bathing daily in the sea for a fortnight. On the morning of August 9th when, after sea-bathing, she was lifted up by the nurse she gave great pain in the right side and had to be carried home.

When first seen the patient was very emaciated, with an anxious expression, and she complained of great pain over the abdomen, where she had much tenderness, even on superficial pressure, but especially so on the right side in the iliac region. The urine passed naturally, but the bowels were confined. She had been given a dose of castor oil the day before which had had little effect. The temperature was 103° F. and the pulse was 110. The abdomen was board-like all over, excepting below a line drawn from the umbilicus to the anterior superior spine on the right side. She was very sick and the tongue was coated with a thin white fur. The diagnosis made was peritonitis probably z, perhaps due to appendicitis.

The patient was placed on belladonna and peptonised milk, light linseed poultices being applied over the abdomen. The sickness remained very obstinate and the bowels were not moved for three days, when a small injection of warm soap-and-water with turpentine was given with a good result. Subsequently this injection was given daily. The abdomen became much less painful and tender, the board-like hardness greatly diminishing, and at the end of a week the peritonitis had subsided. There then remained a large firm swelling, quite smooth to the touch, which occupied the whole of the right side of the abdomen to a finger's breadth below a line drawn from the umbilicus to the anterior superior spine, the tumour extending across the mesial line above the umbilicus for about the distance of two fingers' breadth. The edge of the swelling here seemed to be well defined. The urine was found to be very alkaline, while the lower edge seemed to be sharp and well defined. The urine was required to be very alkaline, containing mucus and a sediment of epithelial scales. No albumin or sugar was present. After the subsidence of the peritonitis the swelling was considered to be due to the liver, but as great uncertainty existed a consultation was held, which resulted in the consultant expressing an opinion that the case was one of subphrenic abscess pushing down the liver. The temperature after the subsidence of the peritonial inflammation returned to some normal figure but occasionally in an irregular manner a degree above the normal. The pulse-rate remained very high (from 110 to 120) and the pulse was very feeble in tone. The respirations varied between 23 and 30 per minute. The heart sounds were normal and the lungs functions, it appeared, had been normally carried out, her periods being both regular and of the usual duration. On examining the site of the old operation seven small hard nodules could be felt in the skin in the course of the scar, the largest being of about the size of a horse-bean. In the axilla there was a hard firm mass as large as a walnut. The skin over the nodules was red and smooth and there were but little pain and tenderness present. There was no oedema of the arm nor were any of the supra-clavicular glands felt to be enlarged. The facts were clearly put before the patient and the probable futility of the operation of double oophorectomy was explained to her. She begged, however, that the chance of cure, such as it was, might be afforded her. I accordingly removed both ovaries and at the same time excised widely the whole infected area of the breast, removing a considerable portion of the pectoral muscle. I then attempted to remove the mass in the axilla, but finding it firmly adherent to the vessels at one spot had per- ceded it; the loss in this operation was occasioned by a wound closed by first intention, as did that in the abdomen. The ovaries were found on examination to be complete and their activity was evidenced by the presence of two recent and well-marked corpora lutea.

The subsequent history of this case is as follows. Menstruation ceased absolutely from the date of the operation and within two months the patient showed evidence of the establishment of the artificial menopause in the occurrence of hot flaming, headaches, and at times fits of nausea. The patient returned on Sept. 12th with a small nodule in the scar of the axillary wound. This was removed without loss of time. A second nodule appeared in the following February and was also removed. Three weeks from her discharge on this occasion two fresh nodules appeared at a point a little lower down. No further operation was undertaken. This patient is now suffering from symptoms obviously pointing to the presence of secondary deposits in the upper dorsal spine and left lung.

The chief points of interest in the case are as follows. The patient had not reached the climacteric and was therefore presumably a case favourable for treatment by oö. hysterectomy. The uterus, however, being quite normal in size, afforded the primary object at least had been attained. In spite of this the result was a complete failure to arrest the progress of the disease. The breast was thus very much larger and the axillary glands also gradually disappeared and cannot at the present time be felt. It has in no way affected the arm, which is at present free from oedema. This disappearance I imagine to be due to interference with the blood-supply rather than to any trophic influence exerted by the artificial menstruation.
menopause, and I doubt not the mass will yet show signs of recrudescence.

Montague-street, W.

NOTE ON AN OUTBREAK OF SEPTIC SORE-THROAT CAUSED BY MILK

BY W. GIFFORD NASH, F.R.C.S. ENG.,
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The sudden outbreak of a very severe form of sore-throat at the end of June has once more provided evidence of the danger of consuming unboiled or uncooked milk and cream. The first case of this outbreak which came under notice occurred on June 27th in the practice of my partner, Dr. H. Savory, who had a throat rubbing examined with the result that *staphylococci and streptococcus brevis* were reported to be present. On June 29th four cases occurred, on the 30th 15 cases, on July 1st 12 cases, on the 2nd three cases, on the 3rd two cases, and from the 4th to the 9th five cases, making a total of 42 cases which occurred in 22 families. Besides these several other milder cases were heard of in which the patients did not need medical advice but who drank the same milk.

With regard to the appearance of the throat, these cases were characterised by the large amount of swelling of the tonsils, fauces, palate, and uvula. The pharynx also in many cases was involved. The affected parts were bright red and extremely tender to the touch. There were patches of exudation. Distinct ulcers frequently were present on the tonsils and fauces and these gave rise to great difficulty in swallowing. The general symptoms consisted of severe headache, giddiness, backache, and pains in the limbs—very much like the symptoms of influenza. The temperature generally was 102° or 103° F., but in a few cases ran up to 104° or 105°. The tongue was dirty and in many instances there were gastric and intestinal disturbances. Great weakness was present and in many instances marked debility remained for a few weeks. In one instance a quinsy formed. I did not see any other complications except enlargement of the glands at the angle of the jaw.

As to the origin of these cases, I found that in every instance the milk was obtained from the same dairy. No case of sore-throat came under notice during this period amongst por-on drinking milk from any other of the numerous dairies supplying milk to our patients. I think this proves conclusively that the source of this outbreak was some infection in the milk and cream of this particular dairy. I believe that in the first week it was most active on June 29th and 30th. On Sunday, June 30th, many people consumed cream with fruit and these included nearly all the women of the family. The temperature was present and in many instances marked debility remained.

On making inquiries from the dairy-farmer I could not obtain any information as to any illness amongst the cows or milkmen. I went over the farm and found that the water-supply for the cows was very good, the cow-sheds were clean, and the milk-cans said to be scalded with boiling water. As far as one could judge the arrangements were excellent. Specimens of milk sent to a skilled bacteriologist a week or so later were pronounced to be practically free from germs. This observation, however, does not prove that the milk on June 29th and 30th did not contain germs capable of producing an epidemic. I should say that this dairy was liable to produce disease it is the strongest evidence of the importance of sterilising all milk. On inquiring as to what was done with milk from cows with sore udders I was told that it was put through the separator, as this is stated by the manufacturers to filter milk, removing tubercle and other disease germs. This point seems to be doubtful and worthy of further explanation.

Outbreaks like this—how the weak points in our sanitary system. It is nobody’s duty to investigate the cause of an outbreak. It is the duty of those connected with the disease to notice it, and therefore the medical officer of health does not hear of it. I think that every case of septic sore-throat should be notified. Then outbreaks due to defective drains, water— or milk—upsets would become known to the medical officer of health and could be investigated by him. The difficulties of tracing an outbreak like this to its origin in the patient can only be successfully carried out by a sanitary expert with the aid of a skilled bacteriologist.

Bedford.

A Mirror

OF

HOSPITAL PRACTICE,

BRITISH AND FOREIGN.

LONDON TEMPERANCE HOSPITAL.

A CASE OF SIMPLE COMMUNICATED FRACTURE OF THE RIGHT TIBIA; NUTRIENT ARTERY OF THE TIBIA TORN THROUGH AT ITS ORIGIN; EXTRAVASATION INTO THE KNEE AND TISSUES; GANGRENE SUPERVENCING ON THE FOURTH DAY IN A HEALTHY SUBJECT; AMPUTATION THROUGH THE THIGH; RAPID HEALING; RECOVERY.

(Under the care of Sir W. J. Collins.)

Gangrene is one of the rarest complications of a simple fracture, but it occurred in the following case as the result of a "so-called" diffuse traumatic aneurysm obstructing the circulation of the limb. For the notes of the case we are indebted to Dr. H. Burrows.

A man, aged 37 years, while bicycling on May 11th, 1902, collided with a hansom cab and was thrown violently to the ground. On admission to the Temperance Hospital he was found to be a healthy, well-developed man. There was a multiple fracture of the upper end of the right tibia running into the knee-joint, into which a large effusion of blood had taken place. There were also considerable swelling and tension, apparently from effusion of blood in the upper half of the leg. Pulsion was made out in the dorsalis pedis artery but it was not distinctly felt in the posterior tibial artery. The leg was put up in a Neville splint with iodine and in good position. On the 15th some anemic blood had formed on the anterior surface of the lower third of the leg. The foot was cold. The general condition was excellent. The temperature had not been above 100° F. On the 16th the foot was still cold. Sensation was lost and no pulse could be felt in the tibial arteries. More bulge had appeared. There was now pain and his general condition was excellent. Sir William Collins diagnosed traumatic gangrene and advised amputation above the knee. The same day he amputated through the lower third of the thigh by a long anterior and short posterior flap. Some extravasation of blood was encountered in cutting the flaps. On the 23rd the patient's general condition had continued good though the temperature had been maintained slightly above normal. The wound was dressed for the first time and the stitches were removed. The flap had united. On June 10th the patient was discharged. The stump was soundly healed.

Remarks by Sir William Collins.—Dissection of the amputated leg showed a comminuted fracture of the upper end of the tibia, the entire nutrient artery in the body seemed to have had the same effect as a pinking of the posterior tibial artery would have had. The slowly supervening traumatic gangrene was doubtless due to the pressure exercised upon the large vessels by the contact of the limb with the bed. The muscles and blood pumped out of the ruptured nutrient artery. The fracture was a "simple" one and until the dissection of the amputated limb it was not clear why in so healthy a subject gangrene should have supervened in the course of three or four days.