spinous process to the outer ankle. The leg was advanced in front of its fellow; the thigh was much abducted; the toes showed neither eversion nor inversion. The psoas and iliacus muscles formed a tense ridge on the anterior and inner side of the thigh; the space between the anterior superior spinous process of the ilium and the trochanter major was elongated. In view of these symptoms, I was reluctantly compelled to differ from the opinion expressed by the hospital surgeon, and to pronounce the case one of dislocation into the obturator foramen.

Having put the patient thoroughly under the influence of chloroform, I proceeded to reduce the dislocation by slowly flexing and extending the thigh upon the abdomen, while an assistant, by means of a towel, drew the upper part of the thigh outwards. With the third or fourth flexion of the thigh the bone slipped into its place. I tied the legs together at the knees and ankles, and kept the patient in bed for a fortnight. During this period he suffered considerable pain, and was feverish, particularly at night.

As might be expected from the length of time during which the bone had been displaced, the limb remained advanced and abducted; this, however, slowly wore off, and the use of the limb gradually returned. At present (Aug., 1870) he has perfect movement in the joint, the lameness is entirely gone, and he can run and jump with great agility.

Willington, Durham, August, 1870.

A Mirror

OF THE PRACTICE OF MEDICINE AND SURGERY IN THE HOSPITALS OF LONDON.

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.

A CASE OF PNEUMONIA IN A DRUNKARD, FOLLOWED BY FURIOUS DELIRIUM AND DEATH.

(Under the care of Dr. HARRIS.)

THE two following cases are taken from the notes of Mr. Symonds, house-physician.

The patient on admission stated that he had been ill for four days with pain in the left side and a slight cough. He was a fairly nourished man, forty-nine years of age, with a well-formed chest, the movement of which was slightly impaired on the left side. His tongue was dryish, red, and glazed; pulse 130, weak, and irregular; temperature 103°. He complained of pain on inspiration in the left lateral region of the chest. Good resonance was elicited all over the chest anteriorly, and, with the exception of some slight tubular breathing below the clavicle, probably transmitted, the respiratory sounds were normal. Posteriorly the resonance was good at the left apex, impaired at the spine of the scapula, and below this point absolutely dull. At the angle of the scapula, tubular breathing with very fine crepitation was audible; at the base, the respiratory sounds were very feeble. All over the right back the results of percussion and auscultation were normal. The heart-sounds were very feeble, but normal.

During the night he had a sharp attack of dyspnoea, but, with that exception, slept well. On the following morning his pulse was 136, full and compressible; temperature 101.6°; tongue moist and slightly furred. The sputa were very profuse, semi-purulent, and had a slightly rusty tinge; the breathing was feeble in front, with fine crepitation beneath the left mamma; at the angle of the left scapula bronchial breathing and well-marked bronchophony were heard.

On examination, the urine showed an abundance of vesical epithelium, and about a sixth part of albumen.

At about eleven in the evening he became restless, and remained in a state of wandering delirium until, at five o'clock the next morning, it passed into most furious delirium. His shouts and raving were so violent that he was

obliged to be removed to a separate ward. By about half-past eight he became exhausted and quiet, and he died at eight o'clock in the evening.

Mr. Symonds elicited by inquiry, that the patient had been an habitual drunkard, and had indulged freely up to the time of his illness.

At the post-mortem examination Dr. Gee found that the body was well nourished, and not jaundiced. The contents of the cranium were in a natural condition, with the exception of an excess of fluid in the ventricles and sub-arachnoid spaces, which did not exert any pressure on the brain, but had rather the appearance of being the result of atrophy. In front of the right ventricle the pericardium presented a white patch, and there were numerous smaller ones on the right auricle. The texture and size of the heart were natural; in the right cavities and left auricle were large loose black clots; the pulmonary artery was not completely filled with black clot, but there was more than usual in the aorta. The right pleura was adherent by old and loose fibrous tissue; the left contained three-quarters of a pint of turbid fluid, and the whole of the posterior half of its opposed surfaces, the inferior third of the anterior part, and the surfaces between the lobes, were covered with a thick layer of soft white lymph, found under the microscope to consist chiefly of lymph-cells and fibrillated inter-cellular material. The right lung was somewhat atrophied, but otherwise natural. The upper lobe of the left was collapsed and œdematous in part; the lower lobe was in a state of red hepatisation throughout; there was no softening, and no coagula were found in the pulmonary artery. The spleen was soft, but not enlarged. The kidneys were rather small, the cortex narrow, the capsule not adherent. A few cretaceous mesenteric glands were found. The other organs were healthy.

A CASE OF MALIGNANT SCARLET FEVER.

The day before admission, the patient, a boy thirteen years of age, was taken with sickness, and a medical man who was called in gave him an emetic. He was well nourished; his expression anxious; his breathing laborious; the lips and teeth covered with sordes; the tongue dryish, and covered with dark-brown mucus and fur. The soft palate and tonsils were acutely inflamed, and covered with thick mucus. The skin was dry and pungent, and covered with a livid mottled rash extending to the extremities; temperature 105.4°; the pulse 172. The cardiac sounds were normal; the respiratory sounds were obscured by the rattle in the throat.

The soft palate being incised, a free discharge of pus took place, especially from the right side, and the breathing became much easier. In the afternoon severe diarrhoea, with rapidly increasing prostration, came on; and at eleven o'clock the same night the patient died in a state of complete collapse.

The treatment consisted in the administration of essence of beef, two ounces of brandy containing a minim of opium every hour, and a draught of decoction of bark, with six grains of carbonate of ammonia, and five grains of chlorate of potash, three times a day.

Dr. Gee's report of the post-mortem examination says that there was much purple discoloration of the surface. The soft palate was much thickened, and, on pressure being made, puriform matter escaped from a small incision. A section through the tonsils showed them to be everywhere infiltrated with pus, though it was nowhere collected in a cavity which could be called an abscess. There was no ulceration of any part of the pharynx or soft palate. The solitary and agminated glands at the lower part of the ileum were much swollen, but not ulcerated. The spleen was of natural size, but the Malpighian bodies were rather too distinct. All the other viscera were natural.

ST. GEORGE'S HOSPITAL.

SCARLET FEVER IN A PATIENT SUFFERING FROM ENTERIC FEVER.

(Under the care of Dr. WADHAM.)

FOR the details of the following case we are indebted to Dr. Laking.

Mary A. H—, aged twenty-three, was perfectly well till fourteen days before admission, when her appetite failed, and she was taken with pains in the back. Three days