and pulse remained normal and no trouble arose at the seat of inoculation.

The bacteriological investigations, preparations of vaccine, inoculations, and determinations of variation in opsonic index were performed by Dr. G. W. Ross, house physician to the case, at whose suggestion the inoculation treatment had been adopted.

Victoria-square, S.W.

A CASE OF LUDWIG'S ANGINA FOLLOWING INFLUENZA.

By C. ASHLEY SCOTT LEGGATT, M.D. EDIN.

THE patient, a woman, aged 37 years, was first seen on Feb. 21st. She was suffering from tonsillitis of the follicular type usually associated with influenza and of moderate severity. The case ran a normal course and the patient was practically well on the 27th. On March 15th she again sent for me as she had a swelling on the right side of the neck which she thought was due to mumps. She said that she had been fairly well during the intervening fortnight but had not felt quite herself, and first felt pain in the glands of the right side of the neck at a dinner party on the night of the 13th. On the next morning there was a swelling under the right side of the lower jaw but when seen by me on the 15th there was no swelling of the parotid nor was there anything to be seen inside the throat though the patient complained of great pain in swallowing. The temperature was normal but the pulse was rather rapid from the first. During the next few days the patient suffered a great deal of pain but remained in much the same condition and on the 25th Mr. E. Venning saw her with me and advised the removal of a septic molar tooth thinking that it might be the source of mischief. No improvement followed, the pulse increasing in frequency, and the temperature beginning to rise every afternoon to 100° or 101° F., so on the 29th Mr. C. A. Ballance saw the case with me. During this day the pain had been severe and the pulse was 140 and at times slightly irregular, and immediate operation was decided upon. One incision was carried along the anterior border of the right sterno-mastoid and another shorter one was made at the posterior border of the muscle. Scarcely any pus was found but all the cellular tissue was grey-black in colour and gangrenous. The glands, too, along the internal jugular vein were in a state of infective inflammation; some of these were removed. It was then discovered that a coagulum occupied the interior of the jugular vein from the base of the skull to the level of the thyroid cartilage. The vein was divided between two ligatures and the proximal part containing the coagulum was fixed to the skin margin. The patient made a rapid convalescence and in three weeks was able to leave for the seaside.

It is difficult to say whether the tonsil or the carious tooth was the source of the infection of the spreading cellulitis of the neck. Carious teeth or caries of the alveolar process are a well-recognised avenue through which infection of the type of Ludwig's angina may arise in the cellular tissue of the neck. On the other hand, there is no reason why such an infection may not spread from an inflamed tonsil, a condition which has been known to occur in certain malignant scarlatinal cases. In this case the septic mischief in the tooth had been going on for years and probably the supervention of influenzal tonsillitis on the top of this was the immediate cause of the cellulitis. A point of great interest in the case is the thrombosis of the jugular vein which is of great rarity in cases of septic cellulitis of the neck. To this cause may be ascribed the slow onset of symptoms and the absence of severe constitutional symptoms. The blocking of the venous channel was nature's effort to localise the inflammatory process.

Walton-place, S.W.

THE DENTISTS ACT.—At Crediton, Devonshire, on June 14th, Mr. William Baker of that town was summoned for an offence under the Dentists Act of 1878. Evidence showed that the defendant had a brass plate at his house inscribed "W. Baker, surgeon dentist, Limited." The defendant stated that he was a doctor of dental surgery of Chicago, America, and that he had never represented himself to be a registered dentist under the Act of 1878. He was fined £5 and costs. The prosecution was instituted by the British Dental Association.

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.

KING'S COLLEGE HOSPITAL.

A CASE OF ABSCESS OF THE LUNG FOLLOWING GASTRIC ULCER; RECOVERY.

(Under the care of Sir HUGH R. BEEVOR.)

FOR the notes of the case we are indebted to Mr. H. R. Allingham, senior house physician.

The patient, a female, aged 20 years, a domestic servant, had suffered from anæmia with much dyspepsia and constipation during the past two years, occasionally vomiting. On Feb. 24th, 1905, she sought advice for pain in the left anterior axillary line at about the ninth rib. Physical examination of the chest and the abdomen was negative and a mixture containing bismuth was prescribed. On the evening of the 26th, after a full and injudicious meal, the patient was seized with very severe pain in the abdomen, screaming out; she had the pulse of collapse and cold extremities. Morphine was given in repeated doses. Pain was localised to the splenic region with general abdominal tenderness. Next morning the pulse had recovered much, her temperature was 100° F., the abdomen was not distended, but there was no apparent movement on descent of the diaphragm. There were marked hypogastric tenderness and an appearance of menses. During the next two days her temperature rose slightly and leucocytosis was 14 000 per cubic millimetre, and Mr. F. F. Burghard was called in consultation. It was considered that the patient needed watching in hospital and she was admitted into King's College Hospital on March 2nd, 1905.

On admission the patient looked very ill, with a drawn and anxious face. Her temperature was 99.2° and her pulse was 120, of small volume. She complained of severe pain in the abdomen, mostly referred to the left iliac region. On examination the abdomen was slightly but uniformly distended, there was rigidity of the muscles of the abdominal wall, and the abdomen did not move on respiration. There was great tenderness, more marked in the left iliac region. There were slight dulness in each flank, and absence of liver dulness. Some vomiting occurred and constipation was absolute (the bowels not having acted for some days), in spite of the free use of enemata. Immediate operation was considered inadvisable on account of the length of time that had elapsed since the onset of the symptoms and the absence of symptoms localising the suppuration. The abdominal signs continued but did not increase in severity and the distension did not become greater. The pain was as before and the pyrexia ranged from 100° to 101°. By March 6th thoracic signs became evident; dulness was present on the left side from the base of the lung to the fourth rib in the axillary line and over the dull area there was loss of breath sounds, and vocal resonance and tactile fremitus. A blood count now showed a leucocytosis of 18,000. On the 9th exploration of the left chest withdrew two ounces of blood-stained serous fluid; the signs in the chest became more marked and the abdominal signs less evident, though pain continued in the abdomen. The apex beat was throughout in the fourth space, just internal to the nipple line. After the 11th the pyrexia steadily rose day by day with a feeble, rapid pulse (112), the respirations being 36, until on the 16th the temperature reached 104.4°, accompanied by a leucocytosis of 32,600 to the cubic millimetre. The pain became severe and was localised in the left side of the chest and the left shoulder. The physical signs were as before except that the mobility of the abdomen was improved. There was no cough or sputum at this stage. A second exploration withdrew a small quantity of blood-stained serous fluid containing a few cells and sterile on culture. An x ray photograph showed a slight depression and flattening of the left dome of the diaphragm and the area above the diaphragm