

of the skin and from want of use, the left leg appeared to be about what might be supposed to be half its natural circumference. By the contraction in the process of cicatrization and by the assistance of smaller skin grafts, at the end of ten years the wound had entirely healed with the exception of two or three small fissures; these remained with rounded, thickened, and indurated edges. The right leg, which had been less severely injured, was also much diminished in size.

CASE 2.—A patient being treated for ascites in one of the medical wards of St. George's Hospital had an umbilical hernia. This when distended was the size of a small orange. The hernia was easily reduced and the sac left empty. Three hare-lip needles were introduced through the neck of the sac and a figure-of-8 ligature applied loosely over the extremities of each. After two or three days the needles were removed, and firm adhesion at the neck of the sac appeared to have taken place. The skin which had covered it became shrivelled, of dusky brown colour, and remained the size of a small nut. So far as could be known there was no return of the hernia. A drawing of the parts by Dr. Westmacott as they were left after the operation is preserved.

CASE 3.—A gentleman had been treated for some two years and a half for dysentery. As there was some irritation about the rectum, I examined it. A bone, which subsequently proved to be a fish-bone, about two inches and a half long, was found to be impacted across the bowel about two inches from its orifice. By means of a long pair of forceps one end of the bone was got into a speculum. The bone was then withdrawn without difficulty. The symptoms from which this patient had so long suffered immediately ceased.

PASTEUR'S PREVENTIVE TREATMENT FOR HYDROPHOBIA.

BY HY. TOMKINS, M.D., B.Sc.,
MEDICAL OFFICER OF HEALTH, LEICESTER.

PERHAPS one of the most reasonable objections made to the treatment by Pasteur of persons bitten by rabid animals, or rather, one may say, to the results recorded by him of such treatment, has been the fact that in a considerable number of the cases treated, evidence that the animal by which the patient had been bitten was actually and undoubtedly rabid is not forthcoming, and opponents have not been slow to urge that it is highly probable in many instances patients have undergone treatment when the dog which had inflicted the bite was quite healthy, or, at least, not suffering from rabies. In the following record of three cases treated at the Pasteur Institute last year it is placed beyond all doubt that the animal, at the time of inflicting the injuries, was suffering from rabies. On Jan. 8th, 1890, a stray dog came into the borough of Leicester from the adjoining suburbs and on its way bit two school children, a boy and a girl, on the face and hands, the wounds upon each of the children's faces being of a very extensive, lacerated character. This occurred outside the borough boundaries, and almost at the same time it bit also a small terrier dog. Continuing its course into the town it bit a young man severely on the hand, and shortly after this it was killed. The patients were seen by medical men and the wounds cauterised, but not until after the lapse of some little time; in one case nearly an hour elapsed. I saw all the patients on the following day, and, with the assistance of Mr. Fraser, the veterinary inspector to the corporation, made a post-mortem examination of the dog. The pathological appearances to the naked eye were practically *nil*, but the stomach contained some pieces of straw and other debris. The cord and medulla were removed. On Saturday, the 11th, I took the three patients to Paris (taking with me the cord removed from the dog), and on Sunday morning they were seen by M. Pasteur, and treatment commenced in the usual manner. From the cord several rabbits were inoculated, and before the end of a week these succumbed to what M. Pasteur declared to be rabies. The man was kept under treatment fourteen days, but the two children, owing to the severity of the wounds, were kept for twenty-five days before being sent home. The small terrier bitten by the dog was kept by me under close observation shut up, away from all other animals, and on the fifteenth day from being bitten it began to

show signs of indisposition (having in the interval been apparently in good health), which soon declared itself as undoubtedly rabies, and the animal succumbed on the third day from the first onset of the symptoms. Being kept secluded and alone, it showed but few signs of excitement, but crawled about, refusing to eat or respond when called to, paralysis of the lower jaw and hind limbs soon supervening. It should be noted that the wound on its hind leg was but a small one, not larger than a threepenny-piece, and at the time of its death was healed.

Here, then, we have indisputable evidence that the animal which bit these three patients was suffering from rabies, and the probabilities are, seeing how easily the second dog was infected, that at least one or other of the three would have developed symptoms of hydrophobia if the treatment for prevention had not been adopted. As more than twelve months have now elapsed since the occurrence, and all of them remain in good health, we may conclude they have now quite escaped from any untoward consequences.

Leicester.

NOTE ON TRAUMATIC CEPHALHYDROCELE.

BY R. CLEMENT LUCAS, B.S., F.R.C.S.,
SURGEON TO GUY'S HOSPITAL, AND TO THE EVELINA HOSPITAL FOR CHILDREN.

IN THE LANCET of January 10th, under the title of "Traumatic Encephalo-meningocele," an interesting case is reported by Mr. H. Burton of a child who, after a severe injury to the head, developed a pulsating tumour of the scalp containing cerebro-spinal fluid. The writer, in his remarks, states that "it differs entirely from the traumatic meningocele described by Mr. Clement Lucas and Mr. Golding-Bird." So far from this being the case, it is precisely of the kind which falls within that category; and had the writer found the opportunity of referring to the original papers, I think he could not have failed to be struck with the resemblance. The only difference, indeed, lies in the fact that in his case the fracture was in the first place compound; but the primary union of the wound which took place allowed the fluid to accumulate beneath the scalp as if that covering had not been torn. Little was known of these rare and interesting tumours till the publication of my first case with a drawing in the Guy's Reports of 1876, and the pathological conditions requisite for the production of the tumour were not understood. Subsequent years placed two post-mortem examinations within my reach, which are related in the volumes of the Guy's Hospital Reports for 1878 and 1884, and I was able to show that these subcutaneous fluid tumours communicated directly with the ventricles of the brain, and I further ventured the statement, based upon the study of these and other cases, that they could only be developed in childhood. Mr. Golding-Bird, in reporting a case in the Guy's Hospital Reports for 1889, gives his own experience in support of my contention. Another very remarkable circumstance which often happens in these cases is a rapid absorption of the bone in the neighbourhood of the fracture, and as a consequence a permanent pulsating mass with heaped up and everted edges of bone may in some cases remain. Such conditions were found in cases reported by Mr. T. Smith, Mr. Godlee, and Mr. Silcock. The escape of the fluid from the ventricular cavity is apparently secondary, to an increased secretion resulting from inflammation of its lining membrane and absorption of the damaged brain tissue along the track of the injury, for the fluid is seldom noticed till some days after the accident. The term traumatic cephalhydrocele would seem preferable to traumatic encephalo-meningocele or meningocele, as the meninges and the brain are both perforated, and do not cover the cyst. As regards treatment, I am convinced that the less done in the way of active interference the better. Aspiration may be used for diagnostic purposes, but can be of little service to the patient, for the fluid invariably re-collects. Pressure during the inflammatory stage may lead to grave symptoms, as in the case detailed. The surgeon should bear in mind the very serious laceration that has taken place in the brain substance, and should ensure absolute quiet and brain rest for a lengthened period. In the

later stages gentle pressure may be of service in preventing a permanent bulge; but I am inclined to think the cases which result in chronic tumours are those in which the serious nature of the injury was not in the first instance understood.

Finsbury-square.

ECZEMA CAUSED BY VIRGINIAN CREEPER.

By W. STUART PALM, M.B., M.C., M.R.C.S.

THE publication by Dr. Burd of a case of eczema caused by contact with the leaves of the above plant recalled to my mind a similar case. A lady patient's maid had been gathering and arranging the leaves of Virginian creeper, and the next day acute papular eczema appeared, first on her hands and then on her whole face and neck, where it produced intense heat and irritation, and oedema of the eyelids. Under treatment the attack subsided in a few days. I was much puzzled to find the cause. The patient had never had a similar attack before, and it was only on close questioning that I elicited the fact that she had been touching the leaves of this plant, and could assign no other cause for it. I was very sceptical as to this alleged cause until the summer after, when the butler in the same house had a similar though slighter attack of eczema after gathering the leaves of the same plant for the table.

Largo, Fife.

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. THOMAS'S HOSPITAL.

A CASE OF RUPTURE OF THE LARGE INTESTINE WITHOUT EXTERNAL WOUND; ABDOMINAL SECTION; REMARKS.

(Under the care of Mr. CROFT.)

THERE are few injuries to any region of the body which prove, in proportion to their number, so fatal in their results as contusions of the abdomen attended with rupture of the intestine without wound of the abdominal wall. To the eye there may be in the early stage nothing more than a bruise of the part struck, and the shock which attends such injury may not be sufficient to prevent the patient from going a long distance before the inevitable septic peritonitis supervenes. As we have already observed,¹ we doubt if there is anyone of large experience in surgery who cannot from his own practice cite striking examples of the misleading appearance of harmlessness these lesions often present. As these lesions are so extremely fatal, the very difficulty of diagnosis imposes the duty upon the surgeon of clearing up the doubt and of determining with certainty whether or not they are present. This is the first point that needs to be made plain. To wait until the diagnosis is certain is to miss the golden opportunity for treatment and to allow the onset of septic peritonitis to rob the patient of nearly every chance of life. Mr. Croft, who has had unusual success in the treatment of these intra-peritoneal ruptures of the intestine, having had partial success in one case,² in which the patient died after secondary resection of artificial anus four weeks after the original injury, and another case in which a brilliant success was reached³ by immediate resection and suture, the only one on record, gave as his reasons for attempting an immediate radical cure in these cases:⁴ 1. That existing peritonitis, although septic, might be abolished, and the parts might be rendered aseptic. 2. That existing peritonitis did not essentially prevent union of the peritoneal surfaces, for experience had now amply shown that these soiled parts might be purified and rendered fit for union. 3. That the empty and paralysed state of the recently

ruptured and contused bowel (small intestine) was favourable for the *technique* of the operation. 4. It saves the patient from the consequences of an almost uncontrollable anus in the small intestine. 5. It also saves him from the very serious risks of a second long and dangerous operation. As our readers will remember, Mr. Croft's successful case, on which these remarks were founded, was treated by resection of the injured part. Since then another case of similar injury has been treated by Mr. Watson Cheyne,⁵ who operated about twenty hours after the accident on a patient aged eighteen, and sutured a rupture in the jejunum. The youth died nine hours later. Here the edges of the wound are described as gangrenous when they were examined post mortem. The case which we give below is only the sixteenth of the kind on record in which a surgeon has performed abdominal section for rupture of the intestine, and the only one in which ruptured large intestine was discovered. The advantage of operation where no rupture was found is shown by a case under the care of Dr. King,⁶ who operated on a boy aged twelve, who, after a kick in the abdomen from a horse, developed symptoms of acute septic peritonitis. On the third day—that of the operation—there was a sudden fall of temperature to 97°, the pulse was 140, the abdomen enormously distended, tympanitic above and dull below the umbilicus. He looked pinched, pale, and anxious, and was tossing and moaning in bed. Acute peritonitis, with contused omentum and intestine, was found, and after cleansing the peritoneal cavity and drainage, ultimate recovery ensued. There was no doubt in the minds of those who saw the patient that he would have soon died without the operation, which was undertaken with but little hope of success.

E. J.—, aged twenty-three, was admitted on the afternoon of New Year's Day into the Edward ward of St. Thomas's Hospital in a state of modified collapse, about an hour and a half after having been severely kicked in the abdomen by a horse. He was in a state highly unfavourable for recovery from any serious injury. After a search for work for a fortnight, he had at last, when in a half-starved condition, obtained "a job" at a tramcar station. At 4.30 P.M. on Jan. 1st he was kicked in the abdomen by a horse. The blow knocked him down, and he was unconscious for a few seconds. He was picked up in a state of collapse, with cold sweat, dyspnoea, and pain in the left side. He recovered to some extent from that condition, and was sent in a cab to the hospital.

On admission, he was found to be still suffering from shock. His pulse was feeble at 80, his breathing was gasping at 40. The abdominal wall was rigid and very tender to the touch, and the skin on the left side of the umbilicus showed a small mark like a subcutaneous bruise. There was no movement of the diaphragm. He kept his thighs drawn up. The pain on pressure was chiefly on the left side and about the level of the umbilicus. He was still pale to the lips, the skin was cold and clammy, and his temperature was 97.4°. A catheter was passed and drew off about two ounces of normal urine. He vomited a short time after admission about two drachms of brownish fluid free from blood or odour. The treatment consisted of sedatives internally and externally. At midnight the temperature was 98.4° and pulse 100. At 4 o'clock the following morning (Jan. 2nd) the temperature had risen to 101° and the pulse was 110, and the tongue had become dry and coated. After 5 A.M. a messenger was sent to Mr. Croft, who reached the hospital at 6.45 A.M. On examination of the patient, he decided to explore the abdominal cavity immediately. The patient at that time manifested well-marked symptoms of acute septic peritonitis. The incision was made so that the umbilicus formed its centre. When the peritoneal cavity was opened it was found to contain a large quantity of turbid fluid with a few soft clots of lymph. The omentum between the colon and the stomach was found severely ecchymosed, and on turning up this structure a rent was discovered on the transverse colon. The edges of the rupture were ragged and faecal. The opening was about three-quarters of an inch in diameter and situated on prominent surface of bowel. The surrounding peritoneum was torn and stripped up. It was remarkable that the fluid exudation was not very obviously stinking, and that very little feculent matter clung about the rupture. The omentum had been torn through near the colon, so as to leave a

¹ THE LANCET, vol. i. 1887, p. 937.

³ Ibid., vol. i. 1890, p. 650.

² Ibid., p. 537.

⁴ Ibid.

⁵ Brit. Med. Jour., vol. i. 1890, p. 789.

⁶ Med. News, Philadelphia, 1890, lvi., p. 227.