spoken intelligibly to his father at 1 A.M.; at 3 A.M. he had become completely unconscious, and was in that condition at the time of my seeing him. I found him lying on his back in profound coma; pupils widely dilated; breathing noisy and rapid; and he was continually vomiting a thick coffee-ground coloured matter with an offensive smell. The dull note elicited at the previous visit over the region of the sixth rib had now disappeared, and, indeed, it required care to detect that the note on percussion in this situation was a trifle less resonant than that obtained above or below the rib. Spleen dulness was not increased. Such violent vomiting took place whilst the exploration of the abdomen was proceeding that all further examination was desisted from. The boy's face was a dusky yellow, and this colour was distinctly marked all over the body. The child died at 11.20 A.M. A post-mortem examination was refused. The urine contained no albumen; sp. gr. 1026. The sample of urine was unfortunately thrown away before any further examination could be made.

The following history was kindly supplied by the medical attendant who was in charge of the case. The patient, the son of a labouring man, was aged five years and nine months. He had always been a fine, well-nourished, healthy boy, and came of a healthy family. He had been apparently quite well up to Oct. 29th, when his mother, noticing that he was looking yellow, took him to the doctor. Beyond the fact of his yellow skin the boy seemed to be in good health and spirits, was not feverish, made no complaint of pain, and his appetite was very good. He, however, occasionally vomited (no note was taken of the vomited matter). He continued in this condition until the morning of Sunday, Nov. 6th, when noisy delirium suddenly set in, and he complained of headache and pain in the epigastrium. The noisy delirium had subsided, being replaced by low muttering, when I saw him at 7 P.M.

It has not been considered necessary to encumber this relation with any account of the line of treatment pursued, which was confined to the exhibition of aperients.

CASE OF POISONING BY THE INGESTION OF HIMROD'S POWDER.

By GEORGE THORPE, L.S.A. LOND.

THE following case, which has lately occurred in my practice, may be interesting and worth insertion in THE LANCET, as I have not heard or read of anything similar.

I was called to A. W—, aged twenty-seven, who suffers from chronic bronchitis and asthma, and had been recommended to use Himrod's inhalation for their relief, which I believe is mainly composed of stramonium, lobelia, and other antispasmodics. Without reading the directions he had mixed himself a teaspoonful of it with water and drunk it. About an hour afterwards I was fetched by a boy, who said "his brother was dying, and would I come at once." On arrival I learnt the above facts from his mother, and found the patient staggering about the room as though intoxicated, frequently muttering, in a state of wild delirium, incoherent in his speech, and totally unconscious of his surroundings. The pupils were widely dilated, cold beads of perspiration stood upon his forehead, and his pulse was very slow and feeble, about twenty-five beats a minute. Altogether his condition was an alarming one. I at once administered an emetic of warm mustard-and-water, and subsequently one of sulphate of zinc, both acting well and bringing up part of the poison. I then ordered cold affusions to the head, and gave him some brandy-and-water, as the pulse was still getting slower. After a time he rallied slightly, and I left, giving directions for him to drink copious draughts of lime-water. I saw him again in the evening, when he was certainly improved, but still delirious. However, on seeing him the next morning he did not seem very much the worse for what had happened.

Considering the critical condition of the patient when I first saw him, and his improvement so quickly after the lime-water, I think that the latter must have some destructive influence over stramonium, as Sir A. Garrod has before proved.

PARKES MUSEUM.—The Clothworkers' Company have just sent a donation of £25 to the Parkes Museum, to aid in maintaining and extending its work of practically teaching the laws of health.

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. Prooemium.

MIDDLESEX HOSPITAL.

THREE CASES OF HYSTERECTOMY; REMARKS.

(Under the care of Mr. HENRY MORRIS.)

WE publish this week the third case of the series in which hysterectomy was successfully performed by Mr. Morris for tumour of the uterus. We would refer our readers to the introductory remarks on page 922 of our last issue.

CASE 3. *Recurrent fibro-cystic tumours of uterus; hysterectomy; wound of bowel; convalescent from operation; death five days after the separation of the clamp and seven days after exposure to infection of scarlet fever.*—C. W—, aged thirty-five, was admitted into Helena ward on Oct. 15th, 1887, suffering from a large abdominal tumour, attended with frequent retching and difficulty of defecation and micturition. The patient stated that the catamenia appeared at twelve years of age, and that she was generally regular. She was married at sixteen, and had two children—the first when seventeen and the last when eighteen years of age. No miscarriages. She had been separated from her husband for seven years. Seven years and a half ago Mr. Morris removed from her a large fibro-cystic tumour of the uterus.

First operation in 1880.—The following is an extract from the notes of the case in 1880 taken by Mr. Harratt, a former house-surgeon of the hospital:—"Catamenial periods regular; discharge small; no metrorrhagia. Two years ago (1878) she noticed a swelling in the right iliac region. She had great pain in the lower part of the back, and her health began to fail. The swelling became larger at each catamenial period, and at the end of the flow decreased in size. This continued for fifteen months. Nine months ago the swelling increased, but failed to diminish with the catamenial flow. At the periods the pains resembled those of labour. For four months there had been a white gelatinous vaginal discharge. Bowels constipated, never acting without medicine. Micturition frequent and scanty. On admission, in 1880, the abdomen measured forty-four inches and a half. There was a large solid tumour occupying the lower part of the abdomen, spreading to the left beyond the middle line, but chiefly seated to the right of it. It did not extend as high as the umbilicus, where there was a slight hernia which had existed for months. The flanks were tympanitic. The tumour was dull and did not fluctuate. The superficial veins were well marked out, but not distended. The cervix uteri pressed backwards against the rectum. The uterus was not enlarged, was normally movable, and did not seem to be connected to the tumour. An operation was performed on April 19th, 1880, as follows: An incision was made from an inch above the symphysis pubis to two inches above the umbilicus, and the abdomen opened. A tumour was seen, free from adhesions in front, larger part solid, upper part cystic. The cystic portion was tapped, and between three and four pints of clear yellowish fluid were withdrawn. This part was firmly adherent to the omentum in front and above, and to the intestines behind. At one part the adhesions were so firm that a part of the cyst wall, equal in area to the outspread hand, was left behind to be dealt with after the removal of the solid part of the tumour. The lower and solid portion was so tightly wedged into the pelvis that it required very considerable traction to raise it out through the wound. The pedicle was short, broad, thick and non-vascular, and attached to the fundus uteri. The right Fallopian tube was adherent to the tumour. A double ligature was passed between the tube and the ovary on each side and secured; then these appendages were removed with the tumour. The pedicle of the tumour was ligatured in three parts by silk ligatures, cut close off and dropped back into the peritoneal cavity. Subsequently the fragment of cyst wall was removed, and with it a considerable piece of