

his appetite was gone, and that on exertion he became short of breath, which symptoms had increased up to the time I saw him. After working two or three days, he found that he had great difficulty in passing his urine, and that when he did so the urine was scanty, very dark-coloured, and smelt strongly of almonds. His bowels were also constipated. During the week he had exacerbations of these symptoms shortly after mixing or sieving the explosive. I administered stimulants, and had the man put into a warm bed. The next morning the patient was decidedly better, but still very blue in the face and finger-tips. He told me he had not passed urine for twenty-four hours, and that he had frequently not done so for a similar period since working at the manufactory; during the day, however, he passed a small quantity, having a strong smell of almonds. During the week the blueness of the face &c. gradually disappeared and micturition became normal, and he returned to his usual state of health.

There have been five men employed at these works, of whom three have been under treatment for poisoning,<sup>1</sup> and all the patients recovered on being withdrawn from this work.

Sicherheit appears to be nitro-benzene  $C_6H_5(NO_2)$ , or dinitro-benzene  $C_6H_4(NO_2)_2$ , derived from benzene or benzol  $C_6H_6$  by the substitution of  $NO_2$  or  $(NO_2)_2$  for one or two atoms (as the case may be) of the hydrogen of the benzene. Nitro-benzene or dinitro-benzene is made by acting on benzol with nitric acid. The smell of almonds to which the patient particularly drew my attention is remarkable, and is easily accounted for: the alcohol  $C_6H_5 \begin{smallmatrix} CH_2 \\ | \\ H \end{smallmatrix} O$  benzol alcohol may be obtained by acting on oil of bitter almonds ( $C_6H_5COH$ , aldehyde of benzyl group) by alcoholic potash, &c. Rotherham.

#### ABSENT RECTUM IN AN INFANT.

BY OWEN PRITCHARD, M.D.

WELL-AUTHENTICATED cases of successful colotomy, or Littre's operation for absent rectum in infants, are, I believe, rare, and my notes of the following case may be of interest.

On May 6th I was sent for to see Mrs. B——'s baby, a boy nearly forty-eight hours old. The mother had been attended in her confinement by a midwife, who stated that, although soap injections had been used, the infant's bowels had never acted, there had been constant vomiting since birth, and that he was now sick unto death, and certainly he looked like it. On examination, the child was found to have the anus and lower part of the rectum perfectly normal, but, on passing the finger an inch or an inch and a half up, the bowel was found to end in a cul-de-sac, and no pulsation or any evidence of bowel above could be felt when the infant cried, though there was enormous distension of the abdomen; it was therefore thought perfectly hopeless to attempt any operation from below, the only alternative being colotomy. The left groin was selected as the most convenient situation for an artificial anus. The child being placed under the influence of an anæsthetic, the operation described by Littre was performed. As soon as the abdominal cavity was opened the bowel protruded prominently, and after being well secured by carbolised silk sutures to the peritoneum and skin, it was opened, when a free motion was immediately passed. The sickness stopped, the distended abdomen became flaccid, and in another twenty-four hours the infant began to look healthy and to take its bottle greedily. On May 8th the bowel had prolapsed about an inch and a half, but was returned after some difficulty, and the nurse was ordered to be more careful in keeping a firm pad over the opening to prevent another accident. Things went on well until May 20th, when I was asked to see the child. The nurse having neglected her instructions, I found the bowel had again prolapsed, this time two or three inches, and had been down some considerable time; it looked almost black, was swollen and bleeding, and was not reduced without great difficulty. After this everything went on well, the little patient looking very healthy and strong.

The tendency to prolapse in such cases, it seems to me, is a difficulty likely to continue, and to remain a source of anxiety and possible trouble in the future; and had I adopted the plan suggested by Mr. Allingham, of drawing

down the bowel as far as it would come before opening the same, the operation might probably have been equally successful and this permanent source of danger avoided.

Southwick-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.

### ST. GEORGE'S HOSPITAL.

A CASE OF LEPROSY; DEATH FROM PNEUMOTHORAX;  
REMARKS.

(Under the care of Dr. CAVAFY.)

WE published in a recent issue of THE LANCET notes of a case of leprosy which had proved fatal from pyæmia, and in which the laryngeal disease necessitated the performance of the operation of tracheotomy.<sup>1</sup> We give below notes of another case of typical character which was under observation in London, the patient dying from pneumothorax secondary to tubercular disease of the lungs. Death in these cases seldom occurs directly from the disease itself—dysentery, renal or lung disease being the commoner causes of a fatal ending. No danger to the other patients results from a case of leprosy in a ward of one of our modern hospitals, and the few cases which come under observation in London are better treated in the general wards than they would be in a special ward set apart exclusively for the treatment of such cases. Leprosy is regarded as an incurable disease, and the record of a single case of recovery does not justify the giving of other than a bad prognosis. The contemplation of patients suffering from a more advanced condition of the same malady, with all its worst features, could not fail to produce an amount of mental depression most harmful to those in the earlier stages, and the combating of this mental state is already a difficult task in those who know the nature of their disease. We are also of opinion that for purposes of clinical teaching it is better that such cases should be distributed as much as possible amongst the hospitals to which medical schools are attached. We are indebted to Mr. E. Le Cronier Lancaster, M.B., M.Ch. Oxon., for the notes of the following case.

William R——, aged twenty-four, was admitted into the William King ward of St. George's Hospital on Aug. 25th, 1888. His family and personal history were good. As far as he knew, there had been no phthisis in his family. His parents are English, but he was born on the Coromandel Coast, and when a baby was taken to St. Thomas's Mount in the Madras Presidency, where he remained until seven years of age, when he came over to England. He enlisted as a drummer-boy at the age of fourteen, and again went out to India at the age of sixteen, and was quartered in Bellary, in the Madras Presidency. He had only been there five months when he first (March, 1880) noticed swellings on both cheeks. The swellings were about the size of large marbles; they remained for about six weeks, and then disappeared. Swellings about the same size then appeared over the front of both thighs, and were so painful as to prevent his walking. A continued fever next attacked him, and lasted three months; he says the doctors never could get his temperature down, and that he was in a "continual heat." He was in the hospital from the end of March, 1880, until the August of that year. As he was still very weak, he was sent up into the hills to do infantry duty, and remained there nearly two years. No new swellings appeared, but the sites of the former ones grew quite dark, the pigmentation remaining for some months. He was then sent back to Bellary, and soon afterwards had another continued fever lasting about three months. In 1884 new swellings appeared on his back and on his legs. In 1885 he noticed that his voice altered and became hoarse, and the alteration has been permanent. In

<sup>1</sup> Brit. Med. Jour., July 20th and Aug. 3rd.

<sup>1</sup> THE LANCET, vol. ii. 1889, p. 166: Mirror of Hospital Practice.

1886 the first phalangeal joints became much enlarged. In the same year he was again in the hospital, this time for laryngeal catarrh, and whilst there noticed that lumps developed very rapidly—"in the course of a few hours"—over his chest. According to his own account he was then for the first time diagnosed as having leprosy, by a civilian doctor. He was discharged from the army in August, 1887, and since his discharge the swellings have become much more numerous. He has never noticed any anæsthetic patches. He says that the swellings "come and go," and he has noticed them develop, especially whenever he is constipated. Since leaving the army he has lost much flesh. For the last three weeks he has had a bad cough, and sweats much at night. He is subject to attacks of general pruritus, coming on about once a month, and lasting for two or three days. He complains of increasing weakness, but thinks that of late the leprosy has not increased, and considers that he has good general health.

*Condition on admission.*—Looks much older than he is—say fifty-five. Has a typically leonine aspect. The skin of the face is yellowish, shiny, and smooth. He has no moustache, whiskers, or eyebrows. There are a few hairs under the skin. The conjunctivæ are slightly yellow. There is much thickening of the subcutaneous tissue of the eyebrows, nose, cheeks, and ears. The lobes of the ears are enlarged, flabby, and pendant. There is hardly any bridge to the nose. The facial furrows are much deepened. The tongue shows three small patches near the tip.—Thorax: Skin smooth and yellowish. There are numerous discrete copper-coloured tubercles, situated in and just beneath the skin, scattered universally over the front of the trunk. There is a scab on an inflamed base on the right elbow, and a large red scaly patch resembling psoriasis over the left elbow.—Arms: Very numerous tubercles, varying in diameter from a pin's head to a fourpenny-piece, on the extensor surfaces of the upper arms, also several maculæ; these maculæ are of various shades of pigmentation—red, brown, black, and a few white. The skin over the backs of the hands and wrists is thickened, red, and in parts scaly. The first phalanges are enlarged, seemingly from skin-infiltration. The nails are all cracked and broken.—Abdomen shows numerous tubercles and maculæ.—Back: There are numerous tubercles and maculæ, especially over the buttocks. Some of the maculæ display a white centre, surrounded by a dark ring.—Legs: Tubercles are scattered all over the thighs. In each ham is the scar of an old ulcer. There are four ulcers over the ankles and lower part of the legs. The largest of these is about four inches long by two inches broad. They have a sodden, white, raised margin, are covered with feeble granulations, and exude much pus. The skin of the foot has a tendency to peel, and the nails are badly nourished.—There are two or three small anæsthetic patches on the extensor surfaces of the arms, one of which is not larger than a pea. Nothing abnormal was detected in the heart or abdominal viscera. A few doubtful clicks were heard at the apices of the lungs. The throat was examined with the laryngoscope, the mucous membrane of the aryteno-epiglottidean folds was thickened and tuberculated, and prevented any view being obtained of the vocal cords.

*Course and treatment.*—The man remained in the hospital until the beginning of January. During the whole of the time his temperature was very irregular, varying between 96.6° and 102.6°. Whenever the fever showed exacerbation, new tubercles appeared, principally on his thorax, back, and arms. The evening temperature was usually the highest, but occasionally the maximum point was reached about 3 P.M. Salicylate of soda was tried in simple doses three times a day, but the administration of this drug was promptly followed by the worst exacerbation of fever, and the most rapid development of tubercles that occurred during his whole stay in the hospital, and after a week's trial it was given up. He seemed to derive benefit from Chaulmoogra oil in doses of fifteen grains three times a day, and also from the outward application of equal parts of Gurjun oil and olive oil. Carbolic acid lotion, boracic acid, and iodoform were tried for the ulcers, of which the latter was by far the most successful, and when he left the ulcers were almost healed. He had a constant cough, due to laryngeal irritation, as nothing definite was ever heard in his lungs. His general health improved very greatly, and he was mainly instrumental in decorating the ward at Christmas. During his last six weeks the temperature was more regular, not rising above

100°; his urine was free from albumen. He went from St. George's to St. Thomas's, where he remained some months.

He presented himself for readmission at St. George's on May 29th, 1889. The leprosy had decidedly improved, there were fewer tubercles, and his aspect was much less leonine. But he was very low and ill, partly from starvation (as he was unable to live on his pension, and could get no work), but principally from phthisis. Both lungs were extensively diseased, and he was much emaciated. He was treated almost solely for the lung mischief, but after a temporary improvement he gradually got weaker, and died on July 13th, having developed a left pneumothorax a few days previously.

*Remarks by Mr. LE CRONIER LANCASTER.*—This case was a typical example of the tubercular variety of leprosy, and ran a characteristic course. The development of the tubercles during the febrile attacks was very well marked. The slight amount of anæsthesia was curious; he was not aware of it himself until it was demonstrated upon him. That there was, however, some interstitial neuritis is probable from the fact that the swollen ulnar nerve could be plainly felt behind each condyle. Dr. Sheridan Delépine, however, has various specimens of the tissues in preparation for microscopical examination. There is no doubt that his leprosy *per se* was considerably better when he died than on his first admission 11 months previously, and the improvement dated from the administration of the Chaulmoogra oil and the application of the Gurjun oil. Salicylate of soda, which has been much recommended for the reduction of the leprosy pyrexia, failed so signally that it was not considered advisable to give it an extended trial. His disease was not inherited, and he stated that though leprosy was frequent among the natives at Bellary, yet he knew of no other European having been attacked. I must thank Dr. Cavafy for his kind permission to publish the case.

#### CITY HOSPITAL (SOUTH), LIVERPOOL.

TWO CASES OF SCARLATINAL NEPHRITIS, FATAL FROM MENINGITIS; NECROPSY.

(Under the care of Dr. W. IRVINE.)

THE occurrence within a short space of time of two cases similar in many respects, and illustrative of a rare sequela of scarlet fever, makes them of sufficient interest for publication. How far the later symptoms were due to uræmia, and how far to meningitis, and the question of the pyæmic origin or otherwise of the meningitis, are not easily determinable. For the account of these cases we are indebted to Mr. C. Knox Bond, resident medical officer.

CASE 1. John F. C—, aged five years, was admitted to the hospital on the 3rd of June, 1889, suffering from scarlatinal nephritis. The parents stated that the child had had scarlet fever, with definite red rash, and sore throat followed by desquamation, five weeks previously. The attack was mild, and the boy had been up and about until five days previously to admission, when he had a fit, followed by vomiting frequently repeated during the next two days. He appeared ill, was breathing rapidly, expiration being attended by expulsive effort, the face pale, aspect dull and heavy. The skin was dry, presented no rash and very slight indication of desquamation on the lower extremities and the palms of the hands. No œdema beyond very slight puffiness on the dorsum of each foot, said to have been noticed previously to admission. Lungs: Resonance impaired over left chest, especially back; movement good; a few bronchitic sounds over left lung. The heart sounds were sharply accentuated at the base and apex. Pulse 140, hard. The urine contained a very slight shade of albumen, treated with picric acid; and gave no blueness with guaiacum and ether. The tongue was thickly coated along the dorsum, yellow; edges clean and moist. Temperature 103.4°. The child remained in much the same condition until June 9th, when the apex of the right lung became consolidated, slight left otorrhœa commenced, and diarrhœa supervened. On the night of the 10th he became very dull, with slight intervals of restlessness and delirium, and was very cold and collapsed, the temperature falling in a few hours from 102.8° to subnormal. This condition was attributed to the effect of the application of ice to the abdomen to check the diarrhœa; on discontinuing this treatment the temperature again rose and the collapse abated. The lung consolidation rapidly