Displacement of the foot inwards without protrusion of the bone, whether accompanied by fracture four or five inches up the shaft or epiphyseal separation, must be very rare. In my case it was easy to see that the tension over the knife-like lower end of the shaft was so great that a very short delay in reduction would have resulted in sloughing. Sir Astley Cooper recorded no less than ten cases of what was at that time spoken of as compound dislocation of the leg outwards at the ankle-joint, but only one of the simple variety. One of these compound cases was evidently one of epiphyseal separation. "Nathaniel Taylor, aged 13 years. The injury had been occasioned by a boat falling upon the leg. A large wound appeared at the outer ankle, through which the tibia and a fractured extremity of the fibula projected; one inch of the malleolus externus remained attached to the astragalus by its natural ligaments; the foot was turned inwards so as to be capable of being brought in contact with the inner side of the leg."¹ There was some difficulty in maintaining reduction on account of muscular spasm and as there was no chloroform to relax it Sir Astley Cooper had to shorten the distance between the muscular attachments by removing the external malleolus and half an inch of the tibia. Mr. J. E. S. Barnett² has recorded a case of compound separation in which the force was not continued to the extent of causing the tibia to follow through the wound, as in Sir Astley Cooper's case. It is a curious fact that while dislocation of the foot outwards is well known under the name of Pott's fracture-di-location inwards, certainly rarer, has been treated with the scantiest courtesy by every author with the exception of the "Old Master."

Epworth.

MENINGITIS CAUSED BY CAMPHOR POISONING.

BY THOMAS HATFIELD WALKER, L.R.C.P.,
L.R.C.S. EDIN.

IN view of the several cases of camphor poisoning which have been reported the following account of poisoning by camphorated oil may be of interest.

On July 31st, 1904, I was summoned to a child, aged two and a half years, who was in convulsions. When I arrived at the house I found the child lying unconscious, bathed in a cold sweat, and with a rapid uncountable pulse. After some cross-examination I ascertained that the grandmother had given the child a large teaspoonful of camphorated oil in mistake for castor oil at about 8 A.M. This appeared to have been given more as a sort of routine than because the child was ill. He was playing about in good health on the previous evening. As it was now after 2 P.M., and as the child had frequently vomited I did not attempt to wash out the stomach but injected a dose of bromide of potassium into the rectum as the patient could not swallow. This appeared to stop the convulsions but the pulse not improving I injected a small dose of strychnine. After this the child gradually improved but on the morning of August 2nd decided symptoms of meningitis had developed. This was treated as usual, tincture of gelsemium being chiefly relied on. By the 5th the case appeared to be hopeless. Professor Thomas Oliver saw the child on that evening, when pronounced Cheyne-Stokes breathing had set in. He confirmed the diagnosis of meningitis caused by camphor poisoning, agreed that the case was almost hopeless, and suggested an injection of caffeine. On the next morning the child was just alive but during the day seemed to improve slightly and by the 7th was able to swallow a teaspoonful of milk and water. From that date until I lost sight of the child, owing to the removal of the family from Newcastle, he gradually improved, with the exception that the right arm and leg remained paralysed. When they left Newcastle in October slight power of movement had returned, in the leg especially.

Newcastle-upon-Tyne.

¹ Sir Astley Cooper: Dislocations and Fractures, Case 164.

² THE LANCET, June 18th, 1898, p. 1721.

MIDLAND MEDICAL SOCIETY.—The inaugural meeting of this society for the session 1905-06 was held at the Grand Hotel, Birmingham, on Nov. 9th, the chair being taken by Mr. Joseph Quirke, the President. An address on the Spleen and its sufferings was delivered by Dr. Frederick Taylor, senior physician to Guy's Hospital.

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., Prooemium.

BELGRAVE HOSPITAL FOR CHILDREN, S.W.

A CASE OF DIAPHRAGMATIC HERNIA.

(Under the care of Dr. EDMUND CAUTLEY.)

FOR the notes of the case we are indebted to Miss Flora Murray, M.D. Durh., senior resident medical officer.

A female child, aged four months, was admitted to the Belgrave Hospital on June 2nd for consolidation of the right lung. She was a healthy child and had had nothing the matter with her until six weeks before admission. She was then taken to the out-patient department of the hospital after an attack of dyspnoea and cyanosis. She continued to attend that department for bronchitis and occasional attacks of dyspnoea. When seen at the out-patient department on the day of admission she had marked recession of the chest wall, dulness over the right base, dyspnoea, and cyanosis. When examined in the ward two hours later she appeared to be in normal health; she was a mouth-breather and snored; she had a little cough and her appetite was good. Examination of the chest revealed recession, equal on both sides, a resonant percussion note all over, weak breath sounds over the right base, and scattered rhonchi. She had nasal obstruction due to adenoids. On the 7th, as she continued in good health, it was decided to remove the adenoid growth from the pharynx; this was accordingly done on the 8th under ethyl chloride. She breathed less noisily afterwards but there was the same amount of recession as before. On the 12th she had distension of the abdomen and vomiting; the percussion note over the right base was impaired. That night whilst being fed she had an attack of dyspnoea with cyanosis and was much collapsed after it. On the 14th there was no dulness but the breath sounds were so weak as to be almost inaudible and she still had vomiting and distension. Two days later she had another attack of dyspnoea and was collapsed, after which partial dulness and weak breath sounds were noted over the right base and axilla. In the afternoon the dulness was absolute and she was explored with a negative result. On the next day these symptoms persisted and physical signs were found on the left side. The vomiting continued. On the 18th the note over the right chest behind had improved, the vesicular murmur was weak but distinct, and numerous rhonchi were heard on both sides of the chest. She collapsed that evening and died.

Necropsy.—The body was that of a well-nourished child of average size. On opening it the following condition was observed. The diaphragm was depressed. The liver appeared to be rotated on its axis; the large lobe occupied the centre of the abdomen and reached down to the level of the umbilicus; the upper and anterior surface presented. The gall-bladder could not be seen. The stomach, which was greatly distended, filled the whole space between the liver and the symphysis pubis except that a few coils of intestine lay in the right iliac region. With regard to the thorax, the left lung appeared to be normal. Further examination revealed congestion of the lower lobe. The heart was not displaced. The upper lobe of the right lung seemed to be compressed; the middle and lower lobes were small and undeveloped. Below this the cavity was occupied by a large circular mass of about the size of a cricket-ball which proved to be a subpleural hernia. The rent in the diaphragm was on the right side and allowed three fingers to pass easily. The hernial contents included all the large intestine and the greater part of the small intestine, the small lobe of the liver, the gall-bladder, and a part of the pancreas.

Some of the most interesting points about this case were the variability of the percussion note and the absence of intestinal symptoms. There was vomiting during the last three days but it was never excessive. The attacks of dyspnoea before the child came under observation were not frequent and she appeared to have enjoyed good health.