was much reduced and there was a freedom from diacetic acid and albumin. The patient had learnt to realise the necessity of giving scrupulous attention to his mode of life and I note that at the last interview in June, 1903, his urine only contained traces of sugar and that it was otherwise in a perfectly normal state.

CASE 17.—In the case of this patient, a man, there was a strong family history of diabetes on the mother's side. I first saw him in April, 1893. He was then 39 years of age. Sugar had just been recognised in his urine through examination for life assurance. The case to begin with was a mild one and the sugar at first found disappeared under the strict diet accompanied with an allowance of six ounces of ordinary bread per diem. Till the early part of 1896 the urine kept free from sugar. In July, 1894, owing to a fall in weight having set in, the bread was raised to eight ounces which immediately stopped the fall and led to an increase. A further advance in the bread, with the allowance of some potato, was found to be tolerated and it was while the case was progressing in this way that the return of sugar occurred. There was evidence at this period that too much whisky was being taken and as time passed on the habit grew. Matters thus proceeded, the urine sometimes containing a certain amount of sugar and at other times none, till 1900, when a sort of climax was reached. The patient was now giving himself up to whisky-drinking to a highly pernicious extent. Previously his urine had been free from albumin and diacetic acid. In October, 1900, it contained both, with 34 per 1000 of sugar. In March, 1901, granular casts were in addition recognised, and in the following October, on account of the marked urobilin colour presented, attention was given to the liver and it was found that it extended down to from three to four inches below the margin line of the ribs. I should like for a moment to direct attention to the assistance derivable from the observance of this urobilin colour in connexion with alcoholism and the liver, and to say that it has often led me to examine the liver and, meeting with enlargement, to draw out information which probably would have escaped being spontaneously supplied by the patient. Through the summer of 1901 a little abatement of the unsatisfactory condition that had been noticed occurred, but at the interview on Oct. 9th a worse state than ever was met with. The sugar stood higher and diacetic acid, albumin, and granular and hyaline casts were all found to have returned. The patient, who was feeling bodily ill and rapidly losing weight, now took alarm and resolved to pull in energetically both with respect to food and drink. The result was that on Nov. 27th the urine contained only a slight amount of sugar and gave only a traceable indication of the presence of diacetic acid and albumin. In the entry for Jan. 10th, 1902, an absence of sugar, diacetic acid, albumin, and casts is recorded. The general health had much improved and the liver was no longer to be felt. On March 7th and on May 9th the presence in the urine of a slight amount of sugar constituted the only abnormality observed, but the end of the turn of improvement that had occurred was now reached. The power to refrain from whisky no longer held out and at the next interview on July 4th sugar, diacetic acid, albumin, and casts had all returned in notable amount and the liver was again to be felt extending below the ribs. On afterwards substituting bitter ale for whisky a renewed start in the direction of improvement occurred. Diacetic acid was for a time lost and upon one occasion, May 7th, 1903, no albumin was to be found. Finally, however, the whisky temptation was too strong to be overcome. The patient averred that he had tried to do the right thing but could not tell me that he had succeeded. His associates drew him from his resolve to keep to the right course. His last visit to me was at the beginning of August and at the end of the month a letter reached me from his son stating that death had taken place somewhat suddenly and that the cause given in the certificate was acute bronchitis and heart failure.

The above cases suffice to illustrate the effect of the excessive use of alcohol in connexion with diabetes. There are no grounds for concluding that the temperate use of alcohol is prejudicial; indeed, my experience leads me to say that I consider it beneficial, but taken in excess there can be no doubt that it seriously aggravates the wrong state accompanying diabetes and in the damage inflicted throughout the system the kidney gives evidence of markedly participating.

It will be seen from what has been stated that the

albuminuria which occurs in connexion with diabetes may exist for a long time without leading to the production of any symptomatic indication of its presence. The condition, therefore, is not to be looked upon as affording ground for apprehension in the same manner as when occurring under other circumstances. It is evident that albumin and casts have a very different signification according to the condition with which they are associated. Experience shows that even apart from diabetes they are with striking frequency come across in persons of advanced age presenting nothing to suggest the existence of renal mischief. They may, it is true, be the inceptive of something that may assume later on a more developed form, but, on the other hand, time may pass away and signs fail to appear of any further development. Caution under the circumstances is needed in framing an opinion regarding the future, and it is only by looking at the case in the broadest manner possible that a trustworthy conclusion can be arrived at.

Grosvenor-street, W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTE ON A CASE OF PERFORATED GASTRIC ULCER FOLLOWED BY HEPATIC ABSCESS.

BY H. HOLLIS, M.D. CANTAB.

THE patient, a female, aged 24 years, who had no important history of stomach trouble, fell from her bicycle and hurt her "chest" at the end of August, 1903. On Sept. 6th she ate her usual breakfast but only had French beans for dinner. In the evening, after walking for a quarter of a mile, she was sick and brought up a small quantity of blood, and was sick again after some brandy had been given. She was seen half an hour after the first attack of vomiting and being in a state of collapse was removed to the cottage hospital. There was great pain in the epigastrium, the face was blanched, breathing was thoracic, the pulse was 120, the abdomen was retracted and hard, and liver dulness was absent. Mr. W. E. Audland and Dr. W. I. Watson agreed with me that the patient probably had a perforation of the stomach. Four hours after the initial attack her abdomen was opened and a hole one-third of an inch in diameter was soon found in the centre of a roughly quadrilateral, greyish, sloughy-looking patch an inch long and three-quarters of an inch broad situated on the anterior of the smaller curvature of the stomach. The patch was inverted, the stomach wall was sewn over it, and the abdomen, which contained a quantity of greenish fluid and several partly digested French beans, was thoroughly washed out. After the operation there was no sickness; the temperature was normal thirty hours after and it continued so for nine days. On Sept. 13th the wound was dressed and all the stitches were removed. On the 15th the temperature began to rise and the pulse-rate to quicken without any obvious cause or any discomfort. After a day or two there was thought to be increased dulness above the liver. The temperature now varied from 99° to 105° F. and on five days between Sept. 15th and Oct. 9th she had a rigor. On Sept. 23rd, 27th, and 30th a needle was put in the dull patch with negative result. On Oct. 2nd there was some hardness in the abdomen below the ensiform cartilage, so the upper end of the operation incision was re-opened and an abscess in the liver was found, the contents of which were most offensive. A tube was put in and the wound was well packed with gauze. For two or three days the patient improved, then she gradually became worse and on Oct. 9th she died.

Post mortem the liver was found to be adherent to the upper part of the abdominal wound and to a small patch of the diaphragm. In the left lobe there was an abscess cavity and a small abscess as large as a Barcelona nut was found in the spleen. The wound in the stomach was quite healed and, indeed, was difficult to find. In the right lobe of the liver were two small dark patches at the site of the exploratory punctures. There was no peritonitis and all the other organs were healthy.

It seems difficult to account for the abscess as it does not

appear to have been part of a general pyæmic condition and the late onset, nine days after operation, and the absence of peritonitis do not point to any connexion with the ulcer. As the patient had never had any vomiting or hæmatemesis can it be possible that the fall from the bicycle was the cause of both lesions?

Wellingborough.

FEVER, FOLIACEOUS DESQUAMATION, MORBILLIFORM ERUPTION, AND ALBUMINURIA FROM COPAIBA.

By J. C. MCWALTER, M.A. R.U.I., M.D. BRUX., D.P.H.

WHEN a patient presents himself with a copious rubelloid eruption, a temperature of 102° F., some congestion of the tonsils, and complains of being deadly sick, one naturally suspects scarlet fever. When, further, the patient is uncertain if he has ever had that disease, when he works in a large butter shop and lives in a lodging-house, and when his urine on being examined is found to contain albumin, the practitioner who decides that he is not dealing with a case of febris rubra undertakes a grave responsibility.

In the present instance, however, the whole phenomena were apparently due to the administration of copaiba in a case of acute gonorrhœa. The sufferer was a young man, aged 22 years, who had been taking 20 minim doses of copaiba whilst his affection was in the inflammatory stage. Although the rash which he exhibited was not unlike a copious copaiba eruption, the temperature of 102° , which had only abated to 101° by the next day after he had ceased to take the medicine and remained in bed, the general feeling of malaise, the throat conditions, and the fact that after three days a desquamation so considerable set in that foliaceous flakes of epithelium were shed off and regular casts of his fingers could be removed, led me to fear that I had been mistaken in attributing the eruption to the drug. This seemed to be the more likely as albumin was present in the urine in the earlier stage, though it quickly passed off. Finally, I sent the patient to the fever hospital but the staff concurred in the view that the symptoms were due to the copaiba and the patient got all right after four or five days though the desquamation continued somewhat longer. Evidently the disease plus the drug had produced a transient acute nephritis.

It is complacently laid down in text-books that when one has doubts whether a febrile eruption be scarlet fever it is safer to treat it as such. But the problem is nowadays not so simple. If a case is declared to be scarlet fever and a working man is sent to hospital and loses his situation he will have a legal remedy against the practitioner if there be any doubt as to the diagnosis. Should he work in a dairy or a butter shop the proprietors will have something to say if they are wrongly tainted with the suspicion of employing a scarlatinous servant; and, on the other hand, if the man really has an infectious disease in such a situation the danger is appalling.

Dublin.

A Mirror

OR

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morhorum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

KING'S COLLEGE HOSPITAL.

A CASE OF PNEUMOTHORAX OCCURRING THREE DAYS AFTER INJURY TO THE CHEST.

(Under the care of Mr. F. F. BURGHARD.)

FOR the notes of the case we are indebted to Mr. Neville Hart, acting house surgeon.

A boy, aged six years, was admitted into King's College Hospital at 11.45 P.M. on August 31st, 1903 having been run over by a hansom cab with three people in it. The wheel, both from the marks on his coat and abrasions on his

body, appeared to have passed from about one inch above the right iliac crest to the neighbourhood of the left axilla. His lungs previously to the accident were probably healthy. When seen some ten minutes after the accident he was severely collapsed; he was pale, with blue lips and cold extremities, his temperature being in the rectum 95.7° F. and his pulse 154, small, irregular, and unequal. He was not unconscious but was in a restless and excited condition. His respirations were 40 and accompanied by an expiratory "grunt." His abdomen was full and moved only very slightly on respiration; it was very hard and tense but not particularly tender. The note all over the abdomen was decidedly tympanitic, the liver dulness being normal with the exception of a somewhat square patch below the ribs which was absolutely dull. His flanks were resonant; his spleen was unpalpable and its dulness was normal. On examining the chest the left side was seen to be immobile and flattened and several ribs on that side were broken. The epiphysis of the right clavicle was separated. On palpation the heart's apex beat was found in its normal place and the crepitus of the broken ribs was very marked. The percussion note was normal all over the chest and the cardiac dulness was unaltered. On auscultation a loud rasping sound was heard all over the left base which was probably due to the friction of the lung against a broken rib. In addition to this a loud "thumping" sound was heard even several feet away. With the stethoscope it appeared to be best heard over the epigastrium. Excessive tenderness was present all over the left side and this made examination difficult. There was no sign or history of blood being brought up nor did vomiting ever occur. The patient was at once put to bed in a partially recumbent position with hot-water bottles to his extremities, but he was very restless and there was a tendency to cyanosis. Oxygen was frequently administered and brandy was given diluted with hot water. At 1.30 A.M. his pulse was weaker and fluttering and strychnine was given hypodermically. Soon after this reaction took place and reached its height at 4 A.M. The skin got warm, the face flushed, and the eyes brightened. His pulse rose to 184 and at 4 A.M. it was full and regular. His temperature rose steadily, being normal at 2 A.M., 100.2° at 3 A.M., and 100.8° at 4 A.M. His general condition was much improved but the dyspnoea was accentuated and he sat straight up; whenever there were signs of cyanosis oxygen was administered. He was still given brandy, though in small quantities and less frequently. He now passed 14 ounces of urine which was quite normal and contained no blood. His respirations reached 48 and increased in rate till 2 P.M. on the next day when they were at 64.

On Sept. 1st at 10 A.M. the dyspnoea was still extreme. The dulness below the liver already referred to was not now found. The signs in the chest were unaltered in front; the back was not examined owing to the patient's critical state. His general condition varied enormously from time to time and his pulse was frequently very weak and irregular. He was ordered spiritus ammoniæ aromaticus and digitalis in a mixture, the benefit of the latter being apparent in the early hours of the next morning when his condition became very critical. Warm brandy and water were administered frequently throughout the day and he had nutrient enemata twice. The child took his milk greedily and without vomiting. On Sept. 2nd at 10 A.M. he was better, though his eyes were sunken and his dyspnoea was marked, but rather less so than on the 1st. There were a few râles at the left apex and weak breath sounds were heard there; at the base the breath sounds if present were still quite obscured by the rasping sounds already described. At the back of the thorax the breath sounds of the left lung extended rather farther down and there was a patch of absolute dulness at the left base. The sounds all over the right lung were louder and somewhat harsher than normal. The administration of oxygen was discontinued and though the patient still took the spiritus ammoniæ aromaticus the brandy was omitted. On Sept. 3rd at 10 A.M. the temperature was 101° , the pulse was 192, and the respirations were 84. The child, who had been beginning to take a lethargic interest in things in general, was cyanosed and again in great distress; he was irritable and restless and on examination the condition of his chest was found to be very different. The left side though flat was not so flat as before and was absolutely immobile. The heart's apex beat was seen in the sixth intercostal space just beyond the right border of the sternum. Vocal fremitus had gone completely from the left side, except over a small area at the left apex. The percussion note was high-pitched all over the left side and in