fossa of the humerus, and any action of the biceps helping in replacement would be exerted at less disadvantage than during flexure. Thus reduction would be easy unless there were such an amount of swelling that the olecranon could not be felt.

Gloucester-terrace, W.

A CASE OF STRICTURE OF THE BILIARY DUCT.

By F. LUCAS BENHAM, M.D. LOND., M.R.C.P.

THE following is an example of a somewhat uncommon condition of obstructive jaundice, difficult of diagnosis during life, and of which, though several other cases have been recorded, the cause is still obscure.

H. W—, aged eighty-six, was formerly a butler, but had for many years been too infirm to work, and had been living on a pension. He had had originally a good constitution, but had suffered for a long while from chronic gout, attacks of which had left his knees stiff and weak; consequently he seldom went out of the house. His skin was pale and rather sallow and waxy, but he had never had jaundice or any attacks at all resembling biliary colic. On April 3rd, 1886, he was suddenly seized with severe pain in the right hypochondrium, with acidity of stomach and constant vomiting. In a day or so jaundice appeared, with bile pigment in the urine, and colourless fæces, just like yeast. The jaundice became deeper. The pain subsided partially to mere aching in two or three days, but the burning and acidity in the stomach and throat persisted. There was very troublesome itching of the skin, the pulse was slow, and the bowels constipated. There was very little recurrence of pain, but the right hypochondrium remained tender. The liver could be felt just below the ribs and xiphoid cartilage, hard, but without any great irregularity of outline. After a few days the patient got up daily, but in about a month (early in May) he became weaker and took to bed again, and then began noticeably to lose flesh. The skin had become of a deeper hue—brownish yellow; urine and fæces as before. Acid dyspepsia occurred on eating anything solid. About the middle of May he gradually became drowsy by day, rambling a little by night, and more prostrate; the tongue, hitherto quite clean, became coated with thick, rough, dry fur. On May 18th partial suppression and incontinence of urine took place, without distension of the bladder; relief was given by stupes. The urine was scanty, and somewhat offensive. On the 19th there was an increase of tenderness all over the abdomen, especially the right hypochondrium. The patient was sinking, and nearly fainted once or twice. Passive congestion of the lungs supervened, and he died on May 20th. The treatment had been by mercury and chalk, with saline aperients, and afterwards iodide of potassium was tried, but without any appreciable effect on the jaundice.

A necropsy was made thirty-two hours after death. The abdomen only was opened. The liver could not be felt through the abdominal walls. Parietes fat. Very little fluid in the peritoneum; no peritonitis. Bowels moderately distended with flatus. Liver small, sunk beneath the ribs; rather hard, but flaccid; very dark, mottled with yellow on surface and section; no perihepatitis. Gall bladder nearly empty; it contained very thick dark-green mucus, and two or three small masses of inspissated pigment. On examining the bile duct, it presented an indurated swelling, about the size of an almond kernel, on the hepatic duct, at its entry into the cystic duct. This was found to be a local thickening of the wall of the hepatic duct, narrowing the tube so as to be almost impermeable, and partially involving the cystic duct also. The mucous membrane, though constricted and shrunk, was smooth and healthy. No gall stone or any sort of concretion was found. The ductus communis was inflamed, but patent. Kidneys large, soft, and red from recent congestion; capsules easily stripped; substance soft, but cortex very thin and atrophied.

Remarks.—This case is similar to one described by Dr. Phillips before the Clinical Society in October, 1887, and to others referred to in that paper previously reported by Holmes, Moxon, and Johnson: the character of the stricture was the same; calculi were absent throughout; there was no ulceration of the mucous membranes, and the cause of the affection was equally obscure. During life I supposed the case to be one of impacted gall stone, or else of cancer of the liver, but without positive evidence of either. One

peculiarity of this case was the sudden onset of the symptoms, which I can only explain by the duct—which from the hardness and thickness of the stricture must have been affected for a considerable time and become much reduced in calibre—having become plugged with mucus. The typhoid condition and nervous symptoms which appeared at the close of the illness may perhaps be attributed to the atrophy of the liver which took place then.

Elizabeth-street, S.W.

GANGRENOUS INFLAMMATION OF LABIA: CASE OF NOMA.

By E. ST. GEORGE QUEELY,

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THE following case has just come under my notice and may be of interest.

Jessie M—, aged nine, had been suffering for about five days previously to my seeing her from swelling and inflammation of the right labium, which her mother had poulticed continually. When I saw her on the evening of Oct. 12th the right labium was greatly swollen, of a dark-red colour, and very painful to the touch, and about the middle there was a small shallow ulcer. The tongue was foul, skin hot, pulse quick, and bowels confined. No history could be obtained, only she felt some irritation there a few days before she complained. She had always been a healthy child, the only illness being an attack of measles about four months before. At first her father thought she had been injured by riding across a fence, and suggested a splinter, but of this there was no sign. On the third day of my visit both labia were very enlarged and of a deep-red colour. There was an ulcer about the size of a threepenny-piece, and a second, but smaller one, above it. The child screamed on the slightest movement. The urine was passed with difficulty in a standing position, causing great agony. There was a slight discharge from the vulva, from which the epithelium was stripped, leading to ulceration the next day. On the fourth evening there was great itching, which lasted for some hours in spite of all treatment. On the fifth day the symptoms were much worse; the glands in the right groin were enlarged and inflamed, and the abdomen was swollen. The ulcerations had become larger, and fresh ones had appeared on the fourchette and perineum. The buttocks were covered with a rash. The vulvar opening was continually closed by discharge, and the labia were gangrenous. The bowels were open, dark-green matter being passed, which was very offensive. On the fifth and sixth nights the patient was slightly delirious. The symptoms remained unchanged on the seventh day; but from the eighth the disease seemed to decline, and on the sixteenth she was able to leave her bed, and two days afterwards was convalescent.

With regard to treatment, the child was confined to bed and absolute cleanliness enforced. She was placed sitting in a warm bath (into which a little potash permanganate was thrown) three times a day, the parts to be gently syringed with Condy's fluid, and lint soaked in a lotion of opium and carbolic applied. The dressings had to be changed while the child was under the influence of chloroform. The ulcerations were checked by the free use of the solid nitrate of silver. I found zinc ointment made with vaseline and a little carbolic acid of more use and better borne by the patient than any other application; in fact, it was the only thing that seemed to give relief from the excessive irritation, and from the time I commenced the ointment the disease seemed to fade. I used it very thickly, especially between the lips of the vulva. Internally, I gave quinine and iron, with abundance of strong liquid nourishing food and port wine. The bowels were relieved by saline aperients.

On my first visit I diagnosed the disease as phlegmonous inflammation of the labia, but as there was no formation of pus or abscess, and as the ulcerations increased and were gangrenous, with ash-coloured secretion and dusky-coloured skin, I saw that I had to deal with a more serious affection, which is not fortunately of frequent occurrence in Queensland—namely, noma. I believe now that this gangrenous inflammation of the labia was a sequela of the measles, as I since found that the child was neglected during the attack, and that she fell into a low state of health in consequence.

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