Feb. 4th the patient was allowed to leave her bed for the first time, and returned home on the 16th of the same month. Her recovery had been slow but steady. The patient could move the arm with considerable freedom, backward, forward, and upward to the head—the backward movement being, however, the most restricted. She could feel and pick up a pin with ease, and said that the numbness and pains had quite left her. The radial pulse was fairly good, but much inferior to that of the left wrist. There was still some tenderness in the course of the brachial artery. The arm and hand required additional coverings when exposed to cold.

Remarks.—The points of interest in this case are many. (1) The sex of the patient; (2) the entire absence of any apparent cause for the aneurysm, traumatic or otherwise; (3) the character of the aneurysm itself; (4) the height to which the arch of the artery reached; (5) the application of the ligature at the outer edge of the scalenus (it is worthy of notice that the ligature was of small catgut and double); (6) the rapid healing of the wound of operation, with the absorption of the large inflammatory effusion, without rise of temperature or other untoward circumstances; (7) the embolism, as I believe, of the radial artery at some point of its course by the dislodgment of a portion of the clot from the aneurysm. The difficult part of the operation was the first stage—that of dissecting down on the aneurysm; from the moment that the aneurysm was laid bare the operation was comparatively easy. There was no difficulty in the application of the ligature. Doubtless the anatomical conditions of the artery and the form of the aneurysm rendered the operation simpler than it usually is.

Chester-le-Street, Co. Durham.

A CASE OF LATENT PERICARDITIS AND SUDDEN DEATH.

By F. STURGES, L.R.C.P., AND J. F. WILKIN, M.D.

THE following case seems worthy of being placed on record, since it illustrates, in a forcible though painful manner, how very obscure and latent the symptoms of fatal pericarditis may be, even in a subject who up to the moment of his death was leading an unusually active life. I have reason to believe, however, that cases like this are extremely rare.

Harry E. B—, a dark, rosy-cheeked boy, aged seven years, and one of a large family, with a perfectly healthy history, had never suffered from rheumatism, scarlatina, or in fact from any illness except chicken-pox, and was accustomed to indulge freely with his brothers in athletic games, no suspicion having ever crossed the mind of his parents that he was not in perfect health. On May 6th, 1884, after returning from morning school, he dined heartily at 1 P.M., and immediately afterwards commenced to play cricket. This he continued to do until it was time to go to afternoon school, about 2.15 P.M. He then ran with two of his brothers a distance of about a quarter of a mile, and on arriving in the playground he suddenly fell down. The master, who saw him fall, ran to pick him up, and, finding he was insensible, carried him into the house and laid him flat on a table, undoing his collar and bathing his face with cold water, while medical aid was sought. Mr. F. Sturges arrived about five minutes afterwards and found him apparently dead, and, perceiving the many difficulties of the case, sent for Dr. Wilkin, meanwhile performing artificial respiration by Silvester's method. A few minutes later Dr. Wilkin arrived, and after about ten minutes artificial respiration was given up, there being no sign of returning life. We were told that the boy had breathed heavily two or three times after he fell. This fact negatived the momentary surmise of possible complete occlusion of the larynx by some foreign body. Death from the brain must also be excluded in a subject so young. Sudden failure of the heart's action was therefore the only conclusion we could come to under the circumstances. But why the heart should fail in this boy, who looked the picture of health and vigour, we could not explain, and there was no history or reason to suppose he had sustained any blow or shock over the solar plexus.

A death-certificate without a post-mortem examination was out of the question, and we were therefore requested to make this examination as soon as possible. This we did on the following day (May 7th), twenty-two hours after death. The pupils were widely dilated, and rigor mortis was well marked; post-mortem discolouration had also set in. On opening the abdominal cavity we found a full stomach; the colon was distended with flatus, and the sigmoid flexure was loaded with fæces; the kidneys and other abdominal organs appeared healthy. On opening the pericardium, a fibrous band was found, about an inch broad and the same in length, forming a connecting link between the left apex of the heart and the pericardium, covering the surface of the diaphragm. Numerous other string-like adhesions were seen, particularly on the left side and base of the heart, and there was also some recent lymph, but no serous effusion. These bands were evidently of recent date, as the heart required careful handling to avoid breaking them down. The left ventricle was decidedly hypertrophied, making every allowance for rigor mortis; it was completely empty, as was also the left auricle. The right side of the heart contained some liquid blood, but there was no clot either there or in the pulmonary artery. The valves were all perfect and there was no endocarditis. The lungs were normal in every way. The cranium was not opened. We were unfortunately not able to obtain any urine for examination, though we have no reason to suppose it would have given anything but negative results. The immediate cause of death in this case must no doubt be attributed to defective innervation of the heart, which was very greatly embarrassed, not only by the adhesions and impediments within the pericardium, but also by the loaded and distended condition of the abdominal organs, and thus it succumbed under the unfortunate strain it was subjected to.

It is difficult to avoid speculating as to the possible origin of the pericarditis in this case, unsatisfactory though it must be; seeing that the boy had never shown a symptom of any diathetic disease whatever, and was, up to the hour of his death, supposed to be in perfect health. Neither is there any clue to a possible traumatic origin. There is, however, the fact that this boy, full of life and spirits, led an unusually active life; and thus it becomes a question whether this inordinate activity may not have induced the hypertrophy, and likewise the disease which terminated so painfully in this instance.

Beckenham, Kent.

THREE CASES OF SUNSTROKE (HYPERPYREXIAL FORM).

By MAURICE KNOX,

SURGEON-MAJOR, ARMY MEDICAL DEPARTMENT.

THREE cases of sunstroke occurred amongst the troops stationed at Bareilly during the summer of 1884. All recovered under treatment. The highest temperature recorded was 110°.

Private R—, aged twenty-three years, was brought to the hospital at 5.30 P.M. on the 16th of June. He had been drinking hard. On admission his temperature in the axilla was 105°; pulse 100; action of the heart fluttering; pupils contracted; quite insensible. He was freely doused with cold water. After twenty minutes his temperature was reduced to 99°, the action of his heart became more regular, and he was able to swallow. Fifteen grains of quinine were given him, the douche was discontinued, and ice was applied to the head. At 10.30 P.M. he became conscious, and another similar dose of quinine was administered. He afterwards recovered without any unfavourable symptoms.

Private L—, aged twenty years. The patient had been exposed to the sun on June 27th, and afterwards felt feverish. He was admitted into the hospital on the morning of June 29th as a case of ordinary febricula. At 4 P.M. he was observed to be in convulsions; the temperature in the axilla was 106°, and shortly afterwards reached 110°. Pulse very rapid; action of the heart fluttering; quite insensible. The patient was quickly sponged over with iced water, and ice was applied to the head and spine. At 6 P.M. his temperature had been reduced to 104°; the convulsions were not so violent; action of the heart more regular; pulse 100. Application of ice continued. At 7 P.M. the temperature was 104°. He was packed in the wet sheet, ice was occasionally

applied to the head, and he was given twenty grains of quinine in solution. At 10 P.M. the patient was conscious, the temperature remaining at 104°. At the morning visit on June 30th he was sensible, complaining of intense headache; skin rather dry; temperature 100°. Ordered ten grains of quinine and an ounce of sulphate of magnesia in solution. The man recovered without any unfavourable symptoms.

Gunner W—, aged twenty-six, a hard drinker, had been exposed to the sun on July 24th, and complained of feeling unwell to the men in his room on the morning of the 25th. At 3.30 P.M. he was found insensible on his bed, and was brought to the hospital at once. He was quite insensible; breathing noisy; pupils contracted; surface of body dark-coloured. Temperature in the axilla, 109°; pulse imperceptible; heart's action fluttering. Ice was applied to the head and spine, and the surface of the body was doused with cold water. At 5 P.M. the temperature was reduced to 103°; but the patient was violently convulsed. The douche was discontinued, and ice still applied to the head. At 9 P.M. the patient was conscious. Temperature, 99°; pulse 90; heart's action regular; breathing easy; no convulsions. He was ordered twenty grains of quinine. The man recovered without any unfavourable symptoms.

Bareilly.

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. BARTHOLOMEW'S HOSPITAL.

CASES OF SLOUGHING OF THE SCROTUM, UNCONNECTED WITH URINARY EXTRAVASATION; REMARKS.

(Under the care of Mr. MORRANT BAKER.)

THE following cases of sloughing of the scrotum are examples of a somewhat rare condition, and will be read with interest. The loose tissue of the scrotum renders it very liable to diffuse inflammation from slight causes, which, if not checked by appropriate treatment, soon passes into gangrene. The patients most likely to be affected by this condition are those whose health has been reduced by illness or intemperance, or who are the subjects of chronic visceral disease. It is sometimes hardly possible to diagnose this condition from that produced by extravasation of urine, without careful inquiry into the previous history of the patient, and an examination of the urethra with instruments to prove the absence of stricture and of calculus.

For the notes of the two cases we are indebted to Mr. J. N. Vogan, late house-surgeon.

CASE 1.—J. Y—, aged fifty-four, a shoemaker, was admitted on June 14th, 1884. A fortnight before admission he suffered from retention of urine. The perineum became swollen. The urine was drawn off, and the scrotum and penis gradually became black. On admission, the scrotum and the skin of the penis were quite black and gangrenous, but the glans penis appeared normal. The pubes and perineum were swollen and red. There was no redness of the thighs or buttocks. A No. 9 soft rubber catheter passed easily and drew off a few ounces of slightly albuminous urine, but with no admixture of blood. Incisions were made in the penis, scrotum, pubes, and perineum, and a poultice applied. A little fluid oozed from the wounds, but with no odour of urine. The patient became delirious and died the next day, after hæmatemesis to the amount of two pints. The post-mortem examination revealed no stricture or injury of the urethra, nor any lesion of the stomach or œsophagus. Kidneys and liver large and soft.

CASE 2.—E. H—, aged sixty, a commercial traveller, was admitted on December 22nd, 1884. He was a fairly healthy-looking man, and stated that a week before his admission he was in good health, when his testicles began to swell and become painful. He knew of no cause for the swelling. He used a lotion as an application to the scrotum. The next morning the testicles were more

swollen, and the scrotum was becoming black, especially over the left testicle. He thought he had used the lotion too strong, as he was told to dilute it, but did not do so. On admission, the scrotum over the left testicle had sloughed entirely; over the right testicle the sloughing was not so advanced. Both testes were exposed. The treatment adopted was a hot bath night and morning, nourishing diet with stimulants, and carbonate of ammonia in five-grain doses. A dressing soaked in solution of iodine (twelve minims of saturated spirituous solution of iodine to half a pint of carbolic acid lotion, 1 in 100) was applied. The odour, which had been very offensive, was almost entirely stopped, and the sloughs separated within a week. The pain ceased the day after his admission.

On Jan. 3rd, 1885, he had effusion into both knee-joints; tongue furred; pulse 120; temperature 98.8°. He stated that he had suffered from slight attacks of gout for the last three years. All stimulants were stopped, and alkalies given.

Jan. 5th.—The urine was faintly alkaline, sp. gr. 1015, pale amber colour and cloudy, containing albumen; half a pint only passed in twelve hours. He was much troubled by cough. There were moist râles all over the chest, back and front; resonance impaired at the left base. The heart dulness extended downwards and outwards into the axillary line. Impulse not heaving; no murmur audible; sounds weak. The wounds were healthy, but the granulations rather pale. The effusion and pain in the knees continued, sometimes more, sometimes less; and the cough remained troublesome, and the appetite bad. The testicles were gradually covered in again by the scrotum. Stimulants were again given, and tonics. On Feb. 16th he was sent to the Convalescent Home at Swanley, wearing a suspensory bandage, the right testis quite covered in, but a little of the left still exposed. At Swanley he gradually got weaker till the 20th, when he became much worse. There was then a basal diastolic murmur and a systolic apex murmur, œdema of both lower extremities, with blebs of serum and patches of purpura on the legs. There was some slight hæmorrhage from the rectum. He died comatose on Feb. 22nd. No post-mortem examination was made.

Remarks.—Cases in which inflammation and sloughing of the scrotum occur, quite unconnected with urinary extravasation, are not very uncommon in hospital practice, although their rarity compared with sloughing the result of extravasation of urine may lead to an error in diagnosis. The cases related illustrate the gravity of the disease, not so much from the effect of the local conditions, which should be recovered from easily enough, as from the depraved condition of the bodily health which is indicated by their occurrence. The second case seemed as if it would prove an exception to the rule; for during the whole of the patient's stay in the hospital no grave general symptom was present, and the local conditions rapidly improved and got nearly well. But a complete collapse took place afterwards under the most favourable surroundings, and when all effects of the local gangrene had disappeared.

LAMBETH INFIRMARY.

CASE OF ASIATIC CHOLERA; DEATH.

(Under the care of Dr. R. H. LLOYD, Medical Superintendent.)

ON July 29th, 1884, about 3 A.M. W. J—, aged thirty-five, a porter and an inmate of the Lambeth Workhouse, was seized with violent vomiting and purging, accompanied by cramps in the abdomen and legs. He was removed to the infirmary, and on admission was found to be in a state of collapse; surface cold and clammy; skin over chest and legs blue; voice (naturally strong) brought to a whisper; pulse almost imperceptible and very rapid; face pinched; skin over hands and fingers in wrinkles, and blue; complaints of cramps in abdomen and legs; intense thirst; feels sick; tongue and breath cold. Ordered turpentine stupes to abdomen, hot-water bottles, hot blankets, hot peppermint; ice to suck.—5 P.M.: Was purged about three times within the first hour after admission, and in the afternoon vomited a chamberful of dark fluid; has passed no urine; temperature 97°. Stimulating aromatic mixture ordered.

July 30th.—10 A.M.: Vomited three times since last report; no purging; no urine; temperature 97.4°.—6 P.M.: Vomited several times during the day; purged frequently; offensive stools, with light-coloured fæces; great thirst; restless; temperature 97°.

31st.—10 A.M.: Passed a quiet night; no vomiting; no