RIGHT PLEURA; PRESSURE ON
THE RIGHT BRONCHUS.

By CHARLES W. CHAPMAN, M.D. DURH., M.R.C.P. LOND.,
PHYSICIAN TO THE NATIONAL HOSPITAL FOR DISEASES OF THE HEART,
SOHO-SQUARE.

THE following case may be read in connexion with a very instructive one reported by Dr. H. Sainsbury in THE LANCET of Nov. 30th, 1895.

Seventeen years ago I was suddenly sent for to see a man who had great difficulty in breathing. On my arrival I found the patient very anæmic and with an anxious expression. The history was, briefly, that he had been in the Australian bush for about four years, and that his health had been failing for two years, during which latter period his glands had gradually become enlarged. He had returned to England to put himself under the care of Sir William Jenner who had, I think, only seen the patient once or twice before I was called in, and in a consultation the same evening Sir William Jenner told me there was no evidence of fluid in the chest when he examined it a few days before. On examination there was general lymphadenoma, with urgent dyspnoea, and the right chest was airless and full of fluid. It was resolved to tap the chest, which I did with a small trocar, but only about two drachms of fluid came away. On a second consultation Sir William Jenner questioned my having entered the pleural cavity, or, even if I had, that the cannula was too small. I accordingly used an abdominal trocar, but with no better result. The patient died the following day. At the post-mortem examination, not only was there pressure on the large veins sufficient to account for the effusion, but the right bronchus was so compressed as to prevent the ingress of air into the lung. Both punctures were seen to be into the pleural cavity, so the dryness of the tapping was owing to the physical conditions within the chest, which, though different from those found in Dr. Sainsbury's case, had a similar effect in not permitting withdrawal of the fluid; there was "no vent" whereby the air could enter.

Weymouth-street, W.

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.

CHARING-CROSS HOSPITAL.

TWO CASES OF TYPHOID FEVER, BOTH COMPLICATED BY
HÆMATEMESIS, AND ONE BY HÆMORRHAGE; ONE
RECOVERY; ONE DEATH.

(Under the care of Dr. GREEN and Dr. J. GALLOWAY.)

INTESTINAL hæmorrhage in the course of typhoid fever is not infrequent, but it is rather difficult to estimate the percentage of cases in which it occurs. One way of estimating it is by taking the percentage of those known to have suffered from it in a certain number of fatal cases, as was done by Hölscher, who found a history of intestinal hæmorrhage in 5 per cent. This, of course, gives but an inadequate idea of its prevalence, for many patients subsequently recover. "Hæmorrhage from the bowel in enteric fever occasionally coexists with hæmorrhage elsewhere, such as epistaxis, hæmoptysis, hæmatemesis, hæmaturia, bleeding from the gums, and purpuric spots, and then the disease has been designated 'hæmorrhagic putrid fever.'"¹ In both the present cases there was vomiting of blood, which was probably dependent on a congested condition of the mucous membrane of the stomach. For the notes of these cases we are indebted to Mr. William Escombe, house physician.

CASE 1. (Under the care of Dr. Green.) Typhoid fever; hæmatemesis; hæmorrhage; relapse.—The patient, a female aged twenty-three years, was admitted to hospital on Sept. 21st, 1895. Her temperature was 101° F. Her illness commenced with headache and pains on Sept. 10th. Her condition on admission was as follows. She was lying on her back; her cheeks were rather flushed, and her expression was somewhat vacant; she was quite conscious, and her memory was good. Her pulse was 104 and dicrotic. The tongue was furred down the centre; the tip and edges were clean. Her abdomen was somewhat distended; there were a few spots typical of typhoid fever. The spleen was easily palpable. The heart and lungs were normal. The urine was highly coloured and clear, and the specific gravity was 1014; there was a large trace of albumin. On Sept. 22nd the patient complained of pain in the left thigh. On examination some œdema of the left leg was found; the upper part of the left thigh was red and tender, and a cord could be felt in the course of the femoral vein. There was slight diarrhoea and the stools were typically "typhoid in character." The fever ran a normal course after this until Sept. 27th, when some blood was passed in the stools. On the following day, at 1 P.M., the patient had an attack of hæmatemesis; the blood was dark-coloured, but was not measured as it was vomited into the bed. This was followed one hour and a half afterwards by a second attack; the blood was of the same character as before and measured two ounces. The patient was treated with a hypodermic injection of morphia; all food was ordered to be fully peptonised, and one drachm of the saccharated solution of lime was added to each five-ounce feed. She was also ordered ice to suck. The pulse was 120, and the temperature remained high. For the next twenty-four hours the motions were black and tarry in character, but there was no more hæmatemesis. Subsultus tendinum was well-marked, and there was distinct tremor in both hands. There were also dulness and numerous râles at the base of both lungs. From now onwards the temperature fell steadily, but the patient was very weak and was kept upon hypodermic injections of liquor strychniæ, two minims every eight hours, and brandy, four ounces. Tenu-grain naphthaline pills, three times in the day, were employed as an intestinal antiseptic. There was no more hæmatemesis or hæmorrhage, but for two consecutive days large erythematous patches lasting about twenty-four hours appeared