when she was alarmed by the pallor and ghastly expression of her face, and found it impossible to arouse her; and then, for the first time, the fearful nature of the mistake was discovered, and medical aid was sought. The child was found in a state of profound coma, with dilated and insensible pupils; the pulse was very feeble; the breathing irregular, with stertor, while frothy mucus was ejected from the nares; the limbs were relaxed, and the body felt quite flaccid. The case was evidently hopeless; nevertheless, every exertion was made by Messrs. Gell, Scott, and myself to counteract the effect of the poison by stimulating emetics, sinapisms, terebinthinate enemata, warm baths, with galvanism, cold affusion, &c. The child never rallied from this state of collapse, but died at half-past six P.M. the same day, or in eight hours and a half after taking the poison.

Remarks.—This case, while presenting a sad commentary upon the evil effects of *free trade* in poisons, is interesting in a toxicological point of view as illustrating the effects of a very large dose of opium upon the young subject. For, in many of the recorded cases of poisoning by this drug, some doubts exist as to the exact quantity which had been taken and the exact period which had elapsed before its physiological effects were apparent. Dr. Taylor states "that the symptoms commence in from half an hour to an hour; but that sometimes they come on in a few minutes, especially in young children." In a case reported by Dr. Skae, "the individual was found totally insensible in fifteen minutes." That in a child of four years and a half old a dose of laudanum equivalent in amount to twelve grains of solid opium should produce poisonous symptoms in fifteen minutes is what we might expect from the known influence of this drug upon young children; and when we reflect that in the present case absorption had been allowed to progress unchecked for a period of four hours, it is surprising that the fatal termination had been protracted for eight hours and a half.

Hinde-street, Newcastle-on-Tyne, July, 1863.

A Mirror

OF THE PRACTICE OF MEDICINE AND SURGERY IN THE HOSPITALS OF LONDON.

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.

ST. BARTHOLOMEW'S HOSPITAL.

INJURY OF THE SUPERIOR MAXILLARY BONE;
OPERATION; BAD RESULT.

(Under the care of Mr. LAWRENCE.)

SUSAN A.—, aged seventeen, was admitted in June last. Twelve months previously she had sustained a slight blow on the face from a slender switch or stick. On admission there was an open wound on the right cheek. Soon after it was observed that the right eye and eyebrow were raised upwards above the level of the other eye, but the sight was unaffected. As there was a prominence at the upper part of the cheek, it was concluded that some growth involved the upper maxillary bone.

Under these circumstances, on the 27th of June, the girl having been placed under chloroform, Mr. Lawrence performed the following operation:—He made an incision from the inner angle of the right eye down to the nostril, thence to the nasal septum, and through the centre of the upper lip into the mouth; he then made another incision from the malar bone to the angle of the mouth: the flap of integument thus formed was raised, and the upper maxilla completely exposed. The malar bone was now broken through by the cutting pliers, the bone being somewhat damaged. An effort was then unsuccessfully made to saw through the malar bone above the alveolar border. Some small portions of growth were scraped away from

the floor of the orbit; the integument was then replaced, the wounds were closed with silver sutures, and the girl sent to bed.

The deformity resulting from this operation was unusually great; for, independently of the incisions, there was the original wound running nearly across the flap from the middle of the lower eyelid outwards. The face altogether had a terribly gashed appearance, justifiable, it would appear, only for the removal of the whole or the greater part of the upper jaw. As it is, the disease seems to be in the same state as it was anterior to the operation. The wound had entirely cicatrized by the 25th of July, but the injured bone still suppurating caused the cheek to become bagged until the pus was squeezed out. The permanent disfigurement is something terrible.

The cheek is now (July 29th) greatly swollen and inflamed, and the bone is suppurating, matter being freely discharged from three or four sinuses. The bone is either becoming necrosed, or the disease is extending. The girl is feverish, and confined to bed.

At the time of the operation Mr. Lawrence remarked to those who were present "that he had removed as much of the tumour as he could from the floor of the orbit, and that he could not exactly state its nature." It seemed to be a sort of soft fibrous-looking substance, as far as the naked-eye appearances went—at least so it struck those who witnessed it.

This case is suggestive of many important inquiries, but we refrain from comment. Mr. Lawrence may possibly be in a position to explain the *rationale* of his operation. We confess we are at a loss to understand it. The proceeding is much talked of in the hospital, and will probably receive attention from the treasurer and governors. We wait with proper reserve for the result of that inquiry.

GUY'S HOSPITAL.

THREE CASES OF THORACIC ANEURISM, ILLUSTRATING
DIFFERENT MODES OF TERMINATION.

(Under the care of Dr. BARLOW and Dr. HABERSHON.)

THE five cases of aneurism of the thoracic aorta which are now detailed illustrate in a striking manner some of the modes in which this dire affection terminates. In the first and last, sudden death ensued from rupture of the sac into the œsophagus in the former, and into the trachea in the latter, whilst in the third it occurred from its bursting into the pleura. In the second case, death was slow, and the suffering most severe from the great erosion of the vertebræ, which had been worn away almost to the spinal cord. The vertebræ were also eroded in the first case, and the sternum in the third. In the fourth case (Dr. Pitman's), the large aneurism produced paroxysms of dyspnoea from pressure upon the trachea and respiratory nerves, and in one of these the patient expired. Wherever the tumours pressed upon the trachea or bronchial tubes, there was the peculiar characteristic hoarseness and laryngeal voice—a symptom of significance when conjoined with others. The left bronchus in the first case and the right bronchus in the third were flattened; in the former to some extent.

The notes of the three following cases we have extracted from the post-mortem records kept by Dr. Wilks:—

CASE I. *Aneurism of descending portion of Thoracic Aorta.*—John J.—, aged forty-five, was admitted March 4th, 1863, under Dr. Barlow. He had been a sailor, and came in with cough and difficulty of breathing. There was slight dulness over the left apex, and the air entered the left lung with difficulty. He was also hoarse, as if from a laryngeal affection. No bruit could be heard; but it was suspected that he had an aneurism. On the 17th of April he brought up a large quantity of blood, and soon after expired.

Autopsy, sixteen hours after death.—An opening was found in the œsophagus, admitting a large probe, the mucous membrane around being thinned and much blackened. On lifting up the left lung, an aneurismal pouch could be seen at the upper part

of the chest; its walls very thin, as if it would soon have burst into the pleura. This lung was only partially inflated with air; large portions of it were of a dark colour, and collapsed, and evidently had not been used for some time. The ascending aorta and arch were covered with atheroma, but not much diseased. Just as the aorta turned downward, it became dilated on all sides, making a sac the size of the fist. The blood had passed through this to the lower part, which was equally well defined with the upper, the remaining portion of the thoracic aorta being of natural size, and tolerably healthy. The margin thus above and below was well defined; it occupied the left side of the second, third, fourth, and fifth vertebræ, which were eroded on the surface. The posterior wall of the aneurism was thus destroyed. The interior had had the serous surface perfect until lately, but it was not fissured. There was one long fissure having rounded edges, and which, passing through the internal and middle coats, had left nothing but the external. This was immediately opposite the œsophagus, and here it was that the blood had passed through. The opening was not direct, but valvular. The left bronchus passed immediately beneath the aneurism, and was much pressed upon. It was probable that the pneumogastric or recurrent laryngeal was involved, but this was not dissected out. The stomach and intestines were full of dark and liquid blood.

CASE 2. Aneurism of the descending Thoracic Aorta.—David G—, aged fifty-seven, was admitted Dec. 31st, 1862, under the care of Dr. Barlow. On admission a bruit was heard over many parts of the chest, and in some places a double one, also at the epigastrium. Subsequently a pulsation could be felt in the epigastrium, and afterwards in the back, clearly indicating the existence of an aneurism there. This had been previously suspected from the intense and continuous pain which he suffered. Nothing relieved him. The lungs at last became involved, and he slowly died on the 24th of May, 1863.

Autopsy, twenty hours after death.—On removing the lungs, a large thoracic aneurism was seen in the descending thoracic aorta, and forming a large projection on either side of the spine. The lungs were adherent to the sac by recent lymph, and the adjacent pulmonary tissue was in an early stage of inflammation. Other parts of the lung and tubes were full of serum. The walls of the ascending aorta and arch were thickened and covered with atheroma. Just as the aorta turned to meet the spine, an aneurismal opening was seen at the back part of the vessel. This opening was the size of a florin. From it proceeded a large aneurismal sac, as large as a cocoa-nut, projecting on each side of the spine, and passing down behind the aorta nearly to the diaphragm. On the right side the sac was firm, being filled with fibrin; on the left side it was flaccid, containing recent blood. The posterior wall had long been destroyed, and thus, when the sac was removed, the vertebræ were seen eroded, and also the heads of the ribs. The upper dorsal were almost completely destroyed, and the spinal canal was nearly reached. The abdominal aorta and thoracic below the aneurism were thickened and irregular, but not aneurismal.

CASE 3. Aneurism of ascending Aorta.—Henry H—, aged forty-nine, was admitted April 29th, 1863, under the care of Dr. Habershon. The patient was a waterman. On admission a large pulsating tumour was found over the sternum towards the right side. The pain was relieved by applications, and he was about to leave the hospital, when he died suddenly in the night of June 24th.

Autopsy, thirty-four hours after death.—A large aneurism had formed at the upper part of the ascending aorta by a longitudinal opening nearly two inches long. The edges of this were round, and passed into the sac, which bulged forwards to the sternum, and on each side, especially the right, forming a large sac the size of the fist. The walls of this sac were thin in parts, and covered with fibrin, especially on the right side, and were in contact with the lung. On this side the right bronchus was much flattened, so that the finger could not be passed into it. The aneurism reached as high as the arch, and below to the heart, where in one spot it was so thin that a rupture into the pericardium would soon have occurred; the aorta below was tolerably healthy. The front part of the aneurism was adherent to the sternum, and in some places the walls had become almost destroyed, so that on removing the sternum the front wall of the aneurism was cut off; the bone was slightly eroded, as was the origin of the upper ribs on the right side. The aneurismal sac was closely adherent to the right lung, and near their junction above a rent had taken place; through this opening blood had escaped into the chest, which was filled with several pounds of clot and serum; the lung itself was collapsed. The left lung was much condensed at its base, or indurated by inflamed

product; it was very tough, white, dense, and quite airless; in its midst were several dilated tubes, filled with a purulent mucus; it was closely adherent to the diaphragm, and the part had been formerly the subject of pleuro-pneumonia. Both kidneys contained large cysts, and in one of these were two or three calculi.

ST. GEORGE'S HOSPITAL.

LARGE ANEURISM OF THE ARCH OF THE AORTA, WITH OLD-STANDING BRONCHITIS; FLATTENING OF THE TRACHEA; FATAL DYSPNŒA.

(Under the care of Dr. PITMAN.)

FOR the notes of this case we are indebted to Dr. Dickinson, curator of the museum.

Ann P—, aged forty-nine, was admitted June 16th, 1863. She had been for years subject to winter cough, but had never been so distressed for breath as during the last six weeks. On her admission loud râles were heard on both sides of the chest, more especially on the right side. The pulse was 96, and nothing remarkable was noted about it. The condition of the heart and large vessels attracted no attention. She was ordered squills, senega, and carbonate of ammonia. On the 22nd she pronounced herself easier, and the respiration was less noisy; but her cough was very troublesome, and kept her awake at night. She complained at times of a choking sensation, which she attributed to phlegm that she could not raise. Her sufferings soon became more acute, and she spoke of passing "fearful nights." Another expectorant mixture was ordered, containing ipecacuanha, and this occasioned a free discharge of muco-purulent secretion from the lungs. She still had alarming attacks of dyspnœa, from which she was restored by ether and brandy and sinapisms. Early on the morning of the 29th a very severe attack occurred; and when seen at midday the extremities were cold, and the pulse at the left wrist could not be felt. She was anxious and distressed. Another paroxysm of dyspnœa came on later in the day, from which she never rallied, and at eleven P.M. she died.

Autopsy, fourteen hours after death.—The body was much emaciated. The left pleural cavity was almost obliterated by old adhesions. The lungs were healthy. The bronchial tubes were reddened and thickened, their lining membrane being bathed in purulent fluid. An aneurismal sac, as large as a small cocoa nut, was found at the highest part of the thoracic cavity. It belonged to the arch of the aorta, beginning immediately beyond the origin of the innominate. The left subclavian started from within the sac, and was occupied for several inches by a cylinder of fibrin, which completely stopped it up. The cavity was filled by a quantity of laminated fibrin. The tumour had extended chiefly in the backward direction, but the vertebræ were not in any way affected. The trachea just above the bifurcation was flattened by the pressure of the aneurism. The kidneys were slightly roughened on their surfaces. All the abdominal viscera, including the arterial vessels, were healthy.

WESTMINSTER HOSPITAL.

ANEURISM OF THE ARCH OF THE AORTA; DEATH FROM HÆMORRHAGE INTO THE TRACHEA.

(Under the care of Dr. BASHAM.)

THE following is an abstract of the case as reported in the hospital books:—

Henry A—, aged forty-three, a metal worker, was admitted three years ago with thoracic aneurism. There was no positive history as to the origin of his disease, but he had been accustomed to lift heavy weights; and a few months before admission, after exerting himself a good deal in this way, he suffered from what he thought was a severe "cold in the throat;" since which time he had suffered from dyspnœa, and had noticed a wheezing noise in his throat. At the time of admission he had occasional sharp pain in the intra-scapular region, working round to the right nipple and along the right arm, with numbness of three fingers of the right hand when exposed to cold. The dyspnœa was severe, often increased by eating, and vomiting frequently followed. There was no murmur over the apex of the heart, but a very decided one over the aortic valves. From two inches to the right of the left nipple and one above