

constable who brought the patient to the hospital said that he found him lying in a pool of blood on the floor of a room in a house in a neighbouring street. A razor lay on the floor about a yard distant from him. He was conscious and breathing quietly. He asked "Where am I?" To the question "Who did it?" he answered in a loud whisper "Me." On the table in the room was a note in his handwriting leaving his body to the hospital, "as it is not worth burial." The gash was not quite central, but it reached rather more to the left than to the right side of the neck. Its length was about five centimetres and it gaped about two centimetres at its middle. Its edges were ragged, and when drawn apart a deep irregular hollow was apparent, the back of which was formed by the prevertebral muscles and vertebral column, on which were seen the lowest part of the pharynx and the œsophagus. The former of these, near its junction with the latter, had in it a wound two centimetres long, opening its lumen. When the upper tegumental margin of the deep gash was raised the upper part of the severed cricoid cartilage came into view; it, with the higher laryngeal structures, had been drawn up within the mandibular arch. The division of the cricoid cartilage had been effected by a succession of sawing cuts, which had also detached completely several small pieces of it which were lying loose in the wound. The lower part of the cricoid cartilage in connexion with the trachea had retracted so much towards the root of the neck that it could not immediately be seen, but with a laryngeal mirror it was recognised at the level of the upper opening of the thorax. First, bleeding having been completely arrested, the cut in the gullet was closed with three sutures. Next, the lower part of the cricoid cartilage was seized with a vulsellum forceps, pulled up and drawn forwards to the level of the margins of the tegumental wound, which made it possible without risk of suffocation to flush out the deeper recesses of the wound with mercuric perchloride solution. This done the upper and lower parts of the larynx were united with two stout silk sutures on each side passed through the cartilages. These held the parts of the larynx firmly together. A large Trousseau's tube was previously inserted in the trachea. A little iodoform was dusted upon the cut surfaces of the wound and this was protected from direct exposure to ward atmosphere by a couple of layers of carbolised gauze strained over an improvised wire cradle serving as a respirator. Little pieces of ice from time to time placed in his mouth seemed to assuage thirst, which by signs he indicated to be very great, nutrient suppositories and enemata were ordered. Throughout the day he was quiet, but at 11.30 P.M. he grew restless, and he tried to leave his bed. For this one-third of a grain of acetate of morphia was hypodermically injected. After this he was again quiet. At 2.30 A.M. on the 16th (next day) death occurred.

At the necropsy, in addition to the laryngeal injuries mentioned, several cuts were found in the thyroid cartilage, especially on the right side, passing completely through it; the arytenoid cartilages had been severed from the cricoid and the right true vocal cord was divided. The bronchi and lungs were found congested, the right lung deeply so, and the left lung emphysematous. In the anterior mediastinum were calcified remains of a caseated lymph gland. The aorta was slightly atheromatous. The left testis had not descended; it was atrophied.

MORPETH DISPENSARY.

CASE OF ACUTE YELLOW ATROPHY OF THE LIVER; NECROPSY.

(Under the care of Mr. STANLEY YEOMAN.)

ON account of the extreme rarity of the above disease and the unprecedented age at which it occurred, a record of the case will prove of value. Bristowe writes: "Cases of malignant jaundice have been observed chiefly in adults and in women more frequently than in men. But children are now and then attacked with it, and we have recently seen a typical case in a child two and a half years old." Greves described a case in a child aged twenty months. The characteristic symptoms of the disease in Mr. Yeoman's patient were well-marked absence of febrile temperature with the presence of hæmorrhages in the skin and from the mucous membranes and an unusual amount of jaundice. No

cause could be ascertained for the onset of this rapidly fatal disease, the etiology of which is still unknown.

M. M—, aged ten months, was first seen on Monday, Feb. 23rd, 1891. The family history was good, except that a sister and brother of the father had died of phthisis. The mother had always had good health although she was a thin and weakly-looking woman with little colour. This was the eighth child; she had lost only one previously. The child had always been considered healthy, but had had a slight attack of bronchitis two months ago. The infant, a fine, healthy-looking child, was suffering from jaundice, which had been noticed by the parents the day before (Sunday). Up to that time she had been in good health. There had been some slight vomiting on Sunday, but nothing serious enough to make the parents uneasy. On examination the child appeared remarkably fine for its age and was well nourished, but suffering from well-marked jaundice, the conjunctivæ being more markedly stained than the skin. There had been some slight vomiting the day before, but none since. The tongue was slightly coated; the bowels had been opened the previous day, the motion being soft and of a pipe-clay colour; pulse and temperature normal; abdomen normal; lungs and heart normal. On Tuesday (the 24th) the jaundice had increased in intensity, and there was some hæmorrhage from the gums, the blood being particularly dark in colour; several petechiæ were observed on the back. The edge of the liver could be made out well under the ribs, and the area of hepatic dulness was diminished. The skin was cool and dry; temperature normal. The pulse varied in frequency. No vomiting. Only a very small quantity of urine (about one drachm) was obtainable, which was of a yellow colour with a greenish-yellow sediment. A play of colours was obtained with nitric acid. The child was evidently worse, and inclined to be restless. The next day the jaundice was still more marked; the child was considerably worse, and very drowsy. The bowels had not acted. The tongue was black, there was considerable hæmorrhage from the gums, and dark blood was issuing from the mouth and nose. Besides the petechial spots on the back there were now several on the arms and legs. The temperature was subnormal and the liver dulness appeared less. No vomiting. The child rapidly sank, and died in the afternoon. During the attack the pulse varied considerably, being usually over 100 per minute. The highest was 120, the lowest 60, per minute. The head symptoms were not marked. There was some slight restlessness at the commencement of the attack and drowsiness towards the end. The treatment at first consisted in large doses of sulphate of magnesia and carbonate of magnesia. On the Tuesday five grains of mercury with chalk were given. The bowels only acted once after the child was taken ill; this, no doubt, was partly due to the fact that the parents neglected to give the medicine regularly.

Necropsy, eighteen hours after death.—A well-nourished child with marked jaundice. There were six large extravasations of blood on the back, from about the size of half a crown to a four-shilling piece. There were fifteen small spots on the left leg, two on the right leg, two on the left arm and seven on the right arm. These were from about the size of a threepenny piece to a sixpence. The heart and lungs were normal. The liver was well under the ribs and very small slightly wrinkled and flabby. The wrinkling increased a few hours after removal. The gall-bladder contained a small quantity of light-coloured fluid. There was no obstruction in the ducts. The lobules were obliterated. Weight seven ounces. The spleen weighed one ounce and a half. There was a small supplementary spleen. The right and left kidney weighed one ounce and three-quarters each. The heart weighed an ounce and a half. The stomach and intestines contained a fair amount of blood, and there were slight extravasations into the coats of the intestines. The large intestine contained hard grey fæces. Other organs were normal in appearance. Mr. Shattock examined a specimen of the liver microscopically and reported thus: "The sections show no trace of hepatic tissue, but simply granular detritus. I should consider it certainly an example of acute yellow atrophy."

Microscopic appearance of the blood.—The red corpuscles were very granular and irregular, and showed no tendency to form rouleaux. The white blood cells were greatly increased in number. There were crystals of tyrosine and cholesterine.

Remarks by Mr. STANLEY YEOMAN.—This case I consider shows in a remarkable manner the close similarity that subsists between phosphorus poisoning and acute yellow atrophy of the liver, a similarity that has led some to

suggest that the two are identical. In arriving at the diagnosis a careful exclusion of the possibility of phosphorus poisoning was perhaps the most important evidence. This was carefully confirmed at the post-mortem examination, since there was not even a minute trace of phosphorus in the stomach or intestines. Another point in the case was the absence of vomiting, which is so characteristic of phosphorus poisoning. On the other hand, the cerebral symptoms were not so marked as might have been expected. One of the most interesting points noticed during life was the remarkable variation in frequency of the pulse. The temperature, nevertheless, never rose above the normal. Considering the readiness with which the temperature rises in children from slight causes, this was well worth noting. Unfortunately, a fair specimen of the urine could never be obtained for careful examination. Finally, I may say that the extremely rapid change in the hepatic tissue, the quick termination of the case, the absence of vomiting, the unlikelihood of a child of that age obtaining phosphorus, and the rarity of phosphorus poisoning, all negative the idea of any foul play. Dr. Philip very kindly attended the case throughout with me, and I have to thank him for many of the above notes, which, unfortunately, I feel are far from complete, as the circumstances surrounding the patient considerably handicapped us.

GOONA HOSPITAL, INDIA.

ABSCISS OF THE LIVER; OPERATION; RECOVERY.

(Under the care of Surgeon-Captain SHAW.)

THE following case illustrates the treatment of hepatic abscess by direct incision and drainage from the side through the abdominal wall, adhesions having taken place between the apposed surfaces of peritoneum. It has been stated by Kartulis that the pus of hepatic abscesses following the dysentery of hot countries does not contain micro-organisms, and that therefore, should any escape into the peritoneal cavity during operation, peritonitis is not likely to ensue. It is almost impossible to exclude dysentery as a cause of the abscess, for not infrequently, although there has been no history or symptoms of that disease in fatal cases, it has been found that dysenteric ulceration of the bowel was present.

L. C—, aged thirty-four, was admitted on April 19th in a feeble and emaciated condition with the following history. Eighteen months before admission he had a severe attack of fever (malarial) lasting three months. He completely recovered, excepting that after meals he was troubled by a sense of weight and uneasiness in the gastric and hepatic regions. Some months afterwards, whilst kneading his abdomen, he noticed a swelling over the liver, and there was slight pain. More than a year elapsed when the pain became so severe that he was obliged to come into the hospital for treatment. He had never had dysentery or syphilis. His condition on admission was as follows:—Very thin, emaciated, and so weak that he could not sit up in bed; pulse 120 and thready; severe constipation, with scanty clay-coloured stools; tongue flabby and pale, except where discoloured with dark patches; complexion muddy looking. No vomiting or cough had troubled him at any time; no purulent matter had been passed per anum. The hepatic dulness reached downwards to the level of the umbilicus, but was not increased upwards. The enlargement was wholly confined to the right lobe. The patient complained of severe headache, and his temperature rose every evening to 100° or 101°. He was ordered a purgative and some "hepatic mixture," with quinine. A severe burning pain in the liver was eased for the time by a blister. Some days later the assistant surgeon tapped a very distinct bulging just below the ninth rib, drawing off twenty-four ounces of pus, and thereby giving much relief.

May 6th.—Again tapped, thirty-two ounces of pus being drawn off.

10th.—Tapped; twenty ounces taken out.

12th.—Eleven ounces more drawn off, making a total of eighty-seven ounces evacuated by the trocar.

After this the pus continued to ooze out of the trocar openings, until the patient was seen by Surgeon-Captain Shaw on May 17th. He was then terribly pulled down, could not sleep, but had no night sweats. The skin over the liver was tense and red and was bulged out, but fluctuation was absent. The pus discharged was very foul. Over the base of the right lung rough friction sounds and small

crepitations were heard, but there was no dulness. As no opening had established itself between the liver abscess and the intestinal canal or the lung, and as the pus would force a passage for itself sooner or later, it was determined to drain the cavity. A probe put into one of the trocar openings followed a sinus running subcutaneously upwards and backwards for three inches and a half. Under chloroform the abscess cavity was explored through one of the openings just below the ninth cartilage, which was about four inches and a half long, two inches and a half broad, and ran obliquely backwards and inwards; its mouth was about one-third of an inch in diameter. A three-inch incision was made parallel to and just below the thoracic margin. The peritoneum was adherent to the abdominal wall; one small vessel was tied, and the necrosed tip of the ninth cartilage, which lay close to the opening, was snipped off. With the operator's finger the walls of the cavity were felt to be ragged and slimy, and about six or eight ounces of chocolate-coloured pus gushed out, mixed with what looked like lumps of white fibrin and with large blood-clots. The cavity was then washed out with 1 in 4000 sublimate solution, half an ounce of iodoform and strips of lint soaked in iodoform emulsion put in, and finally a large drainage-tube and dry dressing, which completed the procedure. Speed was imperative owing to the critical condition of the man. His temperature rose that evening from 97·6° to 100·8°.

21st (the day after the operation).—Morning temperature normal, evening 102·2°; pain much less. A little pus was syringed out of a small recess, which was opened into by the probe. There was no foul smell. The remainder of the case can be shortly stated. For two days after this the temperature rose to 101·2° and 99·8° in the evening, being normal in the morning. The cavity was syringed out daily, the discharge soon ceased, but the drainage-tube and strips of lint were kept in, chiefly to prevent the mouth from closing. Surgeon-Captain Shaw is of opinion now that they might have been removed long before they were. The tube was shortened as the cavity got shallower and narrower. The man himself frequently took out the tube when the surgeon's back was turned and persisted in squatting on his "hunkers" to eat his meals. Thinking himself quite well he left the hospital on the night of June 9th, but was taken back next day none the worse for his exertions.

June 18th.—Tube removed; cavity almost filled up. Liver dulness quite normal and base of right lung quite clear of adventitious sounds. The man has got quite stout. There is now only a very small opening left, through which a little serous discharge comes. He is about to return to his field work in a few days. He will have been about eighty days under treatment.

Remarks by Surgeon-Captain SHAW.—There is nothing definite to point to the exact cause of the disease. The frequency with which the pus had to be drawn off shows how quickly it accumulates in these abscesses and, what is more important, shows, I think, how likely any incomplete measure, such as tapping or aspiration, is to prove a failure. In my opinion waste of time and tissue might have been saved in this case by early incision and drainage. I do not quite understand why the opening of a liver abscess externally below the ribs should be looked on with so much alarm, for, I should suppose, peritoneal adhesions are almost certain to have had time to form.

HULL ROYAL INFIRMARY.—The chairman and managing committee of the Hull Infirmary have received a communication from Messrs. Reckitt, in which the writers express their intention of presenting the Withernsea hotel and grounds to the hospital as a convalescent home. The authorities, in acknowledging the generous gift, express their sense of the benefit the donation will confer on the sick poor of the neighbourhood.

THE NEW HOSPITAL AT HALIFAX.—After some delay the work of erecting the new infirmary seems to have entered a more satisfactory phase. A site, fourteen acres in extent, has been purchased, and the subscriptions already promised, along with the proceeds of the sale of the old infirmary, will, it is believed, be sufficient to cover the cost of the new hospital. The scheme formulated at the outset provides for from 130 to 150 beds, and it is proposed to build an administrative department on a scale sufficient for a hospital of 300 beds should funds be available for that extension.