severely bruised the parts; the simple yet sudden blow from the post completed the rupture, which took place at the junction of the tendon and muscle, and the fact that the rectus was alone implicated accounted for his being able to maintain the erect attitude.

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.

UNIVERSITY COLLEGE HOSPITAL.

MEASLES OCCURRING DURING THE COURSE OF TYPHOID FEVER; REMARKS.

(Under the care of Dr. S. RINGER.)

THE following case is worth recording from the rarity with which accurate observations can be made of these two diseases running concurrently.¹ For the report of the case we are indebted to Dr. C. Arkle, resident medical officer.

Mary P—, aged ten, was admitted on Dec. 28th, 1887. She had been ailing for fourteen days. The onset of the illness was rather sudden. On Dec. 14th she awoke with headache, thirst, and great prostration of strength; was sick once. She had had diarrhoea during this time, the motions being offensive and of a pale colour. The hygienic conditions of the house she was residing in were very unsatisfactory, there being great stench from waterclosets and back yard. The patient's brother had just had measles. She herself had always been very delicate, and when an infant she had rickets.

Condition on admission.—The patient lies in bed on her back. Is of delicate appearance and with listless expression. Complexion dark, pale, and rather sallow. Conjunctivæ pale and rather bloodless. Temperature 103·4°; pulse 120, frequent, soft, and dicrotous; respiration 30. Pulse respiration ratio 1:4. No signs of intra-thoracic disease. Tongue brown, dry, furred, red at tip, and cracked transversely. Lips covered with sordes. Abdomen somewhat distended; very slight tenderness. There are a few spots on the abdomen, small, slightly raised, of a rose colour, and disappearing on pressure; they seem to be well-marked typhoid spots. Bowels constipated. The spleen is enlarged, and can be felt below the thoracic margin. No delirium. Urine febrile.

The patient was kept on strict spoon diet, and, beyond considerable prostration, progressed well, although her temperature reached 105° on one occasion, and for the first six days after her admission averaged 104°. After this date it gradually fell, and reached 98·4° ten days after her admission, or on the twenty-fourth day of her illness. On Jan. 10th, 1888, fourteen days after her admission from a house where there was a case of measles, the patient developed a rash. Her temperature on the previous evening had risen to 100·4°. The rash came out first on the face, and consisted of many discrete red papules, roundish in shape, and with slightly indented edges. Margins of contiguous papules in places confluent; spots slightly raised. The rash was undoubtedly that of measles. It soon spread to the trunk, and appeared there in great abundance; only slightly, however, on the limbs. The spots on the trunk were a little smaller, and not quite so angular as those on the face, looking rather more like the rash of German measles. There was no coryza, but the patient had a slight cough. A few râles were heard in the chest. The temperature fell to 98° when the rash developed. During the next few days the rash gradually faded, there were no further complications, and the patient was ultimately discharged well.

Remarks.—Cases of measles occurring during the course of typhoid fever are uncommon, and some think that the period of incubation and the subsequent course of the disease may be modified by this coincident affection. There

are numerous cases of combinations of acute exanthems on record, but the occurrence of variola and scarlatina together seems the most common. A few cases of measles occurring coincidentally with acute specific and other diseases have been noticed, but records of any anomalies in the course of such attacks are few. In the present instance, the incubation period does not seem to have been shortened at all, as, with the children's ward in quarantine, and the absence of any other case in the hospital, it can be fairly inferred that the patient brought the measles with her from home fourteen days before. The patient was singularly free from cough and coryza; but this is not uncommon in epidemics of measles, and cannot be laid down to the effect of the typhoid. The rash was abundant, and had nothing noteworthy about its distribution; that on the face was a typical rash of measles; on the body the spots were rather paler, and not quite so angular. There was, however, no soreness about the pharynx, throat, or tonsils, no notable glandular enlargement, and the case was considered by all to be undoubtedly one of measles.

GENERAL INFIRMARY, LEEDS.

RUPTURE OF THE INTESTINE; OPERATION; SUTURE OF WOUND IN BOWEL; DEATH; REMARKS.

(Under the care of Mr. ATKINSON.)

FOR the following notes we are indebted to Mr. Henry Littlewood, resident surgical officer.

Charles B—, aged twenty-eight, by occupation a railway porter, was admitted on Aug. 13th, 1887, complaining of having injured his abdomen. The patient was inside a movable hut, which was knocked over by a crane, and, falling violently against a fixed table, he struck the lower part of his abdomen. When the horse ambulance arrived the patient was found to be profoundly collapsed. Brandy was given during the journey; this revived him.

The man was seen in the ward between 2 P.M. and 4 P.M., about an hour after the accident, and the following note was taken: "Patient collapsed, but conscious; decubitus dorsal; legs extended; face pale and anxious; no restlessness or signs of hæmorrhage; pulse perceptible at the wrist; breathing slightly laboured, mainly thoracic. Upon touching the abdomen, as in gentle palpation or percussion, he complained of pain, but not otherwise. Tenderness most marked in the left inguinal umbilical and epigastric regions. Walls of abdomen retracted; some contusion of the left inguinal region. Both flanks resonant; some dullness on left side. Liver dullness present." No other injuries were found.

Soon after admission a catheter was passed, and clear urine drawn off (the patient has a stricture); he also vomited some undigested food free from blood. Hot bottles &c. were ordered to be applied.—5.45 P.M.: The collapse had passed off to a great extent. He complains of great pain in the abdomen, and asks for something to make him sleep. Pulse quicker and better; breathing thoracic; abdominal muscles rigid and retracted. Surface of abdomen exquisitely tender; this is perhaps less marked in the left hypochondriac and right inguinal regions, the contused area not being more tender than other parts. The patient lies upon his back, with the thighs slightly flexed. He cries out from time to time with pain localised to upper part of abdomen. The pain occupies his entire attention, and he wants something to make him sleep.—6.45 P.M.: Patient in extreme pain, begging for relief; says the pain will kill him. General condition much as above; liver dullness still present; abdomen becoming distended.—8 P.M.: Liver dullness gone; pain worse; abdomen more distended; abdominal walls rigid; has not passed flatus since admission; has passed urine. He was now seen by Mr. Atkinson.—8.15 P.M.: One-sixth of a grain of morphia was given hypodermically.—9.30 P.M.: At a consultation the diagnosis of ruptured intestine was confirmed and abdominal section advised. The morphia relieved the patient for three-quarters of an hour or so, then the pain gradually returned, becoming progressively worse.

Operation.—The patient was placed under ether, and Mr. Atkinson made an incision in the middle line of the abdomen, about three inches in length, extending downwards from the umbilicus. Bleeding having been stopped, the peritoneum was opened. Bubbles of gas and blood-stained fluid escaped. It was now seen that some of the intestines were distended, others collapsed; they were

¹ If our readers will refer to THE LANCET for 1866, vol. i., p. 619, they will there find cases of a similar character recorded by Jenner and Kesteven.

injected, several patches of lymph seen on the surface gluing the coils of intestines together. The collapsed portion of gut was followed downwards to the cæcum; not finding the rupture, the distended portion was followed upwards, and a hole in the jejunum was discovered about half an inch in its largest diameter; it was about half an inch from the attachment of the mesentery. The portion of gut surrounding the aperture and attached mesentery were greatly ecchymosed. The mucous membrane was everted. No fæcal extravasation had taken place, but on manipulating the intestine some solid fæcal matter was squeezed out; this was prevented from going into the peritoneum. The abdominal incision was now extended upwards for about two inches. The wounded intestine having been brought to the surface, the wound was stitched up with six chromic gut sutures by Lembert's method. The peritoneum was well washed out with about a gallon of 2 per cent. solution of boracic lotion, at a temperature of 96° F., and Bantock's tube inserted down to the pelvis. The abdominal wound was sutured with wire, and dressed with gauze and salicylic wool; the tube was isolated by means of a sheet of indiarubber, enclosing a sponge to catch the discharges. The operation lasted about an hour and a half.

The patient's condition at the end of the operation was very fair; he came round rapidly from the ether, hiccupped a few times, and soon fell asleep. He remained asleep until 3.15 A.M. on Aug. 14th, when he roused up a little, had slight hiccup, and vomited a mouthful of fluid. He continued to sleep off and on till between 7 and 8 A.M., when he again vomited about two ounces of greenish fluid. Passed urine. The temperature in the axilla at 6.30 A.M. rose to 100°, having previously been normal.—9.30 A.M.: Vomited a little watery fluid.—10.45 A.M.: Hypodermic injection of one-sixth of a grain of morphia; vomited about one ounce of coffee-coloured fluid ten minutes later.—11.15 A.M.: Sponged over; Bantock's tube changed and tube emptied by means of Higginson's syringe used as a syphon; about three ounces of blood-stained fluid removed. The liver dulness has returned to some extent. Has not passed flatus.—7 P.M.: One-sixth grain of morphia given hypodermically. Dressed again at 11 P.M. in the same way; about two and a half ounces of fluid having the same character removed; abdomen becoming distended.—12 noon: Patient complains of pain; hiccupps occasionally. Pulse 136, hard; temperature in axilla 101°.

15th.—1.20 A.M.: Patient becoming restless; still complains of pain. Pulse not so good. Hypodermic injection of one-sixth of a grain of morphia and an enema of brandy given.—3.15 A.M.: Dressed again. No fluid discharged from Bantock's tube. Has passed no flatus. Rectal tube passed, and a little flatus escaped. Twenty minims of ether injected hypodermically.—4 A.M.: Vomiting coffee-coloured fluid.—12 noon: The patient having marked symptoms of peritonitis, and fearing there might be some more fæcal extravasation, the abdomen was again opened. Signs of peritonitis were present. Wound in intestine looked well. No fæcal extravasation. Cavity again washed out with a 2 per cent. solution of boracic lotion at the temperature of 97°. Abdominal wound again stitched up. Bantock's tube replaced. The patient died at 4.20 P.M., having recovered from the operation. Death occurred about fifty-one hours after the injury.

Necropsy, sixteen hours after death.—There was general peritonitis, more marked on the left than on the right side. Near the sigmoid flexure was a large patch of purulent matter, and the lymph in other places was purulent also. The odour given off from the abdomen was unpleasant, but no fæcal matter was discovered. Abdomen contained a little dark reddish-brown fluid. The site of the rupture was about eighteen inches below the duodenum. None of the sutures had given way, and the wound looked quite healthy. There was ecchymosis of the mesentery attached to the ruptured part of the intestine; this had the appearance it presented at the time of operation. On opening the intestine, the laceration was seen to have been perfectly closed by the suture, and the mucous surface around it appeared quite normal. No other part of intestine had been ruptured. Nothing abnormal was noted in the other organs.

Remarks by Mr. ATKINSON.—Perhaps no cases of injury are more obscure than those which result from blows or other external violence inflicted on the abdomen without external wound. Any one of the viscera may be ruptured, or severe internal hæmorrhage take place, without the symptoms affording any distinct indications. Sometimes,

indeed, after the first shock, *all* symptoms disappear, and for an interval of some hours a patient may be unconscious of anything serious having occurred—may even walk unaided a considerable distance, and then, perhaps after swallowing some food, suddenly suffer pain, become collapsed, or develop peritonitis rapidly, and die in a few hours. These cases, affording such uncertain signs, have very rarely been operated upon for that very reason. The diagnosis is so difficult, because one cannot distinguish at first between the syncope of internal hæmorrhage and the shock caused by a rupture of intestine, and in some cases there is but little shock. In the early period we have little more to guide us to a diagnosis than the nature and violence of the injury and the general condition of the patient. If we wait, peritonitis may be developed very rapidly, and this would indicate an immediate operation. But seeing how much this must add to the risks of the condition, and how a few hours' delay may deprive us of the chance of saving life, surely in future we shall be justified in resorting to laparotomy wherever there is reasonable ground for believing that any serious lesion has been sustained. According to the valuable paper by Sir Wm. Mac Cormac published last May, there is *no* pathognomonic sign of ruptured intestine. He is no advocate of the expectant method, but recommends early operation even in the presence of the unfavourable statistics so far. Chavasse, from a collection of 150 cases, estimates the mortality of ruptured intestine without external wound at 96 per cent., which Sir Wm. Mac Cormac thinks below the mark. He says, "Cases do occur in which abdominal section should be practised, and an attempt made to discover and deal with the visceral wound, arrest bleeding, and clear away clots from the peritoneal cavity." There is a difference between the rate of mortality in cases where suture of intestine has followed punctured or incised wounds with or without enlargement of the abdominal opening, and that of cases where laparotomy was performed for rupture or contusion of intestine, whether suture was employed or not. The statistics of Günther under the first head show, out of 56 cases, 42 recoveries and 14 deaths, or about 66 per cent., while of the very few published cases under the second head not one has recovered hitherto.

SALOP INFIRMARY.

A CASE OF PURPURA HÆMORRHAGICA; NECROPSY;
REMARKS.

(Under the care of Dr. CURETON.)

T. O—, aged sixty-three, was admitted on May 5th, 1888. The patient, a farm labourer, has always worked hard, drank moderately, and been able to obtain a sufficient quantity of food, animal and vegetable. His family history is good. He has been married twice, but had no family by either of his wives. He has never had syphilis. The present attack commenced nine weeks ago. He was taking charge of a flock of hill sheep, and was constantly exposed to wet and cold, having, he says, "one cold on the top of another." A week before his illness commenced, he had been dressing a very foul-smelling wound on one of the sheep, the result of a dog-bite. The animal had to be killed on account of the wound, but the patient could not give any idea of the appearance of the carcass. The first symptoms for which he consulted a medical man were cough and dyspnoea, followed in a few days by some bright patches on the calves. His legs became swollen, but not red or painful, and about the same time some pustules appeared on the arms. He was seen again in a week's time by a local practitioner, who informs me that he found the patient in the following condition: "An erysipelatous condition of the face; a peculiar rash upon the arms; high temperature; fluid in the peritoneum and pleura; no albumen in the urine." The patient remained in this condition for six or seven weeks, and was then sent to the infirmary.

Condition on admission.—Over the limbs and trunk cutaneous hæmorrhages are irregularly distributed, in various stages of decolourisation. The greater number of them are about the size of a lentil; the margin is ill defined, and the patches tend to coalesce, particularly on the calves and flexor surfaces of the thighs. The face is unaffected. On the outer side of the ankles and on the hypothenar eminences are extensive ecchymoses. Some of the patches, particularly those on the anus, are covered with small dry brown crusts, and hæmorrhagic papules are seen here and there around the hair follicles. The lower