heard over a small area at the angle of the scapula. The note in front was not impaired and signs of general bronchitis persisted. On the following day an exploring needle was inserted in the fourth space in the mid-axillary line and foul-smelling pus was withdrawn. Accordingly it was decided to resect a rib and to drain. This was done under chloroform, the fifth rib in the mid-axillary line being chosen and about one inch was removed. The lung was found to be pressed tightly against and adherent to the chest wall, entirely obliterating the pleural cavity. A needle was therefore passed into the lung for a distance of three inches and pus was again withdrawn. A large probe was then passed in the same direction into the lung and appeared to be in a large cavity in which the bent end of the probe could be freely moved about. On withdrawing the probe pus escaped, but owing to the amount of bleeding from the lung substance no further dilatation of the passage was undertaken till the following day, when the opening was enlarged with forceps and a small tube was inserted, nearly a pint of pus escaping. As a result of this treatment the patient's improvement was marked. Within 36 hours all mucopurulent expectorations had ceased, the respirations fell from 40 to 22 per minute, and the cough nearly ceased. Three days after the operation the temperature became normal and a corresponding improvement was seen in the pulse rate. The general condition became much better, the appetite returned, and the patient began to gain weight.

At this time iodine baths were being given for half an hour daily with the result that the discharge though remaining profuse was far less offensive. The improvement continued steadily until Feb. 13th when the temperature again began to rise, the expectoration of foul pus recommenced, and the wound simultaneously ceased to procure effective drainage. Accordingly on the 17th, three weeks after the first operation, a further portion of the same rib was excised under chloroform, the lung was freely incised with but little hæmorrhage resulting, and a full-size drainage-tube was inserted. The cavity appeared to be about two and a half inches in diameter and the walls were soft and spongy; several ounces of pus were evacuated. For the three days following the operation the symptoms improved, the temperature fell to normal, expectoration ceased, and the discharge became sweet. About this time the bronchitis began to clear up. Since then the improvement had continued, the discharge had slowly become less, and the cavity had diminished in size. As regards physical signs there remained dulness and extremely weak breath sounds below the level of the operation wound but the tactile vocal vibrations were increased. Above the wound the note was good and air entry and breath sounds were natural and the left lung was also natural. The patient made an uninterrupted recovery and was sent to a convalescent home on May 1st. A sinus about two inches long admitting a small probe still remained but there was no discharge and the patient when last seen on June 1st was in excellent health. He had no cough or pain and had regained his weight and strength. The only drugs given internally were the usual stimulants and expectorants, together with ichthyol in capsules containing ten grains three times a day. For permission to publish the above notes Mr. Denham White is indebted to the courtesy of Dr. Davies.

WEST NORFOLK AND LYNN HOSPITAL, KING'S LYNN.

A CASE OF LACERATION OF THE BRAIN BY CONTRECOUP.

(Under the care of Mr. H. C. ALLINSON.)

FOR the notes of the case we are indebted to Mr. Basil H. Pain, house surgeon.

On June 14th at 1 P.M. a man, aged 46 years, was taken to the West Norfolk and Lynn Hospital on an ambulance with a history of having fallen into the hold, some 15 feet deep, of a vessel unloading in the docks, and that he fell striking the back of his head on a steel plate. On removing the hood of the ambulance stretcher the man was seen lying on his left side, having recently vomited. His pulse was slow (56) and he resisted attempts to get a view of his pupils. He tried to get off the stretcher but did not speak. He was taken into the ward and an examination failed to reveal any signs of external injury. He was cold and collapsed when admitted but soon rallied. He vomited three times within the next two hours. A little

later he answered rationally a few questions put to him by the sister of the ward with the single word "Yes." No paralysis could anywhere be discovered. The knee-jerks were well marked, possibly increased, and his arms and legs were held stiffly. On lightly stroking the plantar surfaces of the feet the legs were quickly withdrawn. There was no discharge from the nose or ears. The eyes were next examined but were unable to afford any assistance in diagnosis, for both showed extensive signs of old iritis, the pupils being eccentric, and in the left eye there was a large coloboma, apparently due to operative interference many years ago. Throughout the night he was very restless, a male attendant being required to keep him in bed. His pulse at 10 P.M. was 100, the respirations were 26, and the temperature was 99.6° F. The next morning a diffuse swelling was apparent over the region of the lambdoid suture. He was able to swallow fluids but never spoke. At 10 A.M. his pulse was 64, the respirations were 16, and the temperature was 99.6°. At 2 P.M. his temperature had risen to 102.4°, the pulse was 100, and the respirations were 24. At 3.30 P.M. he vomited and had great dyspnoea and cyanosis. Tongue forceps and gag being used, free air entry was obtained, but the respirations became slower and more laboured, and finally ceased, his heart continuing to beat about a minute after all respirations had ceased.

Necropsy.—A post-mortem examination revealed a small hæmatoma beneath the aponeurosis of the occipito-frontalis in the middle line in the region of the lambdoid suture. No depressed or fissured fracture could be made out on the surface of the skull, so the skull-cap was removed in the usual manner. The dura mater beneath was not torn and looked normal. The superior longitudinal sinus was empty. On stripping the dura mater off the brain, the blood-vessels running in all the sulci were seen to be much engorged and anteriorly the superior and middle frontal convolutions were reduced to pulp and mixed with blood. The base of the brain was free from injury and likewise the spinal cord. The ventricles of the brain appeared to be natural. An examination of the skull-cap showed that the sagittal suture posteriorly gaped on the slightest pulling apart of the two bones and one small bony projection between the two bones was fractured. Similarly all the sutures on the left side of the base of the skull were clearly marked out by a dark line of extravasated blood in the sutures, suggesting at first glance a fractured base, but on comparing this line with the sutures on the opposite side and stripping off all the dura mater from the base of the fossæ it was apparent that there was no fracture present. No fracture could anywhere be found except the small bony projection between the two parietals mentioned above.

Remarks by Mr. PAIN.—The points of the case which I venture to think are interesting are: 1. The patient's pupils being eccentric and a coloboma present in the left eye they afforded no aid in diagnosis of the brain lesion. 2. A specimen of urine voided some ten hours before death reduced Fehling's solution. The urine was boiled with freshly prepared Fehling's solution. No reduction took place till cooling began, when the whole suddenly turned to yellow, then to red, and cupric oxide was deposited. Some reducing substance was evidently present in the urine, the specific gravity of which was 1014 and contained a trace of albumin. 3. The injury to the frontal lobes, by what I take to be injury due to contre coup. For permission to publish these notes I am indebted to Mr. Allinson, under whose care the case was placed.

MELBOURNE HOSPITAL.

A CASE OF GENERAL PANCREATITIS WITH JAUNDICE; CHOLECYSTENTEROSTOMY; RECOVERY.

(Under the care of Dr. W. MOORE.)

A MARRIED woman, aged 25 years, came under the care of Dr. Moore first in May, 1902, suffering from jaundice with a large tumour in the left hypochondrium and the epigastrium. The tumour was rounded, hard, non-fluctuating, and freely moveable, the percussion note over it was dull, and the dullness was continuous with that of the liver. The tumour was first noticed six years previously, when she had a sharp catching pain in the left side; since then the pain had been dull and more or less persistent. About the beginning of May, 1902, she had an attack of severe pain in the epigastrium and afterwards became markedly jaundiced.