

passed no solid motion. He had sometimes gone to stool as often as sixteen times in the day, but nothing had passed except slime and blood. His abdomen had been distended more than once, but was on admission larger than ever. On Monday, for the first time since the onset of his symptoms, he passed a tolerably solid stool, and since then he has not been to stool. He has taken no food except a little milk and tea. On Tuesday and the whole of the following day he vomited continually; the vomit was brown and offensive to the taste and smell. On the day before admission he passed a little flatus and a little slimy motion.

On admission he was much emaciated. His face and hands were of a dusky-red colour. His hands and feet were cold and bluish. The tongue was dry and covered with white fur. The abdomen was moderately hard, the distension being as great in the lateral parts as in the centre. There was no pain on handling. The coils of the intestines could be seen and felt, but there was no visible peristalsis, even after lightly rubbing the surface, but the patient said he had seen a creeping movement. No gurgling could be heard. The patient was troubled with hiccough and passed a good deal of flatus, especially when speaking. Mr. Bryant passed his finger into the rectum and found a stricture "very much resembling an os uteri."

*Operation.*—On June 18th, under chloroform, a transverse incision four inches long was made midway between the last rib and the iliac crest. The vessels were twisted; the fascia and fat were drawn aside, and the bowel when exposed was secured to the edges of the wound by two silk sutures. The gut was opened, and each of the sutures divided in the middle, and the four corners of the gut were tied back. The wound was dressed with terebene lint and a binder applied. One vessel in the wall of the gut was ligatured. Opium suppository.—20th: Passed a good night, and feels quite comfortable; is taking milk. Temperature 100.2°. Opium pill, one grain three times a day. The posterior sutures seem to have slipped, and there is a good deal of fecal matter about the wound. There was an enormous discharge of feces after the operation, and the abdomen has gone down to the natural size.—23rd: Looks very much better; he has lost the dusky hue of face, and coldness and blueness of the extremities. The tongue is now quite clean and healthy. Is taking milk and arrowroot and beef-tea. Temperature and pulse normal, and the patient is free from all pain. The remaining stitches were removed.—27th: Complains of great pain in the left side. Appetite continues good; the wound looks healthy. Temperature 99°.

July 13th: Temperature normal. There is prolapse of the bowel, but the wound looks well, and the patient is otherwise better.—26th: Daily passes motions per rectum. The colotomy wound nearly healed.

Aug. 13th: Allowed to put his clothes on and walk about.

Sept. 5th: Urine examined; large quantity of urates, no albumen. Colotomy belt supplied.—7th: Discharged. The patient has a perfect artificial anus, and, with the exception of a slight pain across the lower part of his back, is quite comfortable. His general health is good. He relieves his bowels twice a day, and has no inconvenience from the feces escaping.

#### CASHEL UNION HOSPITAL.

UNUSUAL TERMINATION OF MORBUS COXÆ; DELIRIUM;  
CONVULSIONS; AMAUROSIS; DEATH.

(Under the care of Dr. LAFFAN.)

M. D—, aged fifteen, a scrofulous young labourer, was admitted March 14th, 1881, for morbus coxæ in left side. The disease was in the first stage. He was put up in Sayre's long-extension splint (figured in page 269 of Dr. Sayre's work on "Orthopædic Surgery"). This splint, though applied with the greatest care, could not always be borne, and it had to be now and again removed. When the boy was confined to bed he scarcely ever complained of it, and the relief it afforded to the pain was very marked. Though at first, and for some weeks, the same immunity from pain was enjoyed when taking exercise, which he was freely allowed to do in the hospital grounds, yet afterwards the apparatus had to be removed from time to time and the patient allowed to rest in bed. Cod-liver oil and syrup of the phosphate of iron were given internally, and counter-irritation was locally applied. On this treatment he pro-

gressed fairly for some months, but an abscess formed on the front of the thigh which appeared to be connected with the joint; and from this there was a perceptible declension in his condition. Diarrhœa was the most prominent intercurrent symptom, and for this no obvious exciting cause could be assigned.

From the end of August meat had to be stopped on account of diarrhœa.

By Sept. 1st his appetite had almost entirely disappeared. From the 1st to the 3rd he scarcely took anything; on the 4th a violent frontal headache set in, which continued for a whole fortnight, with nocturnal remissions. On the 12th, 13th, 14th, and 15th he was seized with uncontrollable vomiting. On the 17th delirium, with occasional convulsions, set in, and these continued at intervals for about three days, during all of which time he was entirely unconscious. At the termination of the convulsions he was found to be completely amaurotic. On one of those days he vomited a large worm.

From this time forward till the date of his death (Oct. 5th) the vital powers rapidly failed. There was occasional severe vomiting, with delirium and severe convulsions from time to time. On Sept. 26th it was noted that he picked his nose so violently that his hands had to be tied. Floccitation and involuntary evacuations preceded the final scene for some days. Delirium and convulsions were present from time to time, and unconsciousness, which from its first invasion had at intervals been present, became profound and permanent, and closed the final death scene.

*Remarks.*—The treatment pursued in this case did not realise the benefits predicted for it by Dr. Sayre; but, on the other hand, no connexion could be traced between it and the strange cerebral symptoms which carried off the patient. Were it not for a case reported by Dr. Graves in his clinical lectures, and for a few similar ones recorded since then in which cerebral symptoms just as marked as those in my case were present without any cerebral mischief whatever, and where abdominal lesions only were demonstrated after death, it would be deemed absurd for anyone to question the presence of cerebral disease in the foregoing case. Unfortunately no post-mortem examination was obtainable, and I can only therefore indulge a speculation as to whether intestinal worms might not have been responsible for all the head symptoms. Suitable vermifuge treatment was, of course, tried and persisted in from the moment of the first discovery of the worm; but this was barren of result so far as the expulsion of any others was concerned. The case is of some little interest on account of the unusual termination of hip disease it presents, and of the important question of the simulation of profound centric lesions by peripheral irritation, which it at least will recall to the mind of the thoughtful reader.

#### OBSCURE THORACIC TUMOUR.

(Under the care of Dr. LAFFAN.)

The following case possesses the interest which always attaches to those in which certainty of diagnosis is impossible. Positive signs of tumour were absent, but the intermitting dysphagia, pupillary contraction, and inequality of radial pulse, afforded a reasonable presumption of the presence of an intra-thoracic growth. Whether this, however, was cancerous or aneurismal the existing signs and symptoms did not afford means for discriminating. There were present and absent those that pointed both ways; while the last fatal hæmorrhage pointed more towards aneurism, the absence of the peculiar cough, cardiac murmur, &c., told the other way. A post-mortem examination would have solved the difficulty; but the law must deal more liberally with Poor-law hospital physicians if these are to be available when the interests of humanity and science demand. This fact Dr. Laffan has in vain brought under the notice of the Collective Investigation Committee.

N. W—, labourer, aged sixty-four, was admitted on Feb. 8th, 1882. He had, for five weeks before admission, felt the food and drink stop in the passage, and had to be immediately ejected. At other times both food and drink passed down. The first time he noticed the difficulty was on the occasion of taking a pint of porter. During the five weeks previously referred to, when the food and drink did sometimes pass, it was with some difficulty. He was of intemperate habits, and lived, of course, poorly. He had not sustained any injury, and had not had syphilis.

*Present state.*—March 24th: His general appearance is somewhat wasted, particularly about the face. He sleeps

well. He complained of a lightness in his head for the past ten days. His sight is weak; the right pupil is larger than the left. The tongue is somewhat coated and full of transverse indentations. The left pulse is much fuller than the right. Some râles in chest; he coughs a little and expectorates; some slight bronchitis exists; heart sounds normal. The appetite is becoming poorer; he spat up this morning about a wineglassful of blood. On four or five occasions he spat up a trifling quantity; bowels very costive, and not moved without medicine. Urine, specific gravity 1020; no albumen. Soon after his admission a probang was tried, but failed to pass the entire way, and when drawn up was found covered with blood and pus. For the last few days he suffered considerable pain in the epigastrium, between the two scapulæ and in the right shoulder. No other signs could be detected.

*Further history.*—The respiration continued high; the troublesome cough persisted; lightness in the head and weakness of sight occasionally assailed him; the appetite gradually decreased. There was occasional hæmoptysis, sometimes a large and at other times a small quantity of blood being spat up. Pus was spat up on more than one occasion mixed with the blood. He continued to suffer from dysphagia, but inconstantly, as at times the food passed readily. Decubitus was on more than one occasion rendered impossible by the severity of pain between the shoulders. He complained of great coldness in the feet. On April 15th he spat up a great quantity of pus; on that day, and for two days previous, he suffered from a most harassing cough. During the night of the 15th he spat up five or six times a small quantity of pure blood; on the 16th he suddenly spat up a large quantity of blood and died immediately.

*Remarks.*—The treatment in this case was directed to meet symptoms, and any detailed account thereof would convey no information. From first to last bronchitic and emphysematous signs alone were detected. There was nothing detected by auscultation or percussion which could clearly point to the existence of cavity or tumour, and the exact diagnosis therefore must remain in doubt.

#### STANLEY HOSPITAL, LIVERPOOL.

FRACTURE OF HUMERUS, WITH DISLOCATION AT RIGHT SHOULDER AND ELBOW.

(Under the care of Mr. ROBERT JONES.)

R. P.—whilst plastering a lofty ceiling fell, and in falling grasped at an open door. He came next day to the Stanley Hospital suffering from dislocations of the right shoulder and elbow with fracture through the middle of the right humerus. The head of the humerus was felt beneath the clavicle. The radius and ulna were dislocated backwards, and the fracture was oblique. Splints were temporarily adjusted in order to permit of the necessary manipulations for reducing the luxations. This was easily completed without the administration of ether, the splints were readjusted, the arm placed in a sling, and the man requested to attend as an out-patient. In six weeks from the date of injury consolidation had taken place, and movement both at elbow and shoulder was free and painless.

In treating the case it was thought wise to fix the elbow so as to restrain all movement, as signs of effusion appeared on the third day. This, however, was rapidly absorbed. The reductions were easily accomplished by gentle manipulations. The patient had at previous times dislocated both hips, and on three occasions the left shoulder.

BRISTOL GENERAL HOSPITAL.—This hospital, which has been closed for rather more than six months for the purpose of reconstructing the drainage of the building, substituting wood flooring for concrete in the wards, and carrying out other improvements, was reopened on the 21st inst. The cost of the improvements is about £8500; of which £3100 is taken up in the sanitary arrangements, £3200 in the wood flooring, and about £2200 in the painting and other matters. Nearly half of this sum has been paid out of last year's revenue account; and it is hoped that the balance will be raised by subscriptions, and that its liquidation will not compel the committee to sell part of the funded stock of the institution, and thus curtail its already insufficient income. The hospital, which was originally built about thirty-five years ago, was thrown open for public inspection on the afternoon of the 23rd inst.

## Medical Societies.

### ROYAL MEDICAL & CHIRURGICAL SOCIETY

*Congenital Syphilis of the Larynx.*—*Purulent Pericarditis treated by Paracentesis and by Free Incision, with Recovery.*—*Paracentesis Pericardii.*

THE ordinary meeting of this Society was held on the 24th instant, Professor J. Marshall, F.R.S., President, in the chair. At the commencement of the proceedings the President announced that the Council proposed the following gentlemen to fill the vacancies among the honorary Fellows: Dr. W. B. Carpenter, F.R.S., Professor W. K. Parker, F.R.S., Dr. Ed. Frankland, F.R.S., and Dr. Allen Thomson, F.R.S.; and as Foreign Honorary Fellows Dr. H. I. Bigelow of Boston, Professor Charcot of Paris, Professor Du Bois-Reymond of Berlin, and M. Pasteur of Paris. The business consisted of a paper by Dr. Percy Kidd on congenital syphilis of the larynx, and two papers dealing in a most thorough manner with the subject of paracentesis pericardii, by Dr. Samuel West, in which he gave details of a successful case of free drainage for purulent pericarditis (being the second on record), and a full analysis of seventy-nine cases of pericardial paracentesis. Time did not permit of very full discussion of the numerous points of interest raised.

The following is an abstract of the paper on Two Cases of Congenital Syphilis of the Larynx by Dr. PERCY KIDD. The author said the ages of the patients here described were fifteen and eighteen at the time of observation, but symptoms developed at the ages of fourteen and thirteen respectively. In the first case, where laryngitis seemed to have appeared a few months previously, great improvement followed the administration of iodide of potassium. On the contrary, in the second case, where the laryngeal disease was of five years' standing, there were webbing of the vocal cords and polypoid excrescences in the larynx, and here no benefit could be expected from internal remedies. Case 1 is a boy aged fifteen. The family history is indefinite. Mother said to be subject to "rashes." There was a history of cough and shortness of breath for nine months. Three months previously the boy's breathing had become stridulous, and shortly afterwards some dead bone came away from his palate. For three days his breath had been very short and he had lost his voice. The patient is small for his age, speaks in a hoarse whisper; upper incisor teeth distinctly pegged; corneæ clear. No cutaneous eruption or scarring. Chest small; superficial veins distended; supra-clavicular spaces drawn in during inspiration. Very slight dulness at both apices, and weak bronchial breathing. Breath sounds generally feeble. Marked scarring of soft and hard palate; scars whitish; surrounding tissue dull red. Larynx: mucous membrane throughout of a dull red colour. Vocal cords red and thickened. Ventricular bands and aryepiglottic folds swollen, partially hiding the vocal cords. Movements of the vocal cords diminished greatly; abduction and adduction very imperfect; considerable stenosis of the glottis from swelling of parts and fixation of vocal cords. Rapid improvement under iodide of potassium and inhalations of benzoin. Recovery with slight degree of chronic laryngitis and partial fixation of left vocal cord. Case 2 is a girl, aged eighteen. Family history negative. Onset of symptoms sore-throat and hoarseness at the age of thirteen. The patient attributes the throat affection to some medicine she was given while an in-patient at the French Hospital in Leicester-square soon after her symptoms developed. Reasons are given for doubting this. This patient has been hoarse for five years. The chest shows no sign of disease. Lateral incisor teeth somewhat pegged. Palate, pharynx, and left tonsil marked with whitish scars. Larynx: epiglottis thickened and bent backwards towards the larynx; margin irregular and jagged as if partially eaten away; mucous membrane of epiglottis pale; no present ulceration. Vocal cords adherent to one another at their anterior extremities by a web of a reddish-grey colour. On the left cord at its posterior third is a small conical outgrowth. The posterior part of the right ventricular band is occupied by a roundish red swelling, which projects downwards and hides part of the corresponding vocal cord. The left ventricular band at its