intervals for at least one month after the evening temperature has reached normal and not only to use the test throughout the febrile period. It is interesting to note that in diseases in which the reaction is rarely found—e.g., in tuberculosis, pneumonia, and diphtheria—a positive result is of still graver omen than in enteric fever (Ehrlich). In measles in which the reaction is as constant as in typhoid fever no prognostic value attaches to its presence or persistence.

Summary.—(1) In all but severe attacks the diazo-reaction tends to disappear in the course of the second or third week, this disappearance shortly preceding, or coinciding with, the commencement of lysis; (2) its reappearance during or after the completion of lysis is a warning of recrudescence or relapse, or of complications directly due to the specific bacillus; (3) a sudden disappearance of the reaction associated with a deterioration of the general condition is of bad omen; and (4) the character of the reaction is a useful check to the history.

Tooting.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NON-TRAUMATIC CEREBRAL HÆMORRHAGE IN A CHILD, AGED TEN YEARS.

BY HUGH TAYLOR, M.A. CANTAB., M.A., M.D. DUB.

THE following brief note of an extensive cerebral hæmorrhage without any traumatic origin occurring at such an early age is, I have ventured to think, worth recording.

About 10 o'clock on the evening of Dec. 31st, 1904, a little girl, aged ten years, who had "never been really ill in her life" and who had been playing about all day with her companions apparently quite in her usual health, suddenly put her hand to her head exclaiming "Oh, my head!" gave a cry, fell down, and was in a minute or so very sick. The parents were at first inclined to ascribe the attack to a Christmas surfeit but on raising her into a chair they discovered that "she had lost the use of her limbs." I saw her about an hour afterwards. She had been very sick and was still inclined to retch. She was reclining in an arm-chair in a semi-comatose condition, her pupils were dilated and fixed, her temperature was 97·8° F., and her pulse was uncountable. The mouth was drawn over to the right side of the face, the head was inclined to the right shoulder, and her left leg was quite paralysed, but the left arm, so far as I could make out in a somewhat hasty examination in unfavourable circumstances—an ill-lighted crowded hut—was not so much implicated. About 4 A.M. on Jan. 1st she tried to "turn over" in bed, made an abortive attempt at vomiting, and quietly died. The father is a strongly built "ganger"; the mother is a weakly anæmic rheumatic woman, has a large family, and one sister suffers from constantly recurring tonsillitis.

A necropsy made on Jan. 4th disclosed a hæmorrhage which, starting from some vessel in the corpus striatum or optic thalamus, had literally ploughed its way into the right lateral ventricle, the resulting clot completely filling the cavity.

Though the diagnosis was confirmed I am quite at a loss to account for the condition revealed. My colleague, who kindly assisted me at the necropsy, and myself do not profess to be expert pathologists but we could find absolutely nothing to account for the attack, all the other organs being, macroscopically at any rate, quite healthy.

London.

A CASE OF EXTRACTION OF A COIN FROM THE OESOPHAGUS.

BY JAMES LINTON BOGLE, M.D. EDIN.

IN connexion with the case of extraction of coins from the gullet published in THE LANCET of Dec. 10th, 1904, p. 1641, the following one may be of interest as occurring about the same time in my own household.

The patient was a boy, aged five years, who on Dec. 9th whilst playing with a 10-centesimi piece (being 1·2 inches in

diameter and much the same size as a penny) put it into his mouth and accidentally swallowed it. He complained of pain at the back of his throat and in the stomach and was repeatedly sick, vomiting the food last taken. There was no interference with breathing and he readily swallowed liquids. Nothing could be seen or felt on careful examination of the throat and gullet save some slight reddening of the fauces. He was held up by the feet and well shaken without result. The vomiting continued for 24 hours, when the gastric pain became less. He had regular action of the bowels and took liquids and semi-solid food without difficulty. On the 14th—i.e., five days afterwards—the coin had not been voided per rectum, there was still some irritation in the throat, the boy's voice was somewhat weak, and he still could not take solid food. He was therefore on that day taken to San Remo, where, through the kindness of one of my medical *confrères*, an excellent skiagram was taken by the x rays, showing very clearly the coin impacted in the gullet just above the sternal notch, being two-thirds above and one-third below the sternum. Under chloroform attempts were then made to remove it, either by bringing it up or pushing it downwards but unsuccessfully, mainly owing to the want of suitable instruments. As the x ray apparatus still showed clearly the shadow of the coin in the same position I telegraphed to Dr. J. A. Macdougall of Cannes, who kindly came next day to our assistance. Chloroform having again been administered a long flexible coin catcher was passed and at the first attempt this brought up the coin to the rima glottidis. There it was nearly lost again, falling forwards, but it was successfully removed by forceps. The coin had already much changed in appearance, being dark green and somewhat roughened at the edges. The little patient was sick for 24 hours but was in his usual health in three or four days' time. The feature of the case was the smallness of the disturbance caused by the presence of this large coin in the gullet. The boy easily swallowed porridge, soft bread, and ordinary puddings with fluids and the breathing was quite unaffected from the first.

Bordighera, North Italy.

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., Proœmium.

SOUTH WIMBLEDON AND MERTON COTTAGE HOSPITAL.

A CASE OF RUPTURE OF THE PANCREAS; OPERATION;
RECOVERY.

(Under the care of Dr. A. H. GERRARD, Dr. MARTIN RANDALL, and Dr. PATTISON ARMSTRONG.)

FOR the notes of the case we are indebted to Dr. Randall.

The patient was a man, aged 42 years, a carman. On May 13th, 1904, at 9 A.M., he was walking backwards, leading a pair of horses in a loaded van. He went too far and got jammed between his own van and a stationary laden wagon. The pole of his van hit him in the epigastrium. He had violent pain, became faint and collapsed, and vomited. There was no history of blood in the vomit. He was taken to hospital and seen at 10 A.M. by Dr. Gerrard who found him collapsed, ashen in colour, with a weak, small pulse of 90, a temperature of 95° F., and in great pain. He at once ordered stimulants, warmth, and a hypodermic injection of half a grain of morphine. It was ascertained that the patient had had breakfast at 8 A.M. and had passed urine at 8.30. Dr. Randall saw the patient with Dr. Gerrard at 11.30. He was still collapsed and in pain. Midway between the ensiform process and the umbilicus was a bruise nearly two inches in diameter and very tender to the touch. The skin was not broken. The abdomen moved but was very tender, especially above the navel. Liver dulness was normal. There was marked dulness in the right flank. From the gravity of the collapse, the site of injury, and the dulness it was concluded that the patient had some serious

visceral lesion with internal hæmorrhage, and it was decided to operate if his condition seemed to warrant it in two or three hours.

Operation was performed at 3 P.M. by Dr. Randall with the help of Dr. Gerrard. Dr. T. Brice Poole gave the ether. A catheter was passed and drew off normal urine. A median incision was made above the navel. There was no gas in the peritoneum but much effused clotted and fluid blood. No lesion of the stomach, the liver, or the bowel could be found. A large tear directed vertically was then seen running from the stomach to the liver in the gastro-hepatic omentum and there was a tear in the peritoneum over the pancreas. Under this was a tear two inches long in the body of the pancreas, running from the right and below, upwards and to the left, leaving a loose tongue-like process of the gland, the base of which was half the width of the organ. On passing the finger through the tear it came directly on to the aorta. Oozing was free but no large bleeding vessel could be found. The rent in the pancreas was sewn up by four silk stitches passed by means of a curved needle in a holder. The smaller peritoneal sac having been cleansed the greater part of the tear in the gastro-hepatic omentum was sewn up with a continuous catgut suture, leaving a space above for drainage. The abdomen having been thoroughly flushed with hot saline solution an iodoform gauze packing was inserted down to the pancreas and the rest of the abdominal wound was closed. The operation was fairly well borne.

For the first three days the patient was constantly sick and in much pain. Morphine was used. Champagne stopped the vomiting on the evening of the third day. After this he was able to take small quantities of peptonised milk and panopeptone by the mouth. On this day he began to get delusions, thinking the medical attendants were going to poison or to injure him. He jumped out of bed, got the matron on the floor, and did the same the next night to a male attendant. At this time he seemed likely to die. The pulse rose to 150 and he became so collapsed that on May 20th he had $\frac{3}{16}$ th of a grain of strychnine injected four times in nine hours, besides hot brandy and saline rectal injections. Bromides, sulphonal, and hyoscine had no effect in quieting him. Meanwhile the wound was healing and discharging abundantly a viscid, slightly turbid fluid which caused excoriation of the margins of the wound, rendering soothing ointments necessary. The patient was now extremely emaciated and had much bronchitis, with severe cough and much muco-purulent expectoration. The stitches were all removed on the 23rd, the lower part of the incision being healed. On the 26th the patient was sent to Kingston Infirmary as he was so noisy as to make the rest of the small building at disposal intolerable for other patients. His highest temperature was 100.2° on the 18th and the 24th. His pulse varied from 100 to 150. During his stay at the South Wimbledon Hospital no sugar was found in his urine and no special features were noticed about the motions.

Notes on the patient's history at Kingston, by Dr. ARMSTRONG.—On admission there was an incision about two inches long in the epigastrium, to the edges of which a piece of omentum was adherent, leaving two small openings near the upper angle of the wound. From these openings there was a profuse discharge of a whitish viscid fluid. The condition of the skin of the abdomen and the lower part of the thorax resembled that produced by an extensive burn of the first and third degrees. The patient was nervous, depressed, and suspicious, was very emaciated, and had a troublesome cough. Mucous râles could be heard over both lungs but were most pronounced at the left apex. His temperature was 100° F. The abdomen was dressed with boric ointment. Chloralamide (30 grains) was given and the patient slept for several hours.

With regard to the subsequent history, the wound gradually contracted, so that at the end of June there was only a sinus admitting a probe. Under the application of silver nitrate this soon closed. Two sutures presented in the wound on June 3rd and were removed. The bronchial trouble was gone by about June 6th. Examination of the sputum for tubercle bacilli gave a negative result but pneumococci were present. The fluid from the wound was at first viscid, mucoid, and alkaline in reaction and sufficient in quantity to soak the dressings in a few hours. Its irritant character was shown by its effect on the skin. It oozed continuously from the wound whilst the patient lay still but spurted out when he coughed. Later it got more watery. In one and a half hours a fluid

ounce of it was collected. It had a slight digestive action on albumin. Its action on carbohydrates was not tried owing to difficulty in collecting fluid without causing discomfort to the patient. The quantity diminished as the sinus contracted and the flow had ceased a few days before the sinus was quite closed. There was very obstinate constipation until the patient was able to take ordinary diet. There was nothing peculiar in the motions. On June 8th the urine contained a small quantity of sugar. No sugar was present a week later. There was complete absence of chlorides. As to his mental condition, depression and anxiety were marked during the first three weeks. Narcotics were used for the first five nights to induce sleep. With regard to feeding, during the first fortnight peptonised fluids only were given and were well retained. Then, as the patient's condition had improved and he craved for solid food, a small quantity of pounded fish was given and was retained for about five hours. Violent vomiting accompanied by epigastric pain then set in and continued during the night, necessitating hypodermic injection of morphine. Peptonised diet was resumed for a week, then ordinary milk, peptonised farinaceous foods, &c., were given in succession, and on July 4th the patient was on a full diet. The changes of diet were accompanied by discomfort at first but no further vomiting occurred. The patient gained in weight and strength rapidly and left the infirmary on July 28th, the wound having been quite healed for nearly a fortnight.

Remarks by Dr. RANDALL.—The patient has now (Jan. 15th, 1905) been at work since the beginning of October as a carman, having to move and to lift heavy weights. He has some trouble with digestion. The scar bulges a good deal. The case appears worthy of recording because we have found no record of an analogous case successfully treated by operation. Dr. W. Hale White¹ refers to a similar case where no operation was performed. The patient died after a week with extensive fat necrosis. Another fatal case is referred to by Dr. R. Salusbury Trevor,² in which the patient died with fat necrosis and other lesions following injury to the pancreas by a kick from a horse. In the same article a successful case of operation for stab wound of the pancreas is mentioned. Injuries in this region are usually complicated, but the above two cases show that a severe uncomplicated trauma of the gland is not unlikely to be fatal. Hence there is some reason to think that the line of treatment adopted in this case was correct. For some days recovery was not expected. The vomiting and difficulty with the bowels were in all likelihood connected with some bruising of the sympathetic nerve plexuses behind the pancreas and it was not until several weeks after the accident that he was able to take anything except peptonised foods. The delusions were not, in our opinion, connected directly with the fact that the pancreas was injured but were the result of the severe shock on one with a history of mental trouble in the family. The violent outbreaks resulting would certainly have destroyed his life, apart from the prompt treatment of the ensuing collapse by strychnine and other stimulants. It seems difficult to imagine that recovery could have occurred in this case apart from operation when we consider the nature of the lesion and the amount of blood effused. If decomposition had not occurred fat necrosis would have been practically sure to follow and there was nothing to limit the action of the fluid to even the lesser peritoneal sac. From the physiological point of view there is not much to be said. Dr. Armstrong found sugar in the urine once, but it was tested on various occasions besides by all of us with a negative result. The motions showed no special features. That the discharge from the wound was largely pancreatic juice is evident from the condition of the skin and the tests used by Dr. Armstrong.

KIDDERMINSTER INFIRMARY AND CHILDREN'S HOSPITAL.

A CASE OF ANTHRAX (MALIGNANT PUSTULE) TREATED WITH PROFESSOR SCLAVO'S SERUM.

(Under the care of Mr. J. LIONEL STRETTON.)

A MARRIED woman, aged 35 years, was sent to the Kidderminster Infirmary and Children's Hospital by Mr. H. L. Miles on Dec. 23rd, 1904. On admission there was a well-marked

¹ Encyclopedia Medica, vol. ix., p. 89.

² Practitioner, April, 1904.