

surrounding skin, and in no place could the margin be said to be abrupt. She complained a good deal of a smarting feeling in the skin, which she compared to the sensation left after the cut of a whip, but she was not in any way out of health. She was ordered to remain in bed, and to apply constantly a lotion of oxide of zinc, spirits of wine, and solution of lead. In six days the swelling had subsided, and the attack was practically at an end. I saw my patient two months afterwards, and then we could see a clumsy look about the features which she was anxious to get rid of.

I think this is only an exalted degree of what we meet with in every-day experience. The degrees of vulnerability of the skin of the face varies as much as the vulnerability of clothing. It is a matter of common experience that the rays of the sun, cold weather, fierce wind, soap, dust, or heat will produce effects upon the facial skin as varied as the sky; probably few of us resist absolutely the irritating effects of the sun's rays, as is evidenced by the bronzing, or blistering, or the bringing out of freckles. If the irritation only produces a simple erythema we hear but little about it, and it succumbs to some simple domestic remedy. If the irritation produces a crop of small vesicles, we designate it "eczema vesiculosum," and it drifts into our hands. If the irritation produces a crop of large vesications or bullæ, with a good deal of infiltration of the skin, we speak of it as relapsing erythema, or, as some would prefer to say, "relapsing erysipelas." The case I have given an account of is one of a common variety.

Prince's-street, W.

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.

LONDON TEMPERANCE HOSPITAL.

CASE OF ACUTE PHTHISIS, TERMINATING WITH RAPID GANGRENE OF FACE AND CEREBRAL ABSCESS; REMARKS.

(Under the care of Dr. EDMUNDS.)

THE phagedænic ulceration of cheek in this case is the point of unusual character to which we would draw attention, phagedæna being a very rare complication in phthisis, but apt to appear in any patient the subject of exhausting disease. In this patient, although only twenty years of age, there was much œdema of the lower extremities independently of organic cardiac disease or disease of the kidneys, indicating considerable exhaustion. The ulceration is also noticeable for its seat and for its extension into the cranial cavity. Opportunities rarely present themselves of watching the progress and ending of these ulcerations. For the report of the following case we are indebted to Dr. Leonard Wilde.

William H—, aged twenty, was admitted to hospital on June 13th, 1889. His family history was bad, his mother and one aunt having died of phthisis. About three months before admission he caught cold, felt weak, and had night sweats. Cough became frequent, and shortly after he suffered from copious expectoration, which latterly had been offensive. He never had any hæmoptysis. On examination, a large cavity was diagnosed in the upper lobe of the left lung, and commencing softening in the right lung. Both legs were very œdematous, and there was an unhealthy ulcer over the inner third of the left leg. Urine acid; no albumen. Tubercle bacilli were found to be plentiful in the sputa. He remained in about the same condition until July 25th, when he complained of toothache, and the right side of his face was somewhat swollen. A carious upper molar was removed, but the swelling increased, and the cheek became red and shiny. On the 29th there was no evidence of fluctuation internally; but to relieve the tense and œdematous condition an incision was made with a

knife, which had been carbolicised, on the outside of the cheek, and some black sanguinolent fluid escaped, which was highly offensive. A probe was passed into a considerable cavity, left by the evacuation of this fluid, the walls of which were black and glistening. The following day a small black spot appeared near the angle of the mouth, and there was an aphthous ulcer on the corresponding side of the tongue. This black slough quickly spread at its periphery until it finally involved the whole of the cheek. The eyeball became greatly protruded, and there was a swelling above the zygoma, extending over the temporal region. He did not complain of pain, and was quite conscious, but grew gradually weaker, and died on Aug. 2nd.

At the necropsy, the whole of the right cheek was involved in a slough, black in the centre, greenish at the edges, not extending into the mouth, although the buccal mucous membrane of that side was discoloured. The right eye was protruded, and there was subconjunctival œdema obscuring the lower half of the cornea, and when the conjunctiva was incised some purulent fluid escaped. Beneath the scalp the temporal muscle was of a glistening grey colour, and very soft, almost gelatinous. On removing the brain the anterior portion of the temporo-sphenoidal lobe was found to be gangrenous and breaking down into soft shreddy material, and just beneath the grey matter there was a small abscess, containing horribly offensive greenish pus. Scattered over the vessels at the base of the brain were many small yellow tubercles, and around the gangrenous patch was a deposit of recent lymph. The dura mater over the middle fossa of the skull had shared in the same rapidly destructive process, and there was pus on its inner surface. The contents of the right orbit were quite pulpy, and it was impossible to distinguish the different structures. A probe passed through the sphenoidal fissure easily made its way over the lower margin of the orbit into the cavity in the cheek. In fact, the course of the inflammation could be easily traced in two directions, one from the cheek beneath the zygoma to the temporal region, the other along the floor of the orbit through the sphenoidal fissure to the cavernous sinus, spreading thence over the middle fossa of the skull. There was a large cavity in the left lung, and a smaller one in the right. Heart and kidneys healthy; liver fatty.

Remarks by Dr. WILDE.—This case seems to have been somewhat remarkable owing to the uncommon fatal complication of gangrene of the face and the extension of this to the orbit and through the sphenoidal fissure to the temporo-sphenoidal lobe, and also from the rapidity with which the cerebral abscess must have been produced and the absence of any cerebral symptom in spite of an extensive intracranial lesion, though this is not invariably to be expected, as Gowers has pointed out.

ROYAL SURREY COUNTY HOSPITAL, GUILDFORD.

SUPPRESSION OF URINE FOR THIRTEEN DAYS; SINGLE KIDNEY; OCCLUSION OF URETER BY INSPIS-SATED THROMBUS; REMARKS.

(Under the care of Mr. BUTLER.)

IT is fortunate that Mr. Butler was able to obtain (and record) the post-mortem examination in this case, for it is one of exceptional interest. From old disease the patient was placed in the position of one with a single kidney, and injury to this was therefore of increased gravity; had both been in working order it is possible that this kidney would have become hydronephrotic, the block in the ureter remaining a permanent one, and the exact pathology of the condition unexplained. It may be that this is the condition which obtained where hydronephrosis developed subsequently to injury in some recorded instances. That blood clots of large size frequently pass through the ureter after damage to a kidney followed by hæmaturia is well known, and sometimes the symptoms produced by their passage are of considerable severity, like those caused by the passage of calculi; but evidence of the complete obstruction of a ureter by one of these clots has been wanting. Several examples of anuria, due to blocking of the ureter of the only sound kidney by a calculus, or of the simultaneous blocking of both ureters by calculi are on record, and it is a

most fatal occurrence.¹ In such the surgeon can usually obtain a history to assist him in the diagnosis. Various conditions have caused anuria after injury to the kidneys. Mr. Cock recorded² the case of a young man aged eighteen who died comatose on the eleventh day after an accident. Within a few days all the symptoms of the original injury, and of the subsequent peritonitis, had subsided excepting that the catheter withdrew nothing but blood. At the necropsy a ruptured single kidney with other internal injuries was found. In Mr. Poland's case³ complete suppression of urine followed an injury; the patient lived for six days, and the necropsy revealed thrombosis of the renal vessels of one kidney and rupture of the pelvis of the other side. Dr. Moxon gave an account of the case of a man aged twenty-two in whom nearly complete anuria resulted from an injury to the back, probably from thrombosis of the renal vessels. Ashhurst⁴ says that an injury short of actual rupture of the pelvis of the kidney or of the ureter is a strain or laceration of the kidney or ureter followed by adhesive inflammation and obliteration of the urinary duct, with the development of hydronephrosis within a week or two. As illustrative cases he cites that of Mr. Stanley,⁵ who treated a boy of nine, and that of Mr. Croft,⁶ who successfully treated a boy aged twelve in whom hydronephrosis developed after injury to the kidney. There had been hæmaturia for a period of six days.

A. S.—, aged forty-three, labourer, was struck by the handle of a plough in the left lower abdomen. The blow did not knock him down, and though suffering from pain in the back he continued to work for four days after receiving the injury. On the fourth day after the accident sudden total suppression of urine came on, accompanied by rigors, sickness, and violent pain in the back. The patient stated that suppression of urine had been complete for ten days. Until the present attack he had been working in the fields, and there had been no symptoms pointing to renal disease. On admission, the bladder was empty. The breath had a urinous odour, and the abdomen was somewhat distended, and there was tenderness in the epigastrium and flanks. The temperature was 99°, but remained 98° till death. On the day after admission broncho-pneumonia developed, accompanied by hæmoptysis, nausea, vomiting, and diarrhoea. Muscular twitchings were observed during sleep, and the man died on the third day in an attack of general convulsions.

Necropsy.—The blood for the most part was uncoagulated. The bladder was completely empty. The right kidney was cystic and atrophic and weighed 120 grains; it measured one inch and a half in length. The ureter was pervious but thread-like. The supra-renal body was disorganised. The left kidney was much enlarged and bound down by old and recent inflammatory changes, which had involved the atrophied supra-renal body. The ureter was greatly distended with urine, and a solid hard plug could be felt blocking the ureter about its middle. The capsular veins were hypertrophied and engorged. The capsule was very adherent, and the surface of the kidney was mottled with minute purulent collections. On section the radicles of the renal veins were found thrombosed; the thrombi were hard, brown, and gritty, and on first appearance looked exactly like small calculi; when soaked in spirit they became friable, and microscopically they were evidently inspissated blood-clot. A hard brown mass could be seen and felt beneath the mucous membrane of one of the calyces, and near it was a large rent in the softened kidney substance. Through this rent an inspissated thrombus had passed, and, gaining the pelvis of the kidney, become impacted in the ureter. On opening the pelvis several brown hard bodies were observed, and both these bodies and the plug occluding the ureter on microscopic examination were proved to be inspissated thrombi.

Remarks by Mr. BUTLER.—It is probable that the blow in the abdomen was the cause of the thrombosis. The actual cause of death was occlusion of the ureter, for the high tension of the urine distending the ureter indicates that the physiological action of the kidney was not entirely arrested. It is also remarkable that both supra-renal bodies were disorganised, though all signs of Addison's disease were absent.

ROYAL PORTSMOUTH HOSPITAL.

A CASE OF INTESTINAL OBSTRUCTION; RIGHT LUMBAR COLOTOMY; RECOVERY; REMARKS.

(Under the care of Dr. T. WARD COUSINS.)

IN the absence of evidence as to the exact seat and cause of obstruction in this case, and for the reasons which are given in the remarks, the colon was opened in the right lumbar region, and the patient effectually relieved. The questions of surgical procedure in similar cases of obstruction of the large bowel have been so recently under the notice of the profession in our columns¹ that we do not purpose to reconsider them here.

The patient was a tall man of full habit, aged sixty-four years. He had been accustomed to heavy work as a railway porter, but he had never had any serious accident or illness. As a general rule his bowels had always acted regularly, but during the last seven months he had been much troubled with constipation. Last June he suffered several days from "stoppage" of the bowels, and the attack was attended with great abdominal pain and vomiting, but the symptoms fortunately at length yielded to large injections of oil and warm water. Another attack occurred in September, and at the suggestion of his medical attendant, Dr. F. Pierce of Southsea, he was removed to the Royal Hospital. On admission the condition of the patient appeared to be very critical, and his sufferings were very distressing. The bowels had not acted for ten days, and the abdomen was very tense and tympanitic. His mouth was dry, and he vomited large quantities of a dirty brown fluid. After the failure of the usual treatment right lumbar colotomy was performed and the intestine immediately opened. The evacuation of a large quantity of soft faecal matter took place, and relief to the symptoms followed at once. The subcutaneous tissue around the gut had been carefully protected by the free injection of warm lanoline. A few days after the operation faeces began to pass through the canal, and at the end of a month the bowels acted nearly every day, and no faecal matter passed out of the lumbar opening. He left the hospital in October with the wound healed all but a narrow fistula, through which flatus occasionally escaped. On Nov. 27th, 1889, the patient came to report himself at the hospital. He is now in good health, and has been able to do some light work at the railway.

Remarks by Dr. COUSINS.—The case is an illustration of intestinal obstruction caused by faecal accumulation. Habitual constipation had weakened the peristaltic movements, and prolonged dilatation of the colon at length terminated in its complete paralysis. In cases of this kind the bowel immediately beyond the distended part has been found firmly contracted, with congestion and inflammatory infiltration of the intestinal coats. Distension and paralysis of a portion of the canal generally occur in patients advanced in age, and the large intestine is the usual seat of the obstruction. At the time of the operation the condition of the patient appeared very unfavourable, but after a careful examination of all the details of the case, right lumbar colotomy seemed to offer the best prospect of relief, and this opinion was based upon the following considerations:—1. The great distension of the abdomen and the early development of meteorism. 2. The negative result of rectal exploration, and the capacity of the lower bowel for retaining large injections of hot fluid. 3. A well-marked localised fulness and resistance on palpation over the umbilical region. This swelling was elastic and not doughy in character. 4. The age of the patient, the clear evidence of constipation for many months, and the absence of other indications of abdominal disease.

¹ THE LANCET, 1889 vol. ii., pp. 1061 and 1211. Mr. Bryant: Bradshaw Lecture.

A MORTUARY FOR THAMES DITTON.—At a meeting of the Kingston Rural Sanitary Authority it was reported that the plans and estimates for the erection of a mortuary at Thames Ditton had been under the consideration of the vestry. The Lord of the Manor had made a grant of a suitable piece of land for £10, and the vestry wished for the sanction of the Sanitary Authority to carry out the work. The board sanctioned the work, the expenses of which, however, were not to exceed £100.

¹ Estimated mortality 82 per cent.

² Guy's Hospital Reports, vol. xiv.

³ Ibid.

⁴ Encyclopædia of Surgery, vol. v. p. 879.

⁵ Medico-Chir. Soc. Trans., vol. xxvii., 1844.

⁶ Clin. Soc. Trans., vol. xiv.