down. Middle lobe quite healthy. In the left lower lobe, a piece of lung of the size of a small orange was in a state of grey hepatisation, the lung-tissue surrounding it being fairly healthy, except that it was oedematous.

The most interesting feature in this case was the implication of the upper and lower lobes in the pneumonic process, the middle lobe being unaffected. I have not met with a similar case. During the life of the patient the opinion formed from the physical signs was that he had phthisical consolidation of the apex and pneumonia of the base. One other point is also worthy of remark, and that is the extreme restlessness of the patient just before death. I have seen two or three cases of pneumonia lately in which the patients have insisted on getting out of bed to use the night commode or for some other purpose, death ensuing almost immediately afterwards.

No. 9 is a case of pneumonia complicated with pleurisy and pericarditis. The patient had previously been in the hospital suffering from pericarditis, though what it was due to did not clearly appear. He left the hospital on May 17th, by his own wish, and was readmitted on May 20th.

R. T—, aged twenty-seven, an ostler. He states that he was taken ill on May 19th, with rigors and sharp pain in the left side, as if "knives were being jobbed in." Spat up two ounces of black blood yesterday. Has had a cough the last three days. Temperature 104.6°; pulse 116, full, soft; respiration 36, shallow, painful. Lying on right side, too exhausted to be examined.

May 21st.—Right side normal. Left apex, good resonance and vesicular breathing; dull up to fifth rib; faint tubular breathing; the dullness gradually increasing towards the back, reaching to midway between angle and spine of scapula. Posteriorly there is loud tubular breathing and bronchophony; absent vocal fremitus; pleural friction in infra-axillary region. Sputa viscid, rusty; respiration 48; pulse 108, full; chlorides almost absent from urine; temperature, morning and evening, 103°. He was ordered carbonate of ammonia, brandy, and a jacket poultice.

22nd.—Pulse 112, of fair volume; respiration 52, panting; countenance somewhat dusky; sputa viscid, rusty. Had a very bad night. Posteriorly the left side is dull all the way up, with loud tubular breathing. Vesicular breathing at left apex anteriorly. Right side normal. He seems much distressed and is very restless. Urine slightly albuminous and containing hardly any chlorides. Temperature: morning, 102°; evening, 102.4°.

23rd.—Not much change, except that his temperature fell in the morning to 99.8°; evening, 101°.

24th.—Pulse 148, very feeble and running; respiration 52. Dull up to third interspace anteriorly, but not transgressing the median line; vesicular breathing above; loud pericardial friction sound. Posteriorly the chest is dull up to the spine of the scapula, with tubular breathing, but no vocal resonance or fremitus. Aspect very distressed, livid; conjunctivæ jaundiced. Urine bile-stained, containing one-sixth of albumen. Morning temperature 100.4°.

25th.—Died at 2 A.M.

The post-mortem examination showed the whole of the lower lobe of the left lung, except a small patch at the base, to be in a state of grey hepatisation; the upper lobe was oedematous. The lung was closely adherent to the costal pleura by a thick layer of lymph, resembling half-melted butter in consistence. About half a pint of straw-coloured serum in pleural cavity. Right lung healthy. Pericardium much dilated, containing half a pint of light-yellow serum. Surface of pericardium like a nutmeg-grater, with some shaggy lymph hanging from it, but no adhesion. Liver and kidneys in a state of cloudy swelling.

No. 10 is only noticeable for the extremely rapid way in which the physical signs of pneumonia cleared up.

J. B—, aged twenty-one, a stonemason, admitted on the 1st of May. Taken ill on April 27th with rigors, heat of body, pain in the right side, and cough. On the day of admission he was too exhausted to be examined; his temperature was 103° F., and at night it went up to 105°, the next morning it had fallen to 100°, and, although the sputa were still rusty, there were no physical signs of pneumonia; by the evening his temperature was normal. Discharged on the 14th of May, quite well.

No. 11.—T. W—, aged thirty, a labourer, admitted on the 14th of May. In this patient the pneumonia commenced at the left apex posteriorly, the day after his ad-

mission tubular breathing being heard over the scapula, but there was no increased vocal resonance or fremitus in spite of the dullness. On the next evening (16th) fine crepitation was heard all over the upper lobe posteriorly, and loud tubular breathing; and on the morning of the 17th the pneumonic process had extended to the front, as there was dullness at the left apex down to the second rib, with fine crepitation. On the 20th he had slight epistaxis; his temperature was 101.6°, on the 21st it had fallen to 99°, and on the 22nd it was 98°, so that the epistaxis may be considered in the light of a critical phenomenon. The delirium of this patient was of a very violent character, as, according to my experience, is so frequently the case in apex pneumonia. Huss remarks, however, that this is not especially the case. Besides being delirious, he was at times very restless at night; for which he had chloral prescribed, on one occasion with the effect of giving him an hour's quiet sleep. In several other cases of pneumonia I have seen it given with a satisfactory result. Dr. Habershon, however, says it is not a safe drug to employ where the respiration is liable to embarrassment.

No. 12—the last case—occurred in a healthy youth of the age of eighteen, a porter. He states that he was quite well up till the morning of May 14th, when he was taken suddenly ill about 10.30 A.M. with frontal headache, followed by pain in the chest; has not had rigors. Cough commenced on the 16th. Sputa were blood-stained on the 17th. Temperature on the evening of the 18th, the day of his admission, was 103.2°; the next morning it went up to 104.2°. Physical examination showed that the middle of the right lung was affected, as from the angle to the spine of the scapula there was dullness on percussion, with tubular breathing and loud bronchophony; at the angle of the scapula there was a little fine crepitation; both above and below the dull region there was good resonance, with fair vesicular breathing. The sputa were rusty. Pulse 108, feeble, dicrotous; respiration 44 per minute. On the evening of the 19th the temperature had fallen slightly, being 103.6°, and it continued falling, so that by the evening of the 21st it had reached 98.4°. The physical signs on this day were a little medium crepitation at the apex of the right lung in front, posteriorly quite resonant up to the angle of the scapula, from there to the spine of the scapula impaired; above the spine, resonant. Vesicular murmur, with medium-sized crepitation, over the dull region, with increased vocal resonance. Pulse 96; respiration 44.

May 22nd.—Pulse 72, very small and feeble; respiration 32. Only very slight impairment of resonance over the right scapular region, where the breathing is feeble, with occasional crepitation.

For the next five days the temperature kept below normal. He was discharged on the 4th June, perfectly well.

The chief points to be noted in this case are the limitation of the pneumonic process to the middle and posterior part of the right lung, the anterior surface being unaffected, and the rapid fall of temperature on the fifth day of the disease, which continued to drop without any break till the morning of the 23rd, when a temperature of 97.4° was recorded. This patient also afforded an instance of loss of sensibility about the bladder, as he allowed it to become much distended without making any complaint, but was able to pass his water when urged to do so.

Since May 18th, the date of admission of the last of these cases, four patients suffering from pneumonia have been admitted into the Westminster Hospital, and have all done well.

STRANGULATED UMBILICAL HERNIA.

By W. C. ARNISON, M.D.,

SURGEON TO THE NEWCASTLE INFIRMARY.

ON March 20th I was requested by Mr. Charles Carr, of this town, to visit Mrs. D—, aged thirty-eight, mother of eight children, suffering from strangulated umbilical hernia. The history was a very common one. The hernia appeared seven years ago, after one of her confinements. No truss was worn, and not much inconvenience felt. On reaching the house, we found that an enema, which Mr. Carr had ordered in the morning, had been followed by a

very large evacuation, with great relief to all the symptoms. It was therefore decided to defer any operation, as the hernia had always been, as it then was, irreducible.

On March 23rd Mr. Carr again requested me to see the patient, as the symptoms had returned after a period of relief, and there was now stercoraceous vomiting, its first appearance, although symptoms of strangulation had existed, more or less, for twelve days.

The patient was of the corpulent build so common in these cases. At the umbilicus was a lobulated tumour, the smaller portion as large as a walnut, prominent, and thinly covered with skin; the larger portion, buried in a thick layer of subcutaneous fat, could be felt under the integument. Attempts at reduction had failed, and the time for delay had clearly passed; an immediate operation was therefore advised and submitted to.

With the patient under chloroform, a last attempt was made to reduce the hernia. That failing, an incision was made in the median line on the lower side of the tumour, and the sac readily reached. Finding it impossible to get even the finger-nail between the sac and the edge of the umbilical orifice, I was compelled to lay the sac open, and then readily returned a considerable knuckle of intestine. The opening was still occupied by omentum, which could not be returned until I had traced it up into the smaller portion of the original hernia, into which it passed through an orifice so narrow as to require enlarging by the knife, after which it was easily hooked out by the finger and passed into the belly, leaving the ring clear. The wound was then closed by sutures, covered with a compress, and the whole secured by a broad calico band pinned tightly round the body.

The operation was concluded at 6 P.M. About three hours afterwards the bowels acted of their own accord, and during the following day flatus was freely passed. On March 25th there was vomiting, which soon ceased; and on the 26th the bowels again acted freely. The highest temperature reached was 102.2°, on the 25th. Progress towards recovery has been slow, owing to the formation of abscesses near the wound, but these are now (July) nearly well, and the patient has gone into the country.

The treatment after the operation was almost *nil*, a spare diet for a few days, an opium pill at bedtime, and ice occasionally. When the abscesses formed they were treated by incision and drainage-tubes.

This is the third operation for umbilical hernia which I have reported in THE LANCET, all successful. I hesitate to speak with confidence from an experience founded on only three cases, but, giving it for what it is worth, I should say that the cases in which it is possible or safe to operate without opening the sac must be very rare, and that the dangers of that proceeding have been a good deal exaggerated, although I would fully acknowledge the special desirability, in this form of hernia, of leaving the sac unopened whenever possible.

Newcastle-on-Tyne.

OVERWORK AS A CAUSE OF INSANITY.

BY GEORGE H. SAVAGE, M.D. LOND.,

ASSISTANT-PHYSICIAN TO BETHLEM HOSPITAL.

As the question of overwork has been raised in the pages of THE LANCET, I have thought it might be of interest to collect some observations made in Bethlem Hospital. It must be premised that the assigned causes of insanity are frequently incorrect, yet at Bethlem we have good opportunities of getting true family histories from the nearest relatives.

Among the men we find many cases in which overwork, especially if associated with worry and money troubles, is the cause of a break-down. Among the women we find very slight evidence of overwork acting as a cause of insanity. Of course there are cases such as those of widows who have to struggle to maintain a large family, but the cases are less common than among the men.

Continuous monotonous work, such as letter-sorting and shorthand-writing, is apt to act injuriously. We have seen

cases in which continuous railway travelling acted as a cause of nervous exhaustion. One patient, who has been several times under our care, attributed his symptoms to night work as a "reader" for a daily paper. Diversified mental work never seems to produce the effects that monotonous toil does, unless carried to a great extreme.

I append a few particulars as to the cases attributed to mental overwork that were admitted into Bethlem Hospital during 1874 and up to June, 1875. There were twenty men and eight women.

The ages of the men were as follows:—One under twenty years, nine from twenty to thirty years, five from thirty to forty years, four from forty to fifty years, and one over fifty years. In three only was there a distinct history of insanity in the family; in two others there was at least oddness in other members of the family. The occupations were various; but in all there was a possibility of overwork, which was not clear among the women. There was one belonging to each of the following employments:—Architect, surveyor, accountant, inventor, musician, clergyman, artist, artmaster, schoolmaster, policeman, and bootmaker. There were seven clerks, including two law-writers, and two students: one an Oxford man who had exhausted himself in getting a double first, and the other a medical student preparing for his second College.

In the above cases there were few complications. In one there had been rheumatic fever and chorea; and one, the bootmaker, was distressed by a rupture that interfered with his work. Three were unduly anxious about competition, one about competitive designs, one on account of his pictures being rejected at the Academy, and a third about his "second College." In one only was there a history of drink.

Most had limited incomes that depended solely on their own work. Several owed their exhaustion to following more than one calling; thus one was a librarian all the week and a preacher on Sundays, others worked all day in an office and then did copying at night. Nearly all the cases were admitted in a very weak condition; some refusing food which they fancied they had not earned.

We had every variety of mental disturbance, from acute mania to profound melancholia. I would specially call attention to one series of cases—namely, the general paralytics. We had, among our twenty cases, five suffering from this disease, one of whom sank very rapidly. Besides these we had several cases that caused us considerable doubt as to diagnosis and prognosis. They were admitted weak, tremulous, and with loss of memory, and in some cases buoyant and exalted. They look like general paralytics, but rest and good diet cured them. Another condition was that of self-condemnation. These patients fancied they had not done their duty, and were commonly suicidal. One we learnt afterwards committed suicide.

Among the men one-half were married. This contrasts with the cases we have to consider found among the women.

There were eight women whose friends thought overstudy had produced insanity. These were all single; three were under twenty years, two under twenty-five years, two under thirty-five, and one under forty-five. In two only was there known to be a family history of insanity. Three had been hysterical before the attack of insanity, three had suffered from other physical ailments—namely, rheumatic fever, chorea, and uterine disease.

The form of insanity varied. We had several with that exaltation that has been noticed as not uncommon in the insanity of young women. This may be in part due to romantic ideas that were bred of novels.

The occupations were as follows:—Five were teachers, one a school-girl, and two dressmakers. Of the teachers, three were in elementary schools, one an ordinary governess, and one a teacher of music and languages.

In none of these cases among the women could I get evidence that satisfied me that real mental work was the cause of the insanity. In one certainly the attack came on two days after an examination, but this girl had a sister who has been in Bethlem.

To sum up, I would say that overwork rarely, if ever, alone sends us patients on the female side. On the male side we do have a fair number who are really broken down by long hours and monotonous mental toil. I believe the monotony is the chief evil.

It will be seen from the above that heredity does not play a very large part in these cases.