a pea to a cob-nut, and resembled in appearance the caseous material found in lymphatic glands. Several slides were examined by Neelsen's method for tubercle bacilli, but without success. Under the microscope these masses were found to be almost entirely caseous, and stained badly. They were surrounded by a narrow zone of small cell tissue, in which many giant cells were seen. There can be little doubt doubt they were of a tubercular nature. There is a general impression that tubercle bacilli are not found in Addison's disease, but this is not the fact. However, it is admitted by the authorities that they are difficult to find, and the same is true of tubercle in bones and joints.

I have called this a case of Addison's disease without pigmentation, not implying by that title that I look upon it as a distinct form of the disease, but simply a case that ran such a rapid course that pigmentation had no time to develop, and have published it to show how hard the diagnosis of such an early case must be, and the many points for discussion which may be raised in its progress. Impotence I do not find mentioned anywhere as a symptom of the disease, but it is certainly one which one would expect to find in such a supremely "nervous" disease as Addison. I have to thank my friend, Mr. Targett, for kindly examining and reporting on the condition of the suprarenals, and Mr. Dunn for his assistance during the progress of the case.

Liss, Hants.

TYPHOID FEVER; PERFORATION (?); LOCAL PERITONITIS; OPERATION; RECOVERY.

BY JOHN W. TAYLOR, F.R.C.S.,

SURGEON TO THE BIRMINGHAM AND MIDLAND HOSPITAL FOR WOMEN;
CONSULTING SURGEON TO THE WOLVERHAMPTON HOSPITAL
FOR WOMEN, ETC.

THIS patient was under the care of Dr. Walter Garman of Wednesbury, and I am indebted to him for all the early history of the case.

Richard C—, aged thirty-three, single, a furnace worker in a tube manufactory, was taken ill about the middle of August, 1888, and had to leave his work the first week in September, when Dr. Garman was called to attend him. During this attendance the patient passed through the ordinary course of a severe attack of typhoid fever, in which the signs and symptoms of this disease—abdominal pain and tenderness, diarrhoea, the rose rash, and the typical temperature—were all well marked. Other cases of typhoid fever were occurring in the same neighbourhood about this date. From this attack the patient began slowly to recover, and it was thought that he had become convalescent. A relapse, however, occurred, and during this relapse the symptoms became much more acute and dangerous than they had previously been. The abdomen was distended and extremely tender, and at one period so marked was the collapsed condition of the patient that perforation was suspected. The patient lived through this time of severest danger, and then it was noticed that a tumour was forming in the upper part of the abdomen, between the sternum and the umbilicus. This steadily increased in size, and as it grew the patient began to suffer from attacks of hæmatemesis. These became alarming, on one or two occasions as much as a pint of blood being vomited. It was at this stage of his disease that I saw the patient with Dr. Garman, our consultation being held on Dec. 12th, and the perforative stage of the disease—if such it was—having occurred some ten days previously.

A prominent rounded swelling occupied the epigastric and upper umbilical regions. It was continuous with the liver. The latter was not displaced upwards by the tumour. On palpation a sense of deep fluctuation, or rather that feeling of elasticity which is significant of distant fluid, was plainly perceptible. I diagnosed the enlargement to be cystic, involving the left lobe of the liver, and advised an early operation. This was performed two days later, another attack of hæmatemesis having occurred the night previously. The steps of the operation done were exceedingly simple. An incision was made in the middle line between the sternum and umbilicus, and gradually deepened until the fluid was reached. The peritoneum in this situation was absolutely adherent, and we had to cut through what appeared to be the thinned edge of the left lobe of the liver before reaching the cyst. About three pints of brown,

slightly turbid fluid were evacuated. A finger inserted into the cavity which had contained this collection found it sharply bounded by a transverse line below; its height and depth were out of reach. Owing to the adhesions it is impossible for me to state the exact situation and relations of the cyst. It appeared to come towards the surface between the liver and the stomach, and perhaps it may have had direct connexion with the lesser sac of the peritoneum. A large rubber drainage-tube was left in the cyst and the incision closed around it. The patient made a rather slow but steady convalescence, and finally a complete recovery. On one occasion only did he have any return of the hæmatemesis. This was after eating rather heartily of fowl and pigeon-pie some ten days after his operation. On account of this all solid food was stopped for some time longer, until Dr. Garman felt satisfied that he was able to take it without danger.

The interest of the case is of course much more clinical than surgical. Typhoid fever is, unfortunately, still so common that it is very possible the foregoing history may some day be repeated. If so, the record of this case may be of service. The operation was performed in one of the little houses of a court at Wednesbury. No trained nurse was available except at the time of operation, and the patient has mainly to thank the nursing of his sister and the careful attention of Dr. Garman for his recovery. Whether the true sequence of events was that which appears in the title of this paper cannot be absolutely known. It appears to me to be the most rational explanation of the history I have related.

Birmingham.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF INTUSSUSCEPTION OF NINE DAYS' DURATION SUCCESSFULLY TREATED BY INFLATION.

BY T. GRANT LANGHORNE, M.R.C.S., L.R.C.P.

THE history of the case is as follows. On Saturday afternoon, Jan. 25th, the mother noticed that her infant, nine months old, was very sick, throwing up its milk as soon as it swallowed it, and also that it had diarrhoea very badly. She informed me that the child was perfectly well in the morning, crawling about the floor as usual. She gave it a powder, but the next day, being no better, she took it to the chemist, who gave her some powders. The sickness and purging, however, got worse, and the child strained very much, but nothing passed but blood and slime. On Thursday, the 30th, she sent for me, but I was away in the Bush, and did not see the child till Sunday about 11 P.M. I found the child in her mother's arms, with its legs drawn up, and evidently in great pain. The face was pinched and white and her feet and hands quite cold, although the temperature of the room was 85° F. The abdomen was swollen and tympanitic and very tender. Tongue dry and glazed. She was sick every few minutes and constantly straining, nothing but blood and mucus passing. On introducing my finger into the rectum I fancied I could feel something come down when she strained, so I gave her chloroform, and could then distinctly feel the invaginated gut with a well-marked dimple on its anterior surface. My other hand on the abdomen made out a well-defined sausage-shaped tumour in the left iliac fossa. The child seemed to be dying, and the parents were very anxious that something should be done, so I determined to try to replace by means of inflation, but with, as I thought, no hope of success, considering the length of time the gut had been invaginated. I took an ordinary pair of bellows, wrapping a piece of oiled rag round the nozzle, and, keeping one hand on the abdomen, slowly distended the rectum. After about two or three minutes' gentle blowing, I felt the tumour in the abdomen suddenly disappear. Making sure the intestine had ruptured, I withdrew the bellows and introduced my

finger into the rectum, and found the invaginated gut had disappeared. I prescribed small doses of opium and left. The next morning I called expecting to hear my little patient was defunct, but, to my surprise, the mother informed me that she had not been sick since I left, and that, although there was a little mucus passing every hour or so, there was no tenesmus. The abdomen was softer, and could be touched without making the child cry, and no tumour could be detected. The rectum was also quite empty. I ordered white of egg in a little water and a little veal broth at frequent intervals, and to continue with the opium mixture. The child made an uninterrupted recovery.

I think this case worthy of reporting on account of the length of time the gut was invaginated (nine days). As far as I know it is the first successful case that has been replaced by inflation after so long a period. I should have thought that after nine days adhesions would have taken place, and that any attempt at reposition would have proved fatal by rupture. This is the second successful case I have had; the first one I saw on the second day, and used the same treatment. It also shows the great help of an anæsthetic both in the diagnosis and in the treatment, for until the infant was thoroughly under I could feel nothing definite, and as regards the treatment it is no less important. This case, when taken with other successful cases, will encourage others to try the same treatment before opening the abdomen, which operation, especially in a Bush practice, does not hold out any great hope of success.

Millicent, South Australia.

GURJUN OIL AS AN EXPECTORANT.

BY WILLIAM MURRELL, M.D., F.R.C.P.,

LECTURER ON MATERIA MEDICA AT THE WESTMINSTER HOSPITAL.

A FEW weeks ago, in a communication to THE LANCET, I stated that at the suggestion of Dr. Walshe I had been using copaiba as a remedy for chronic bronchitis and winter cough. I found that it was an excellent expectorant, but had this grave disadvantage—that in a large proportion of cases it brought out a rash attended with intense itching, and often accompanied by irritation of the throat, diarrhoea, and vomiting. To obviate this difficulty I endeavoured to find some drug allied to copaiba which would exert the required action on the bronchial mucous membrane without affecting the skin. After one or two unsuccessful trials I thought of gurjun oil, which at one time was extensively used to adulterate copaiba. Gurjun balsam or wood oil, as is well known, is a balsamic exudation obtained by incision and the application of heat from the trunk of *Dipterocarpus turbinatus* and other species growing in the East Indies. It is a transparent liquid of the consistence of olive oil, of an opaque, dingy, greenish-grey colour, as seen by reflected light, and having an aromatic odour and taste not unlike that of copaiba, but without its acidity. Some years ago it was brought prominently into notice by Dr. Dougall of the Andamans as a remedy for leprosy, but seems to have attracted but little attention in this country. There is practically no demand for it here as a therapeutic agent, and it is a very inexpensive drug. I gave it first in doses of a drachm and then of two drachms three times a day, enough being ordered to last a week. I prescribed it in the form of a mixture, with liquor potassæ, spirit of nitrous ether, mucilage of acacia, and cinnamon water. It certainly was not a very inviting combination, especially as it had a tendency to "curdle," but it seemed eminently adapted for exciting a rash if the drug were eliminated by the skin. After a time I gave it mixed with extract of malt—two drachms of the balsam to an ounce of the extract—three times a day, and this was taken without difficulty. The chronic bronchitis—many of whom had previously taken copaiba—reported that it acted admirably as an expectorant, "clearing the chest" and easing the cough. In several cases I gave in addition tincture of jaborandi or nitrate of pilocarpine at bedtime so as to produce profuse sweating, but no eruption resulted. My colleague, Dr. Colcott Fox, tells me that there are one or two cases of gurjun rash on record, but I have not been fortunate enough to see one. It is true one patient—a woman—told me that the medicine brought out some spots, but they disappeared in a few hours, and increasing the dose failed to reproduce them. It seems to me that gurjun

oil has all the advantages of copaiba as an expectorant, without the grave disadvantage of exciting an eruption. It has been recommended as a remedy for gonorrhœa and gleet, but I have had no experience of its use in this direction.

Weymouth-street, W.

A CASE OF DIPHTHERITIC PARALYSIS IMPLICATING LARYNGEAL MUSCLES.

BY JAMES B. BALL, M.D., M.R.C.P.,

PHYSICIAN TO THE THROAT DEPARTMENT, AND SENIOR ASSISTANT PHYSICIAN, WEST LONDON HOSPITAL.

W. Y—, aged twenty, a milkman by calling, was admitted into the West London Hospital on May 31st, 1889, suffering from weakness of the legs, hoarseness, and other troubles. I am indebted to Dr. Herringham, under whose care he was, for the opportunity of examining the patient's larynx, and for permission to make use of the notes of the case. The following history was obtained:—He had always enjoyed good health. Ten weeks previously to admission he got a cold, and lumps formed at the side of his neck. He did not lie up or consult a doctor; the cold gradually got better, and the lumps went down. Three weeks before admission his voice began to get weak, and he had difficulty in calling "Milk" on his rounds. About a week later, he became rather suddenly very weak on his legs and had to take to his bed, where he continued until admission. About the same time that he took to his bed he found that fluids used to come through his nose in drinking.

On admission, he was rather pale. His pupils were normal and equal, and reacted well to light and accommodation. There was no facial paralysis and no weakness of the arms. His fingers felt dead; his feet were numb. The knee-jerks were absent. The gait was reeling, and he required assistance in walking. The urine contained no albumen. The voice was hoarse and had a nasal twang. He could swallow solids well, but fluids returned through the nose, and some went "the wrong way" and made him cough. The soft palate moved slightly on the right side in phonation, but the left side did not move. The sensation of the palate and pharynx was apparently much diminished. On June 3rd I examined his larynx. The colour and conformation of the parts were normal. The left vocal cord lay motionless in the cadaveric position. The right vocal cord moved well, but in phonation was curved, with the concavity inwards, from loss of tension. About a week after admission fluids ceased to come through the nose; otherwise his condition remained much the same till June 15th, when his gait was noted as being steadier and his voice stronger. His left vocal cord, however, was still motionless, but the right cord had recovered its normal tension. On June 22nd the left cord moved up to the middle line in phonation, but was not abducted much, if at all, beyond the cadaveric position, with deep inspiration. His voice at this time was good, except for the nasal twang. On July 7th he was discharged from the hospital. His general condition had much improved. He could walk steadily, but his legs soon got tired. The numbness of his hands had somewhat increased. The grasp of the right hand was weak and there was slight incoördination in the movements of the hand. The movements of the soft palate were more free than on admission, but were still imperfect on the left side. The voice had a slight nasal twang, but was otherwise good. The abduction movement of the left vocal cord was still impaired. The treatment throughout his stay in the hospital consisted of ten-drop doses of tincture of nux vomica, with nitro-muriatic acid, three times daily. The patient was lost sight of after leaving the hospital. I saw him, however, in the early part of last February, and he stated that he lost all numbness of his hands and feet, and gained his usual walking powers and natural voice, about two months after leaving the hospital, and he was able to resume his usual work. At the time I saw him his knee-jerks were present, and the movements of his palate and vocal cords were normal. Although the actual nature of the so-called cold which this patient had suffered from, ten weeks before admission, was not determined at the time of its occurrence, there can be no doubt, from the subsequent course of the case, that it was an attack of diphtheria.

Wimpole-street, W.