

with pains all over the body; the urine was quite black, scanty in quantity, and was passed frequently; the temperature was 103° and the pulse was 88 per minute, strong, and regular. As the bowels were constipated I administered three grains of calomel. I prescribed 15 minims of liquid extract of cassia Beareana well diluted with water, to be given every half hour at first and afterwards every hour. For nourishment Brand's extract of meat was given. To allay the thirst from which the patient was suffering I prescribed rice- and barley-water. I gave champagne occasionally in small quantities. After the first dose of cassia Beareana all vomiting ceased, the patient dozed on and off throughout the day, and the temperature fell gradually from 103° at 11 A.M. to 99·8° towards evening, when an enema was administered which acted fairly. The patient passed a much better night, had no headache, and slept at intervals. On the morning of the 28th her temperature was 100°, the jaundice was still very marked, and her pulse was 90 per minute, good and regular. She vomited some bile at 6 A.M. and an enema was administered which produced a large motion, constipated in character and containing scybalous lumps. Cassia Beareana was administered every hour during the day. Towards evening a distinct improvement was observable in the urine voided, which was fully 50 per cent. lighter in colour than it had been in the morning. The temperature remained at 100° all through the day, there was no vomiting, and the patient took nourishment well. On the 29th the jaundice steadily diminished, the urine became practically normal in colour, and the tongue was less furred. The dose of cassia Beareana was diminished to ten minims administered every two hours. The temperature ranged from 100° to 101° during the day; there was no vomiting. The patient took nourishment freely and slept much in the course of the day. The urine voided towards evening was quite clear. On the 30th it was found that the patient had passed an easy night. The temperature was 101°, the jaundice had practically disappeared, and the urine was clear and was passed freely. As all the urgent symptoms had now disappeared I left the patient in charge of an experienced nurse with instructions to continue the cassia remedy and to communicate with me should any fresh symptoms arise.

I am of opinion that recovery was due solely to the beneficial action of the drug given—namely, liquid extract of cassia Beareana—the patient being advanced in years and this being her second attack. I should most decidedly administer the same drug should I ever meet with any more cases of blackwater fever and I would give it with the greatest confidence.

Chaki Chaki, Pemba.

#### A CASE OF FULMINATING APPENDICITIS WITH SEPTIC PERITONITIS.

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THE following case presents one or two points of interest, the chief one being the distance travelled in the removal of the patient to the infirmary. This was done with ease under the influence of morphia and with apparently no ill effects.

The patient, who was a female, 26 years of age, was perfectly well on Dec. 4th and first came under medical observation on Dec. 5th on account of pain in the "stomach." On examination slight pain and tenderness with a certain amount of dulness were found to exist in the right iliac region. Her pulse-rate was 90 and her temperature was 99° F. On the following day the symptoms were much the same. On the 7th, less than 48 hours from the commencement, she complained of great pain in the right iliac region and it was then found that there were tenderness and dulness in the right flank, tympanites, and loss of liver dulness. Her temperature was 101° and her pulse-rate was 130. A diagnosis of perforation of the appendix was made. She was then put well under the influence of morphia and removed a distance of two and a half miles to the infirmary. The removal was borne very well. On admission the patient complained of no great pain; the physical signs were the same as above enumerated. A consultation was held at which the previous diagnosis was confirmed and an operation was decided upon.

The operation was performed on Dec. 7th by Dr. E. S.

Norris, senior surgeon to the infirmary. An incision was made over McBurney's point about three and a half inches in length. On opening the peritoneal cavity a quantity of offensively smelling pus escaped but there was no free gas. Some coils of intestine covered with flakes of lymph were floating free in the fluid. There was also some matting together of the other coils and on breaking down a few adhesions pockets of a clearer fluid were found. The appendix was not seen, so no attempt was made to remove it. The peritonitis extended right down into the pelvis and as far as the hand could reach in the abdomen. The cavity was then washed out with warm boric lotion of the strength of 1 in 40. During this process the patient, who had been anaesthetised with chloroform, stopped breathing, whereupon artificial respiration was performed and injections of strychnine and ether were given. The washing out was also stopped. When she had recovered somewhat a Keith's glass drainage-tube was inserted right down into the pelvis and absorbent dressing was applied over this. She was then removed to the ward. She had recovered from the effects of the anaesthetic but was very collapsed, so further hypodermic injections of strychnine and ether were given and also a nutrient enema containing two ounces of brandy and the yolk of one egg. Some time afterwards she vomited twice and in the evening passed a well-formed motion. Rectal feeding was continued every two hours for two days. On the second day after the operation feeding by the mouth was begun and as no vomiting occurred this was continued in gradually increasing quantities, peptonised milk, eggs, and brandy being given. The bowels were kept open by injections of two drachms of glycerine about every other day. The day after the operation the patient's general condition was fairly good but she had the facies abdominalis well marked. The wound was dressed frequently and about three ounces of offensive pus were withdrawn daily by the syringe. The glass tube was kept in for a week and then an indiarubber one was substituted. During the first week the whole thickness of the abdominal wall, about an inch in width for the entire length of the wound, sloughed away and the bowel was seen at the bottom of the wound. The patient progressed well from this time and is now quite well, the wound having healed completely.

Windsor.

#### NOTE ON CONDITIONS MODIFYING EXANTHEMATOUS ERUPTIONS.

BY JOHN REID, M.A., M.D. ABERD.

IN medical practice there is often a temptation to diagnose a recrudescence of a previous attack, or even a fresh zymotic disease, on the appearance of a fresh eruption, while probably sight is lost of certain factors in connexion with such cases—namely, (1) the fact that the skin has passed through an inflammatory stage and is on that account a *pars minoris resistentiae*; (2) that the zymotic disease may have attacked a constitution weakened by rheumatism or gout, where rashes often appear; and (3) that some local mischief may favour, or rather tend to induce, eruptions. As illustrating the above principles I trust the following cases will prove interesting.

CASE 1.—A girl, aged nine years, with a rheumatic diathesis suffered from a burn of the second degree on the leg covering an area two inches square. Bronchial catarrh and herpes on the face and eyelids preceded varicella. The mouth was full of pustules and it was extremely difficult to feed the patient, as the state of the lips and mouth interfered seriously with movement and the irritation of food matters was great. Lichen urticatus and general desquamation followed the varicella. Quinine and cod-liver oil formed the dressing and the administration of an alkaline stomachic mixture completed the treatment.

CASE 2.—A boy, aged 12 years, passed a tænia solium after a dose of male fern. In a week he had an attack of typical measles, with fever and bronchitis. He was treated with an ammonia mixture. In this case also the rheumatic diathesis was present. Koplik and Filatow's spots were seen. The rash disappeared on the sixth day and on the following day an exactly similar rash without fever—erythema morbilliforme—suggested a return of measles. here was intolerable itching. After replacing the ammonia mixture by a mild stomachic the rash and itching disappeared within 24 hours and were followed by desquamation.

CASE 3.—A male child, 11 weeks old, suffered from proctitis with rectal prolapse and bubonocoele of the left side.

The symptoms improved under lead lotion and belladonna and the internal administration of bismuth. Pneumonia of the left base came on, necessitating the administration of brandy. Next followed typical measles with Koplik and Filatow's spots. The measles lasted for six days and then pneumonia returned in the left base. A speedy desquamation followed. An erythema of one day's duration came on and finally herpes over the left groin and left buttock, as well as near the anus and on the anterior third of the penis. The prepuce was inflamed and required treatment. Further symptoms were gastro-intestinal catarrh with green clayey motions and protracted convalescence joined to slight bronchitis, although the child rapidly put on flesh and drank milk heartily. This child, as well as the other members of the family, had rheumatic symptoms. It should be stated that snuffles were present although no other signs of specific disease presented themselves. The teeth of the other members of the family were good and regular as to time. The father and mother were healthy.

Southfields, S.W.

## 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.

#### ST. GEORGE'S HOSPITAL.

##### A CASE OF EXTENSIVE PERICARDIAL EFFUSION ; OPERATION ; RECOVERY.

(Under the care of Dr. ARTHUR LATHAM and  
Mr. H. S. PENDLEBURY.)

A MAN, aged 53 years, came under the care of Dr. Arthur Latham on Sept. 1st, 1902, at St. George's Hospital. He gave a history of good health until the early part of last March. He denied having had syphilis and asserted that he had always been a moderate drinker. In the early part of March he began to suffer from shortness of breath. This symptom gradually became more troublesome and the patient in consequence was obliged to give up work on March 28th. On April 4th the left pleural cavity was tapped and ten ounces of serous fluid were withdrawn. Further small quantities of blood-stained fluid were removed on May 23rd, July 22nd, and August 5th. During August the patient developed marked œdema of the legs and some distension of the abdomen. He also became jaundiced. When he attended at the hospital he complained of sleeplessness and of cold extremities. He was suffering from considerable dyspnoea, with slight cough and expectoration; the face was sallow and somewhat cyanosed; the pulse-rate was 76, the volume being small and the wave full though regular; the respirations were 24 to the minute; the temperature was normal. The legs were markedly œdematous and there was evidence of a considerable quantity of free fluid in the abdominal cavity. The apex of the heart could not be felt nor could it be located by the stethoscope, as no cardiac sounds could be detected; the area of cardiac dulness was much increased. The note over the left axillary base was dull, there was diminution of the voice sounds, and on auscultation distant tubular breathing was heard. Over the base of the left lung posteriorly the note was impaired, there was distant tubular breathing, and a few moist sounds could be heard. The urine had a specific gravity of 1028, was normal in colour, somewhat diminished in amount, and contained a very faint trace of albumin. On Sept. 3rd the patient was given a little chloroform by Dr. Ll. Powell. Mr. H. S. Pendlebury tapped the pericardial sac in the fourth costal interspace one and a quarter inches from the left border of the sternum and drew off 95 ounces of serous fluid which was dark brown in colour owing to the presence of a considerable quantity of methæmoglobin. No further evidence was obtained by a careful examination of the fluid. The patient slept well during the

night and felt much more comfortable on the following morning. The heart sounds could now be heard over the præcordial area but were still very faint. During the night 90 ounces of urine were passed. On the 8th the patient was comfortable and the œdema of the legs and the distension of the abdomen were considerably less. He was sleeping well and the coldness of his extremities had diminished. The pulse was of good quality and the wave could be easily felt. The heart sounds, however, were again becoming more distant and the cardiac dulness was again increasing, consequently Dr. Latham asked Mr. Pendlebury to drain the pericardial sac, which apparently had been distended with fluid for several months and was still secreting to an appreciable extent.

The operation was performed on Sept. 9th. Having decided to drain the pericardium for some time it was of the first importance to choose a procedure which would insure drainage from the lowest approachable part of the pericardial cavity. Consequently Mr. Pendlebury determined to perform the operation so clearly described by Dr. Cyril Ogle and Mr. Herbert Allingham in THE LANCET of March 10th, 1900, p. 693, with such modifications as might appear necessary. A vertical incision some four and a half inches long was made with its centre at the lower border of the seventh costal cartilage parallel with, and one inch from, the left border of the sternum. The skin and fascia were reflected inwards and outwards and the abdominal muscles were then detached from the seventh costal cartilage. The cellular interval, "costo-xiphoid space," containing the superior epigastric artery was then broken into, some of the muscular fibres of the diaphragm being torn. As the pericardium was distended it was easily brought into view, but as Mr. Pendlebury wished to have sufficient room to insert the fingers after opening it two inches of the seventh costal cartilage were first removed by cutting it through with bone forceps and disarticulating the fragment from the sternum. The internal mammary vessels were now exposed and held aside. Had it been necessary it would have been easy to secure them. More loose connective tissue, fat, and the triangularis sterni were gently pushed aside and the pericardium—tense and thick—was exposed. Owing to the conformation of the chest the wound was somewhat deep and to obtain more complete and convenient access to the pericardial contents after opening two inches of the sixth costal cartilage were likewise removed. The pericardium was incised where it bulged downwards through the torn cellular space and the cut edges were seized with clips. Some 20 ounces of blood-stained fluid, similar to that removed by tapping on Sept. 3rd, escaped. The incision into the pericardium was increased to allow of three fingers being introduced to examine as far as practicable the heart and parietal pericardium. These were found quite smooth and apparently normal. Unfortunately, the man's chest was very deep and it was not possible to explore thoroughly the back of the heart and pericardium, as can be done so readily in children after this operation. There were no adhesions to be felt and the fingers could be interposed between the heart and the diaphragm. A peculiar vibratile thrill was noticed on palpating the ventricles during systole. These manipulations had no harmful effect on the pulse; indeed, the escape of the remaining fluid had distinctly increased its strength and promoted its regularity. It was only possible to stitch one corner of the pericardium to the skin at the lower end of the wound; a tube was introduced and the upper three inches of the incision were united by silkworm gut sutures. The tube was removed on the fourth day after the operation as it was blocked with the clotted discharge. On the eighth day, the 16th, the stitches were removed, only a small sinus remaining where the pericardium had been sewn to the skin. This sinus did not completely heal till nearly three weeks afterwards, a little easily clotting fluid trickling away from time to time. Throughout convalescence the patient's temperature was normal. On the 16th the patient had improved to an extraordinary extent. He was sleeping well and was free from dyspnoea, there was hardly any œdema of the legs, and there was no evidence of the presence of fluid in the abdomen. The percussion resonance of the sternum was normal and there was no extension of dulness to the right of the sternum. The cardiac sounds could be heard distinctly and the position of the apex appeared to be normal, although the thickness of the patient's muscles made an exact localisation impossible. Towards the base of the left lung there was some impairment