the neural bones (taking care to avoid the spot where the spectacle frame is riveted), and up the other ridge, and the flap was turned up. The bone was then chipped away with forceps until there was space enough to thoroughly clear out the right sinus. The reason why there was no discharge into the right side of the nose was then explained, for with the finest probe I could find no sign of an infundibulum on that side. The sinus discharged through the opening at the back of the septum into the left inferior nasal meatus. The usual funnel-shaped indigo rubber tube was passed through this into the nose and the wound was closed. The patient did very well.

The points to be noticed in this case are—(1) the absence of the right side which led to the belief that the right sinus was healthy and did not need interference, there being sufficient disease on the left side to cause all symptoms; and (2) the amount of room gained and the very small apparent scar left by the incision, which I have since employed with success in more than one case of double empyema.

Devonshire-street, W.

PHLETHYSM WITH PECULIAR CARDIAC PHYSICAL SIGNS.

BY W. SOUTHWICK WELLMORE, M.R.C.S. ENG., L.R.C.P. LOND.

The case of phlethysm with peculiar cardiac physical signs reported by Dr. Hale White in The Lancet of Nov. 19th, is of such interest that no apology is needed for recording an exactly similar case which came under my notice a few days ago.

The patient was a soldier and was under treatment in the Royal Victoria Hospital at Netley. He was twenty-seven years of age. When I first saw him a week before his death he was evidently in the last stage of phlebitis, with extreme debility, emaciation, cough, and abundant expectoration. Examination showed that the right side of the chest was extensively diseased from apex to base. There were evidences of considerable cavitation at the apex and of a moderate amount of fluid at the base. The left lung was also diseased but in much less degree, the apices only of both lobes giving morbid physical signs. On examination of the heart at first I could make out no impulse and, moreover, there was no cardiac dulness to the left of the sternum. In the usual situation of the apex the heart sounds were very faint, almost inaudible, but on tracing them to the right they became much audible and were of almost normal intensity in the fifth right intercostal space, 2½ in. from the mid-sternal line; here also a feeble but perfectly distinct impulse could be felt. There was no visible pulsation in any part of the pericardium. The temperature was 101° 6 F. and the pulse was about 100. It appeared on close questioning that these attacks occurred every four days—that is, one, say, on the Monday, the next on the Thursday, always with two clear days. The attacks commenced about 4 p.m. and lasted until the morning; they were accompanied by some headache, great lassitude, aching of the limbs, and the other symptoms of intermittent fever. I ordered 5 gr. of sulphate of quininum. The dose was to be repeated at 8 a.m. On calling the next morning at 10 I found that she had taken both doses; there had been no singing in the ears, the temperature had fallen to 96°, and she was ordered 10 gr. of quinine daily for two days more. In all she took 26 gr. This sufficed to stop the quartum, of which there was no recurrence, and produced no cinchonism—a sure sign that it was needed. The rarity of quartan ague must be great, as I have never seen a case for forty-seven years when I resided on the borders of the Essex marshes.

Auckland, New Zealand.

A Mirror of HOSPITAL PRACTICE, BRITISH AND FOREIGN.


ST. THOMAS'S HOSPITAL.

A CASE OF RUPTURED INTESTINE WITHOUT ABDOMINAL WOUND; LAPAROTOMY; DEATH NEARLY A MONTH LATER.

(Under the care of Mr. W. H. BATTLE.)

Rupture of the intestine without any wound of the abdominal wall is probably not very rare yet the number of cases which have been recorded is by no means great. The amount of damage exhibited by the skin of the abdomen is no criterion of the severity of the injury inflicted on the subjacent viscera. The skin may show only a slight abrasion and yet rupture of the liver or the intestine may have occurred. In cases like these, when the wheel of a cart has passed over the abdomen or a severe kick from a horse has been received in the same region, the diagnosis is exceedingly difficult. If the bowel has been ruptured by what signs can it be known? Unfortunately no very definite sign is possible to this question. The great amount and persistence of the collapse may suggest that an injury greater than a mere contusion has been inflicted but it cannot be said that reliance can be placed on this. It was formerly maintained, and the view is still held by many, that absence of liver dulness always occurs in rupture of the stomach or intestine and that the presence of this physical sign is pathognomonic of this condition, but neither of these statements is absolutely true; it usually happens that a rupture of the intestine or of the stomach allows sufficient gas to escape