haste, as her relatives in attendance were greatly alarmed at her condition. I was informed that within an hour of taking the medicine involuntary twitching of the legs and arms commenced, with evident distress, great restlessness generally, and inability to speak or swallow. I found the pulse 120, small and jerky; the temperature 103.2° ; the face flushed; pupils widely dilated; and the conjunctivæ injected. The tongue was dry and brown, and the power of articulation and deglutition almost suspended. The respiration seemed unaffected comparatively, but the patient was apparently in a partially comatose condition. As the symptoms closely resembled the physiological action of atropine, I injected half a grain of morphia hypodermically, which within an hour acted so favourably as to enable the patient to swallow small quantities of beef-tea and stimulants. At 11 A.M. I was informed the patient had slept well at intervals, the skin being bathed with copious perspiration; she had also been able to articulate and swallow with increasing facility. I found the pulse down to 75, and the temperature slightly above 98° , but she was, to my great satisfaction, comparatively rational and intelligent, but complained much of diplopia. Since then both her physical and mental condition have continued to improve, so much so that at my visit on Sunday morning she recalled me to express her solicitude about her sister's health, who, in the paroxysms of mania, had been the special object of vituperation and violence. I have since given her one-sixth of a grain of hyoscyamine with an equal quantity of morphia every third night. I am so encouraged by the ultimate results of the hyoscyamine treatment in this case that I shall not hesitate again to employ this powerful remedy; but I think the immediate effects of half a grain of the drug, such as I have described, strongly cautions the exhibition of a much smaller dose—say one-fourth, or at most one-third of a grain—until at least the tolerance of the patient has been tested; for had I given one grain, as recommended, I question very much whether my patient would have survived the ordeal.

Ventnor.

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.

COMPOUND COMMINUTED FRACTURE INVOLVING THE ANKLE-JOINT; ANTISEPTIC TREATMENT; RECOVERY.

(Under the care of Mr. BELLAMY.)

FOR the notes of this interesting case we are indebted to Mr. E. S. Pattison, Mr. Bellamy's house-surgeon.

Rebecca G—, aged fifty-nine, was admitted April 18th, 1878. On the evening of the date of admission the patient, while drunk, fell downstairs and sustained a simple fracture of the lower end of the tibia and fibula. She was then picked up by some friends, also drunk, and made to walk about. This made the fracture compound. The woman was then brought to the hospital. When admitted she was very drunk, and had an open wound about as large as a sixpence on the outer aspect of the right leg over the external malleolus. Some loose fragments of bone were found there by the house-surgeon, and from the escape of synovia there was evidently a fracture opening into the joint. The wound was dressed antiseptically, and the limb placed on a side-splint.

The wound was dressed again next day, and syringed out with a solution of carbolic acid (1 in 20). A good deal of blood had oozed out during the night. The limb about and above the seat of fracture was red and somewhat swollen.

On the 22nd the limb was swung in a cradle. The patient had passed a fairly good night, and there was not much pain or tenderness.

On the 28th the antiseptic dressing was left off. The discharge was profuse, and there was a good deal of bogginess about the adjacent parts. The surface looked foul and almost gangrenous. Poultices were constantly applied.

On May 2nd the wound looked unhealthy, and the swelling extended towards the foot and some distance up the leg. The patient's general condition was fair.

On the 9th an incision was made to the outer side of wound, and some matter evacuated. Poultices were continued.

On the 15th the poultices were still applied. The wound looked healthier. The discharge was puriform and partly bloody.

There was no material change during the next ten days. On the 27th Mr. Bellamy made an incision above the wound, and passed a seton through it to allow drainage from a pus-cavity existing there.

On the 31st a large surface of denuded bone could be felt at the bottom of the sinus, but no loose bone. The wound looked rather healthier, and the œdema of foot, which had been marked, was less.

On June 12th there was no great change in the case. The wound was kept open, and continued to discharge pus. After this, however, more progress was made. On the 25th the wound was nearly healed; the poultices had been left off, and the wound dressed with red lotion.

On July 1st the wound was entirely healed, and a plaster-of-Paris bandage was applied. On the 13th the patient was discharged cured.

Remarks.—The object of recording this case is to hint to the ordinary practitioner the value of the immediate application of the antiseptic method. No doubt, had the case been treated without this precaution, excision or amputation would have been necessary. The patient had every complication to fight against: her physical condition, atheromatous vessels, and a wound of the perineal artery (which, by the way, does not appear in the report)—all evidently a great strain upon her constitution.

CENTRAL LONDON SICK ASYLUM, CLEVELAND STREET.

INTESTINAL OBSTRUCTION; GASTROTOMY; DEATH.

(Under the care of Dr. LEDIARD.)

D. C—, aged twenty, labourer, was admitted on March 27th, 1878. He stated that he had always enjoyed good health up to the present attack, which commenced suddenly with pain in the abdomen five days before while he was drinking some beer in a public-house. He immediately went home, not many yards off, and passed a free motion. The same evening he had rigors for two hours, and took some brandy, but vomited soon after, and continued to vomit when any food was taken. The bowels acted three days before admission, but after that he had passed nothing, and the abdominal pain had persisted. For the last three days he had suffered from thirst, and his belly had been swollen from three to four days.

On examination, the patient was healthy-looking, of fair and fresh complexion, and well nourished. His expression was anxious, and he evidently suffered acute pain in the abdomen, which was swollen, tender, and tympanitic. The shape of the belly was somewhat unusual, the most distended part lying between the navel and the ribs, whereas the lower region tapered off towards the groins; girth, two inches above the umbilicus, thirty-two inches. He lay on his back with one arm raised above the head. No tumour could be felt in the abdomen. The distension was uniform, and the pain general. He could not bear the weight of the poultices applied on admission. Pulse 112, regular and a little jerking; respiration 40, shallow and thoracic; the skin felt hot and dry, but the thermometer registered 98.2° only after repeated trials. The patient had no inclination to go to stool; he had not passed any blood or mucus; the tongue was dry and brown in centre, but furred at the sides. He vomited constantly anything taken; urine muddy, with urates, sp. gr. 1022, no albumen. A simple enema was given, and opium ordered every four hours, with an effervescing mixture containing hydrocyanic acid.

On March 29th the expression was better; the bowels had

been slightly relieved by the enema, the motion being partially solid, but presenting nothing peculiar. The patient had not slept; sickness continued. Temperature normal; pulse 130. The tongue was red and moist. He sucked ice continually, but could not keep any nourishment down. Turpentine stupes were applied to the abdomen, and another enema was given. The sickness continued, but he slept a little next day, and respirations fell to 14. Thirst as before. One arm raised above the head. An enema brought away a solid and pale motion.

On the 31st the girth was $33\frac{1}{2}$ inches. The tongue was the same as before; sickness was almost incessant, the vomited matter being inoffensive. The abdominal pain continued. Cold cloths were applied to the abdomen. Temperature $99\cdot8$; pulse 96.

On April 1st the vomited matter was yellow and stercoraceous. The girth was $33\frac{1}{2}$ inches. There was a bitter taste in the mouth. The seat of the most intense abdominal pain was under the ribs on the right side and round the navel. There was hiccup for the first time. The stomach-pump tube passed five inches, and was then stopped by the promontory of the sacrum. Digital examination of the rectum gave negative results. Fifty ounces of warm water were injected into the bowel, but more would not pass. What was injected came away again very soon. The man had passed no flatus since admission, and now complained of feeling choked.

In the evening his symptoms were much the same, but the vomiting was worse. Accordingly at 10.30 the patient was chloroformed, and, with the assistance of Mr. R. W. Lyell and Mr. Ridley Webster, Dr. Lediard opened the abdomen in the middle line between the navel and pubes, and brought into view several coils of gut distended and acutely inflamed. On passing the finger within the peritoneal cavity, recent adhesions were found between the visceral and parietal layers of the peritoneum. The incision was enlarged to a little above the navel, and the finger passed among the coils of small intestine met with a band stretching from above downwards, and apparently causing constriction to the bowel at some point. The band was not very tense, and when brought to the surface was found to consist of a portion of the omentum twisted into a cord. A double ligature was applied, and the band was divided between with scissors, the only visible effect of this being to liberate another coil of gut, which protruded at the incision and showed no mark of constriction. The intestines were so inflamed and soft that the finger lacerated the peritoneum at one part during an attempt to draw the gut down a little. This was treated with a catgut ligature, and the wound was closed with deep superficial sutures, with some difficulty, owing to the inflated condition of the gut. Opium was continued.

He passed a restless night, sickness persisting, but the vomited matter was thin, watery, of dark-brown colour, and inoffensive. Next day the abdomen was much distended; expression anxious; temperature $96\cdot6^\circ$; pulse 96; respiration 20. Opium continued; brandy, milk, and eggs were given frequently. At 6 P.M. he became uneasy; yellow vomiting returned, but without the faecal odour. At 8 P.M. he was in pain and very restless. At 10.30 the pulse was 88, the temperature $96\cdot6^\circ$; the expression was anxious. No motion had passed since the operation.

He had a restless night; stercoraceous vomiting returned, cold perspiration followed, and he died somewhat suddenly at 9.45 A.M. on April 3rd, about thirty-four hours after operation.

It was only possible to make an examination of the abdomen at the region of the wound. When the stitches were removed it was found that the small intestines were acutely inflamed, recent lymph and adhesions existing. No rupture of the bowel was found, the jejunum and ileum were much inflated, and contained a quantity of offensive contents resembling pea-soup. The upper end of the divided band was found continuous with the great omentum, which was folded across the upper part of the abdomen, where there was no peritonitis. On examining the pelvis, a coil consisting of five inches of the ileum near its end was found lying towards the right side of the sacral promontory. It was sphacelated, and bound down by a band, which constricted it against the brim of the pelvis. In this region there was intense peritonitis. The band was adherent to the pelvis on either side of the strangulated gut, which showed a broad groove where the band had passed across; and on tracing the band upwards amongst the coils of intes-

tine, the divided end was found lying free. The ascending and descending colon was empty; the transverse portion was not seen. The divided band, on dissection, was found to be composed of omentum alone. The distal portion was condensed, matted, and converted into a cord-like structure. The vessels were filled with coagula, and there was also some bloody extravasation. The length of the band was five inches, the part causing the constriction being the terminal portion only. The catgut ligature was *in situ*.

Remarks.—The case is an important one, since it shows that division of the band only is not always sufficient to liberate strangulated gut. Now, if the lower end of the band had been followed downwards at the time of the operation, it would have been possible to break down the adhesions and released the bowel, but the intestines were in such an inflamed state that it would scarcely have been prudent to have subjected them to the pressure necessary for a more thorough examination for the exact point of constriction; even the first attempt to draw a coil down lacerated the peritoneum, as before stated. As to the mode of origination of the adhesion of the omentum no opinion can be offered. The adhesion was probably recent, because there was no difficulty in detaching the band from the margin of the pelvis. The appearance of the band, Mr. Lyell thought, was in favour of its having been dragged on considerably by the inflated gut. The post-mortem examination showed how rotten the gut was, for during the handling necessary it burst in several places, and deluged all with faecal matter. If the operation had been performed before peritonitis was established, a more careful search might have been made for the exact spot of strangulation, and a very different aspect might have been given to the patient's chances of recovery.

SUSSEX COUNTY HOSPITAL.

ACUTE YELLOW ATROPHY OF THE LIVER.

(Under the care of Dr. KEBBELL.)

WILLIAM D—, aged twenty-four, coachman, was admitted April 27th, 1878. There was no history of syphilis, but he had been leading until recently a very intemperate life. His health, however, had been fairly good until about three weeks before admission, when he first noticed that his urine was high-coloured, and he began to have frequent attacks of giddiness, sickness, and vomiting, with general discomfort and weakness, which continuing to increase, he applied for admission into the hospital.

He was then very weak, had lost flesh considerably, face pinched, cheeks and lips dusky, skin generally of a dingy yellow tint, conjunctivæ jaundiced. Evening temperature 100° ; pulse 84. The following morning, temperature $98\cdot4^\circ$; respiration 20; pulse 96. Temperature never rose over 101° . Tongue moist, with thin white fur; breath had a peculiar earthy and livery smell, stated by Mr. H. N. Smith, house-surgeon, to be very similar to that of a patient who died of acute yellow atrophy in Guy's Hospital. The hard edge of the liver was felt just below the ribs, and dulness extended up to the fifth rib; splenic dulness deficient; pupils were dilated, even, but inactive; systolic murmur at base of the heart; breathing sounds healthy; he complained chiefly of feeling very thirsty, hungry, and weak; no vomiting or pain. Ordered a couple of calomel and colocynth pills, and to have gentian and ammonia mixture three times a day.

On the 29th the stools were reported to have a fairly healthy appearance. Urine contained copious deposits, chiefly of phosphates. No leucin or tyrosine was detected. From this time the man gradually became more drowsy, with active delirium at night. Continued to complain chiefly of excessive thirst, hunger, and drowsiness. The pupils became much dilated and very insensitive. The liver dulness diminished rapidly, and latterly almost disappeared. He died comatose and paralysed on May 5th about 5 P.M.

Necropsy nineteen hours and a half after death.—(Reported by Mr. H. N. Smith, house-surgeon).—Brain-substance generally soft, especially internally. The base of both lungs intensely gorged, sinking in water. The pericardium of the heart contained a small quantity of bile-stained serum, the heart weighing nine ounces and a quarter. Commencement of aorta slightly atheromatous. Spleen healthy, weighing three ounces and three quarters. Peritoneum healthy. The liver was very small, only thirty-one ounces, flabby, unable to support its shape; capsule loose and puckered.