when he was seized on the morning of Feb. 1st with a most intense rigor, followed by the usual very hot stage and excessively profuse perspiration. For the first week after this rigor he had two rigors quite as severe every twenty-four hours, but without any marked periodicity, and was then left so exceedingly weak and ill that recovery appeared utterly hopeless. Dr. Johnston consulted with me repeatedly and at the end of this week of misery we concluded that he must certainly die. When the first rigor seized him he was put upon large doses of quinine and his allowance of stimulants was increased. Fortunately he could still take a fair amount of nourishment. His stomach retained everything, and this gave us a little hope. Another point in his favour was that even during the highest state of fever the temperature did not go much beyond 103°, falling to almost normal after the sweating stage. At the end of a week the rigors diminished in frequency to one a day, then one in two days, and before they finally left, which they did at the end of three weeks, one every third day, also gradually lessening in intensity. His weakness was now extreme. During all this time the wound in the perineum was perfectly healthy; no abscess, either external or internal, was formed. It was three or four months before any diminution of the circumference of the legs was apparent. All this time the urine had been daily carefully measured and the density taken. During the rigors, and when the profuse perspiration existed, the quantity had diminished. It certainly increased again, but never was so much as 90 oz. or 100 oz. in the twenty-four hours, and the density began to rise. In short, the blood got rid of the poison and the urine gradually became normal in quantity and quality. It was so at the end of three months after the operation and has remained so until now. I do not think the operation had anything whatever to do with the prolonged and varied illness; the blame must be attached to the state of the system, whatever that might be, caused by the polyuria. After the rigors had quite passed away, a long flexible indiarubber tube, with a stopcock at the end of it, was attached to the stiff tube in the bladder, and as his urine could be retained for about four hours the stopcock was then turned and the bladder emptied. The stiff tube had so completely accommodated itself to the perineal opening that there was little or no leakage. This tube was easily removed and a fresh one put in about every ten days.

At the end of seven months after the operation the patient was able to be out of bed and lie on a couch, and was soon afterwards assisted daily into another room. His health was now perfectly restored and he gradually recovered the use of his legs. In the month of December, nearly twelve months after the operation, he was able to go to Edinburgh and attend to business, doing so ever since, with frequent journeys elsewhere. The only pain or inconvenience he suffers from, and which he has always had since the operation, is a spasmodic contraction of the bladder, more or less daily, with the passage of a little urine through the urethra.

There are one or two points in connexion with this case which I should like to bring prominently forward. For many years before suffering from his bladder trouble the patient conducted a very large business. He had often very little opportunity for micturating and gradually accustomed himself to do without emptying his bladder for ten or twelve hours. I think one of the functions of the prostate gland is to assist the vesical sphincter. The prostate began to enlarge at an unusually early age, when the patient was not much over forty. Professor Annandale was astonished at its size. Then the irritation of the enlarged prostate or that of the urine, constantly retained in the bladder, had in some way produced the polyuria, which disappeared with the trouble caused by the enlarged prostate. Again the polyuria was disposed of in the same way as any other form of blood poisoning, but without any tangible manifestation, by severe rigors and intense diaphoresis.

High-street, Montrose.

ILKESTON COTTAGE HOSPITAL.—At the annual meeting of the friends of this institution, held a few days ago, the chairman was able to give a very satisfactory account of the success which has attended the work accomplished during the past year. Its finances also bear a similarly favourable aspect. One pleasing feature in the career of the hospital has been the practical appreciation shown by the working classes in the progress of the charity. Reference was also made to the proposal to build a new hospital, for which funds are already to some extent available.

AN OBSCURE CASE OF CANCER OF THE PYLORUS UNDETECTED DURING LIFE.

By J. BALMAIN MACLEOD, M.D. ABERD.,
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MISS C—, aged fifty years, consulted me for the first time on April 4th, 1890, for indigestion. She stated that she had always enjoyed good health till towards the end of 1889, when she had a sharp attack of influenza, from which she made a very slow recovery, and then, for the first time, symptoms of indigestion set in. The patient was a thin, wiry, pale-complexioned person. She complained of pain over the region of the stomach about an hour after taking food, which passed off in about half an hour, leaving her entirely free from pain till the next meal. Tongue very much furred; bowels constipated; appetite poor; stomach and bowels distended with flatulence. Nothing abnormal could be detected on examining the stomach. She had had no vomiting, but complained of acidity. I put her on a course of bismuth, rhubarb and soda, and carefully dieted her. On this treatment she seemed to improve, and left Dundee on May 6th for a change of air. On June 18th she again reported herself; she appeared to have improved by the change, but still suffered more or less from a fixed pain in the stomach; referred to a spot towards the left of the epigastric region. After seeing her for a few days she went to the Highlands for a further change, where she remained for about six weeks. Towards the middle of September, however, the pain appeared to increase, and was more constant than before, and now was not influenced by food; the pain was of a dull aching character, referred to a spot in the left epigastric region. She also complained very much of flatulence, with fetid eructations. Various remedies were tried, peptonised foods prescribed, but the pain persisted. Bismuth and morphia in powder were ordered, which had a decided effect in dulling the pain. About the middle of December Professor Grainger Stewart of Edinburgh saw her in consultation, and after a careful examination could detect no organic lesion, although by this time she had emaciated very much and had a cachectic appearance. He gave as his opinion that the dyspepsia was of a neurotic nature, and advised very much the same treatment to be continued. For a few weeks she appeared to rally and kept comparatively free of pain while taking the bismuth and morphia. Her appetite was wonderfully good and the food well digested, but she steadily emaciated from week to week and died on May 19th without any pain or suffering during the last fortnight of her life, and was calm and collected to the end.

On May 20th Dr. Stalker, for some time pathologist to the Dundee Royal Infirmary and my junior colleague there, kindly conducted the post-mortem examination along with me, and we found as follows: The body was extremely emaciated and anæmic, with commencing cedema of the extremities. On opening the abdomen the stomach was found adherent to the under surface of the left lobe of the liver, and was held well back. The adhesion took place all along the line of the lesser curvature of the stomach, from the pylorus to the cardiac end. The pylorus itself was surrounded by a thick hard band or ring of scirrhus cancer, interrupted only at the posterior part, where for about half an inch the ring was almost absent. A finger could very easily be passed through the pylorus. There was no dilatation of the stomach and no secondary deposit anywhere.

Remarks.—The great interest attaching to this case is the difficulty of diagnosis met with during life. I all along entertained a strong suspicion of malignancy (and expressed it) based upon the steady emaciation of the patient, her cachectic appearance, her period of life, and a family history of cancer, an aunt having died of the disease; but the fact that there were no symptoms of vomiting, and never had been, combined with the position of the painful spot well toward the left of the epigastrium, militated against and obscured a diagnosis of cancer of the pylorus. It is probable that there was some consecutive atrophy of the glands of the stomach,

and that this atrophy, even without pyloric stricture, may have produced the graver nutritional disorder that was apparent from the first; and the fact that the pylorus was adherent to the under-surface of the liver and was dragged to the left side beyond the reach of palpation, though immediately over the spot to which she always pointed as the seat of pain, was another obscuring element. The limited amount of organic change in the pylorus during the fifteen months she suffered under the affection is also interesting. The post-mortem examination was therefore specially instructive, and is my plea for publishing the case.

Airliebank, Dundee.

REPORT OF A CASE OF HYDROPHOBIA.

By J. L. KERR, M.D. ABERD., C.M., F.R.S. EDIN.,
PUBLIC ANALYST; LATE EXAMINER IN CHEMISTRY AND IN MEDICAL
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A GIRL aged eleven years was bitten upon the hand by a stray dog on May 24th, 1892. The wounds were upon the fingers and thumb of the right hand and were small, being perforations of the skin without any laceration. I cauterised them with strong carbolic acid shortly after their infliction. They healed quickly; the girl showed no symptoms of any kind and the whole incident was well-nigh forgotten. On Nov. 29th, 1892, 189 days after the hand was bitten, she began to be ill. She had no marked symptoms during the day, but ate and drank very little and complained of pain in the right forearm and elbow. In the evening of the same day she complained of inability to swallow, and said when she tried to drink "it took her breath." She also said her heart beat very fast, which it did; the pulse rate was much accelerated and the heart's action turbulent in character. The temperature was normal. The patient had an anxious look, but no other noteworthy symptoms. She either had inability to swallow or her repugnance to do so was so great that she would not try. She passed a very restless night and in the morning the respiratory spasm and the rapid pulse rate had much increased. Any efforts to swallow liquids or solids were made with great unwillingness and produced marked respiratory spasm and general muscular spasm of the whole body in a slight degree. She complained of hunger and thirst, but no persuasion would induce her to eat, drink or suck ice. She was very lively and talkative, "like as if she was drunk" her mother said, both at this time and during the quiet periods throughout the illness. Towards the evening she had short periods of maniacal delirium, for which she apologised, saying that "she could not help it for it came on her all at once." On the third morning she had increased respiratory spasm and great hyperæsthesia of the skin, for a draught of air or a touch or the fear of a touch would produce a general spasm of all the muscles of the body. During the quiet periods her pulse rate was 138 per minute and was easily accelerated by the least excitement. She ate about ten grapes with little difficulty. About half-past two o'clock in the afternoon she had a severe attack of maniacal delirium, with loud and piteous cries, lying on the floor, the limbs moving about and the body twisting from side to side in a peculiar way. At the same time she vomited small masses of solid mucus, exactly resembling nummular sputum, and from this time onwards she was unable to swallow her saliva and spat it out almost constantly. At half-past six she had general convulsions; she lay upon her back in bed, moaned piteously and then flexed and extended the upper and lower limbs very rapidly; she was cyanosed and the eyelids became swollen immediately afterwards. After the cessation of the convulsions the jaw dropped and she was unable to close her mouth completely. The weakness increased very rapidly, and about eleven o'clock in the evening she had another attack of convulsions, not so severe as the first, followed by gradually increasing paralysis of all the muscles of the body, and she died by failure of the heart at three o'clock in the morning of Dec. 2nd, 1892.

Crawshawbooth, Manchester.

Clinical Notes: MEDICAL, SURGICAL, OBSTETRICAL AND THERAPEUTICAL.

MALARIA WITH RUPTURE OF THE SPLEEN AT THE END OF THE FIRST WEEK.

By SIDNEY J. PALMER, M.B. DURH., M.R.C.S.

THE following notes may be found of interest on comparison with a case reported in THE LANCET of Sept. 17th last by Dr. Bowie.

The patient aged twenty-six was admitted into hospital on Sept. 19th, having arrived the day before from the Danubian port Galatz, being a fireman on board a ship. He left the latter port on Sept. 3rd in apparently good health, though he was drinking freely whilst on shore. He worked in the usual manner until Sept. 12th, when he was suddenly seized with shivering and vomiting and had to go to his bunk, where he was treated by the captain with quinine. The shivering fits continued daily until he arrived at Liverpool on Sept. 18th. He, however, felt better and went home in a cab from the ship; feeling worse the next day he applied to the hospital and was admitted. He was found on examination to be in a very weak condition, although he was able to walk. He was very anæmic, with marked pallor of mucous surfaces and slightly jaundiced complexion. He felt very cold. Temperature 101.6°; extremities cold; tongue clean and moist. Heart: No murmur heard, but all sounds weak and distant. Apex beat not felt, best heard in the fifth space one inch inside the nipple line. Lungs: Breath sounds normal. Abdomen: Slightly tympanitic over front. Splenic area of dulness considerably enlarged (eight inches vertical, five inches in the transverse diameter). No tenderness on palpation or percussion. Liver: Slightly enlarged. He says he has never had ague before. Had rheumatic fever a year ago; all the joints affected. No other illness that he remembers. He ascribes the present attack to having drunk largely of Danube water, with which the ship was supplied at Galatz. The patient was put to bed, hot bottles applied to the feet and quinine and caffeine given internally. Five hours after admission the patient suddenly became very blanched, complaining of great pain over the abdomen. He was found to be lying on his left side, his legs drawn up and quite collapsed. He could not move on account of pain. The left half of the abdomen was found to be absolutely dull as far as the middle line and extremely sensitive on percussion. Morphia was given, but he rapidly sank and died half an hour after the initial symptoms of collapse.

Necropsy, thirty-six hours after death.—Post-mortem rigidity poorly marked. On opening the abdomen, which was considerably distended, a quantity of dark blood escaped. On further examination a large collection of dark clot was found in the left flank, surrounding and quite hiding the spleen. On removing the spleen—which was done without any force, no adhesions being present—and the adherent clots, a ragged rent was seen to extend for three inches across the lower part of the anterior margin. The rent in the capsule, which was very thin, corresponded to the tear in the spleen substance itself and there was no stripping away of capsule from surrounding spleen substance. The parenchyma was of lighter colour than usual and very soft and diffuent. The spleen and clot weighed 3 lb. 2 oz.; the spleen separated from the clot weighed 14 oz. The liver weighed 62 oz., pale and greasy on section. Intestines shrunken and empty; nothing found on opening them. Kidneys, each 6 oz.; pale, otherwise healthy. Stomach empty; nothing abnormal found. The heart weighed 12 oz.; valves and apertures healthy; muscular substance pale and flabby. The lungs were healthy. The reason this case appears to be worth publishing is the rarity of spontaneous rupture occurring so early in the disease. The evidence that the malaria had only existed for seven days is undoubted, and I have not been able to find a case on record occurring so soon after the first evidence of malaria. Most of the cases on record have been where malaria was of some months' or years' standing, and generally preceded by muscular effort. Here, however, the patient was lying in bed at the time of rupture, and there is nothing to account for it except causes in the organ