another rise on the 9th to 104°. The patient became comatose at 4 P.M. on the 9th, having previously complained of severe headache for some hours. On the 10th the temperature gradually and steadily rose and at 5 A.M. on the 11th it was 107° and the patient died.

A necropsy was made eight hours after death by Dr. W. S. Lazarus-Barlow, when the body was found to be moderately nourished, with intense bronze jaundice. The hair was iron-grey. The lungs weighed respectively the right 32 ounces and the left 28 ounces, and were emphysematous anteriorly and congested with localised patches of semi-consolidation posteriorly over both organs. The larynx, the trachea, and the bronchi were congested and much mucus was found therein. The bronchial glands were large and soft; the pleurae and the pleural cavities were normal. The pericardium contained bile-stained fluid. The heart weighed 12 ounces; it was flabby but fairly normal otherwise, the edges of the mitral flaps being rather thicker than normal. The great blood-vessels also were normal. No ascites was found in the abdomen. The liver weighed seven pounds; it was enlarged and of a deep green, almost black, colour. Its substance was fairly firm. The bile passages were much dilated throughout the organ. The gall-bladder was dilated and full of pale-green bile of a watery consistence. The cystic duct was much dilated and the common bile duct was sufficiently large to admit the little finger in its main course. At the papilla in the duodenum the orifice was of the normal size, but the whole papilla and a small portion of the duct behind the opening were enlarged and firm, so that a mass of the size and somewhat of the shape of a small bean lay beneath the duodenal mucous membrane. The pancreatic duct was much dilated and bile could be made to flow through the unopened papilla by pressure on the gall-bladder. On slitting up the common duct from the papilla it was seen that there was a soft and ulcerating mass of material lying immediately within the orifice. From the surface of this a fluid having the appearance of pus could be scraped. The mass surrounded the entire lumen but did not extend further along the duct than about three-eighths of an inch and it did not invade deeper tissues. The tail of the pancreas was very dense but the head was of normal consistency. Wirsung's duct was dilated throughout. The spleen weighed 13 ounces; it was soft and large. The kidneys weighed respectively the right nine ounces and the left 13 ounces. They were highly congested and bile-stained and were apparently the seat of a tubal nephritis. The adrenals were normal, as also were the bladder, the stomach, the oesophagus, and the intestines.

Microscopically the growth was a columnar cell carcinoma. The position of the tumour and its relationship to surrounding parts is well shown in the accompanying illustration.

In THE LANCET of Feb. 16th, 1901, p. 467, will be found an excellent paper by Dr. H. D. Rolleston on Primary Carcinoma of the Ampulla of Vater. Of the 21 reported cases he regarded about seven as being above suspicion. "Most of the remainder are either carcinoma of the termination of the common bile duct or of the duodenal surface of the biliary papilla."

In the case under consideration there are several points of interest. In the first place, the patient complained of intense itching for a week previous to the appearance of jaundice. The cause of the itchiness in these cases is not known, but its occurrence in hepatic disorders independently of jaundice seems to show that it is not due to the bile pigment. In Halsted's case of "Primary Carcinoma of the Duodenal Papilla and Diverticulum of Vater"¹ the patient's first symptom was "itching of the skin, which came on suddenly and soon became severe." Next the absence of vomiting, diarrhoea, and pain is deserving of attention. The combination of jaundice with enlargement of the liver and a distended gall-bladder clearly pointed to some obstruction in the common duct. The suddenness of its occurrence seemed to exclude malignant disease and the absence of pain negatived gall-stones, so that I was inclined to regard the case as one of catarrh or swelling of the common duct, though in a case of this sort I should have expected to have found signs of gastro-intestinal derangement, such as vomiting and diarrhoea; moreover, the amount of liver enlargement and the distension of the gall-bladder struck me at the time as being very unusual. The last point to which I wish to direct attention is the temperature. The rapid rise of temperature which occurred on the second day after the patient's admission into the hospital was due, I

believe, to the broncho-pneumonic condition. In looking back over the case one can see that the possibility of a new growth within the common duct or in the ampulla should have been considered, but the extreme rarity of the condition

A, Opening of the right and left hepatic ducts. B, Stomach. C, Opening of Wirsung's duct. D, Growth in the ampulla of Vater. E, Head of the pancreas. F, Duodenum. G, Site of opening of the cystic into the common duct. Opening of the cystic into the common duct = circle three-quarters of an inch in diameter. At the ampulla immediately above growth = one and a half inches.

led to its being overlooked. The case illustrates the great complexity of the problem to be solved in endeavouring to arrive at the cause in any given case of jaundice.

As regards treatment there is little to be said. The result of operative interference in Halsted's case is not encouraging. Though the immediate result of the operation was good the patient died some 15 months later from recurrence of the carcinoma in the head of the pancreas and duodenum. The lesson taught by this case is the necessity for an early diagnosis so as to ensure the complete removal of the growth.

Wimpole-street, W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

POISONING BY IRISH YEW.

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BRIGADE.

So far as I am able to learn the following is the first case recorded of poisoning by Irish yew. The plant was mistaken for savin and taken by a woman, aged 24 years, who was three months pregnant for the purpose of procuring abortion. The leaves and twigs of the tree were placed in a pan and packed tightly so that the vessel might hold as much as possible. The pan was then filled with water and the whole was boiled for some hours. At the end of that time the pan was

¹ The Johns Hopkins Hospital Bulletin, No. 106, January, 1900.

about two-thirds full of a black liquid. An ordinary teacupful of this was taken by the woman three times a day. For three or four days nothing unusual was noticed but then the patient began to have what she described as a feeling of pins-and-needles at the pit of the stomach. This got worse and she began to feel ill. At the end of a week nausea and slight griping pains in the abdomen were experienced. On the next day there was some vomiting and the pains were more severe. After a fortnight—during the whole of which time the administration of the decoction was continued in the same doses—the pain was most severe, the vomiting almost incessant, and the patient became unconscious. She remained so for some hours. She was so ill that she was thought to be dying. There was no delirium. After this she refused to take more than one teacupful a day which she continued for a week, not feeling any ill-effects, and then gave it up. Abortion was not induced and six months afterwards she was delivered of a full-term child which had been dead for a short time.

This woman suffered from most of the symptoms of poisoning by the common yew (*Taxus baccata*). Her recovery after taking what appear to be enormous doses may be due either to the vomiting, though this did not occur until she had been taking the stuff for at least a week, or to the possibility that the Irish yew is less poisonous than its relative.

The poisonous principles of yew do not seem to have been investigated with any thoroughness. We are told that the active principle is an alkaloid named "taxine," but what are its nature, formula, and properties I have failed to discover. It would be most interesting to know also whether this is found in all varieties of yew and in what proportions.

Lancaster.

DIPHTHERIA IN THE NEWLY-BORN.

By GEORGE A. AUDEN, M.A., M.D. CANTAB.

DIPHTHERITIC infection of the newly-born child appears to be an accident of extreme rarity. Dr. Abraham Jacobi¹ makes an indirect reference to some cases quoted by him in 1880 and these are probably the cases to which Professor William Osler refers in the recent edition of his "Practice of Medicine." Apart from these scant references I have not been able to find any published account of the occurrence. The confirmation of the clinical diagnosis by the result of a bacteriological examination gives additional interest to the following notes.

On the evening of May 12th, 1901, I attended a woman, aged 35 years, in her second confinement, when she was delivered of a full-time healthy child. On May 20th, the eighth day, a greenish, slightly blood-stained, discharge was noticed issuing from the left nostril of the infant in sufficient quantity to stain the pillow. He became fretful and began to take the breast indifferently. On the following morning there was an acrid sanious discharge from both nostrils which soon became excoriated. The child was very fretful and refused food. An attempt to examine the fauces was unsatisfactory and revealed nothing. On the tenth day (May 22nd) there was much nasal discharge, the nostrils being almost occluded. The child breathed with difficulty and with a little inspiratory stertor. There was no recession of the chest walls but the child was somewhat cyanosed and there was great difficulty in getting him to take food. There was a moderate degree of diarrhoea, the pulse was imperceptible, and the temperature was 101° F. Both fauces were seen to be oedematous and upon each tonsil there was a typical patch of membrane. 200 units of antitoxin were at once injected and repeated in four hours and again in the evening, by which time the child's general condition had much improved. The temperature remained at 101°. On the eleventh day (May 23rd) there was less difficulty in breathing but the discharge from the nostrils continued. The temperature varied between 100° and 101°. The child took the breast every two hours. Dr. C. P. White (demonstrator of pathology, Yorkshire College, Leeds) reported on a swab taken on the previous day: "Undoubted diphtheria bacilli in the swab; long forms showing marked segmental staining; streptococci also present." On the twelfth day a slight nasal discharge continued; there was still some exudation on the right tonsil. The bowels were still

loose with greenish stools. The temperature was 100°. The child took the breast and slept well. On the thirteenth day the temperature was 98·6°; there was no sign of exudation on the tonsils and the pulse was good. On May 31st the mother's right breast became very inflamed and an abscess appeared to be imminent. The inflammation, however, subsided under treatment. She stated that one month before the child was born she had suffered from a very severe sore-throat which had continued to cause difficulty in swallowing until a week before the confinement. The sanitary arrangements of the house appeared to be satisfactory and no external source of infection could be discovered. There were never any indications of paralytic symptoms and the child is now remarkably robust and healthy.

Although there is no doubt that breast-fed children are less liable than others to contagious or infectious disease, it is difficult to harmonise the facts of the above described case with the theory put forward by Schmid and Pflanz² that the maternal milk possesses antitoxic properties. In the present instance the mother fed her child throughout his illness and so far from transmitting any antitoxic elements may herself have been the source from which the infection was derived, for the severe sore-throat from which she suffered immediately before her confinement may not improbably have been due to the specific diphtheria bacillus.

York.

A CASE OF RUPTURE OF DUPUYTREN'S CONTRACTION.

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IN October, 1900, a man, aged 45 years, was seen at St. George's Hospital with the following history. For 15 years he had suffered from a gradually-increasing contraction of the ring and little fingers of the left hand. There had been no obvious cause to account for this contraction which had put him to great inconvenience; there was, however, a well-marked family history of gout and he had suffered from gout himself. Whilst walking down Piccadilly he had tripped over his stick and fallen heavily on to the kerb, his left hand receiving most of his weight. He heard a "loud snap" and found that his fingers had been forcibly straightened, the skin at the root of the little finger being torn. When seen at the hospital there was a gaping wound at the base of the little finger about three-quarters of an inch long. The tendon of the flexor sublimis digitorum was exposed at the bottom of the wound with its tendon-sheath intact; there was slight hæmorrhage but the digital nerves were apparently uninjured. At the base of the ring finger there were some extravasation of blood and swelling. Both fingers were now quite straight. The wound, which had been contaminated with dirt, was thoroughly scrubbed with 1 in 2000 mercuric biniiodide solution and a rough splint of pure tin was moulded to the fingers, the wound healing by granulation. Both fingers were vigorously moved daily, this somewhat retarding the healing of the wound which took place in about four weeks. At the end of this time the patient was discharged, being told that the contraction would return unless the fingers were thoroughly exercised and kept straight. These instructions were conscientiously carried out, and when seen in January, 1902 (15 months after the accident) there was no sign of re-contraction and full movement of both fingers was possible. The slight contraction of the palmar fascia which was noticed before, of course persisted.

Accidental rupture of Dupuytren's contraction is a very rare accident and the above case is interesting as showing that this accident may occur, not only without harm, but even with much benefit to the patient. The most noticeable point in the case is that there was no sign of recurrence of the deformity; the slow progress of the disease, however, may account for this. Mr. W. Anderson, in his Hunterian Lectures on Contractions of the Fingers, related a somewhat similar accident. In this case a contracted finger in Dupuytren's deformity was torn by the handle of a railway carriage and was set free, but the benefit was only temporary. Dupuytren originally practised division of the contracted cords and the superjacent skin in

¹ Article on Diphtheria in Stedman's Twentieth Century Practice of Medicine, vol. xvii., p. 78.

² Wiener Medicinische Wochenschrift, No. 42, 1896, quoted by Jacobi loc. cit.