mitted to compression, the condition will, in a similar manner, be favourable to a transudation of hepatine, and its admixture with the blood. In the human subject, saccharine urine has been noticed in cases attended with an obstruction to the flow of blood towards the heart. For example, it has been observed in whooping-cough, coma, and pneumonia; and I look upon it here as entirely referable to a physical alteration of the conditions in the liver. In whooping-cough, the protracted paroxysms of coughing not only occasion a great amount of venous congestion, as is indicated by the countenance of the patient, but the liver must, at the same time, be compressed externally by the violent action of the abdominal muscles. In coma, with stertorous breathing, the impediment to the circulation of blood through the lungs produces general congestion of the system, and in this the vessels of the liver must participate. A case of this kind only recently fell under my notice. A man, one of the carpenters of our hospital, suddenly fell down in the street in a fit of apoplexy. As there was great lividity of the face, with slow, stertorous breathing, I suggested, about eighteen hours after the fit had occurred, that the urine should be tested for sugar. It was highly albuminous, and gave, after the albumen had been coagulated and separated, a copious reaction with the copper solution. There was no evidence that this person had saccharine urine previous to the occurrence of his apoplexy. In pneumonia, where a large portion of the lung is rapidly involved, the patient is likely to suffer from great dyspnoea; and thus, through the circulation being influenced, saccharine urine may be occasioned at the commencement of the disease.

After division of the pneumogastrics in the lower animals, I have often observed the production of saccharine urine. It depends upon the activity of the respiratory function being so diminished as to offer an impediment to the natural flow of blood through the system; and it is only where this is prominently the case that sugar is to be recognised in the urine.

ON

CONGENITAL DISLOCATIONS OF THE HIP.

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CONGENITAL dislocations at the hip-joint have of late years occupied so much attention, and been the subject of so many curative efforts, that a general account of the anatomical peculiarities of such cases must be both interesting and instructive, and this information is the more desirable because it has been affirmed that the joint is commonly found perfect in form, although the component pieces are separated, and that attempts to re-approximate the articular surfaces are indicated and have been successful.

We must be most careful in admitting such evidence; for many cases have been included under the head of "congenital dislocations of the hip," which have no right to be so denominated. It requires a practised eye and hand to detect with certainty every form of hip accident in the adult. How much more so must it be in the young; how easily may it be overlooked in the infant.

Much valuable information on this subject has been collected by Dr. Gurlt, of Berlin. He remarks that in the majority of cases the head of the femur is thrown upwards on the dorsum ilii, sometimes upwards and outwards. The dislocation may be complete or incomplete, single or double; whether it is single or double depends on the changes of form in the pelvis. Congenital dislocations are often combined with other malformations.—(Beiträge zur Vergl. Pathol. Anatomie der Gelenk-krankheiten, s. 455.)

In children who have not yet learnt to walk, we find in these cases that the head of the femur is either completely absent, and supplied by a flat surface lying on the trochanter, (Vrolik, "Tabulæ ad Illustrandam Embryogenesin," s. 106, tab. 84, figs. 1 and 2;) or the head of the bone is deformed and flattened in those spots where it comes into abnormal contact with the ilium, (Parise, "Archiv. Génér. de Médecine," ser. 3, t. xiv., 1842, p. 446.) The cartilaginous covering is irregular, and of different thickness. The changes in the acetabulum depend on whether the dislocation is complete or incomplete. In the former case, the acetabulum is either normal or flatter than natural; the flattening is remarkable when the

head of the femur is deficient, (Paletta, "Exercitationes Patholog.," s. 171, p. 90.) In the latter, the rim of the acetabulum is compressed where the head of the femur rests against it, (Parise, op. cit.) In some cases, the fatty tissue in the acetabulum is hypertrophied, (Paletta, op. cit.) In others, the joint is distended with synovia, (Parise, op. cit.) The capsule is mostly normal, though occasionally distended by an increase in the quantity of synovia. The ligamentum teres is almost always present in infants, and elongated and thinned, but sometimes thicker than natural, (Parise, Vrolik, op. cit.) The formation of a new joint is always incomplete. Tournaï relates the particulars of a case of dislocation downwards and inwards, ("Ueber Angeborene Abweichungen in der Contiguität des Knochensystems," Münster, 1834, s. 9.)

In older children, who have learnt to walk and have sustained the weight of the body, the head of the femur is flattened and deformed, as above stated, but also small, and little developed; the neck of the femur is shorter than normal, and altered in direction—i. e., more horizontal; the acetabulum is flatter and smaller, and full of fat. The want of relation between the acetabulum and head of the femur is more marked, and the former is no longer fit to receive the latter. (Vrolik, "Essai sur les Effets Produits," &c., s. 454.) The capsule is generally thickened, but capacious, covers the head of the femur, and allows of some movement. The ligamentum teres is mostly present, but elongated and flattened. In some cases, fragments of it alone remain adherent to the femur. The formation of a new joint is very incomplete; the impression on the ilium is faint. In most cases, the thickened capsule has to bear the weight of the body, as the bones are scarcely in steady apposition. (Vide Gurlt's "Beiträge zur Pathol. Anatomie Gelenk-krankheiten.") The direction of the pelvis is more oblique than natural. When both bones are dislocated there is anterior curvature of the spine; when only one, the spine is curved laterally, and the vertebræ are rotated.

Although I have not yet met with a case in which this deformity could be rectified, still it is pleasing to know that patients may gain the power of walking freely, and that the spinal curvature may be lessened by proper apparatus.

New Bridge-street, Dec. 1860.

A Mirror

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

Nulla est alia pro certo noscendi via, nisi quam plurimas et morborum et dissectionum historias, tam aliorum proprias, collectas habere et inter se comparare.—MORGAGNI. *De Sed. et Caus. Morb.*, lib. 14. Proæmium.

WESTMINSTER HOSPITAL.

INJURY TO THE JEJUNUM FROM A CONTUSION;
SUBSEQUENT RUPTURE AND FATAL PERITONITIS ON
THE FIFTH DAY.

(Under the care of Mr. HOLT.)

THE three cases which we now record in our "Mirror" are examples of the most serious form of injury to the bowels, for the integrity of their structure was invaded, so that an escape of fecal matter took place into the peritoneum, which was fatal. In the first two, the mischief arose from violence; and in the third, from the impaction of a bone. In that which immediately follows, it is most probable that the rupture of the bowel was not immediate, but that the bruise by the saddle was so severe at the point of rupture that the intestine was unable to recover itself, and hence the occurrence of fecal extravasation some time after the injury was received. For the notes of the case we are indebted to Mr. W. B. Slayter, house-surgeon to the hospital.

D. W—, aged forty, a mounted rifleman, admitted June 23rd, about eight o'clock P.M., under the care of Mr. Holt. It was stated by his friends that they were returning with him