

whom he had operated some years ago gained two stone in weight in the six months' interval before the pain again returned.

### ST. BARTHOLOMEW'S HOSPITAL.

#### CIRRHOSIS OF LIVER; ERYSIPELAS.

(Under the care of Dr. BLACK.)

THE following account is interesting in many ways. We do not often meet with cirrhosis of the liver at so early an age, nor in a man not addicted to drink, and who has not had syphilis. The cerebral symptoms were also peculiar. His death was apparently due to exhaustion during a severe attack of erysipelas ambulans. The notes of this case have been forwarded us by Mr. H. Thompson, house-physician.

A. O.—, aged twenty-six, a saddler, was admitted into hospital on Feb. 16th, 1872, complaining of pain in the region of the spleen; also, he is unable to work on account of his hands shaking whenever he attempts to do anything. He is a stupid, drowsy-looking man, with sallow complexion and conjunctivæ slightly tinged with bile. Bowels regular; fæces very pale. Urine: sp. gr. 1020, no albumen, but traces of bile. Heart and lungs healthy; liver smaller than natural; spleen much enlarged, and can be felt 8 in. below the costal cartilages. No anasarca or ascites. He has been married five years, and has two children. Has always been a temperate man; never had syphilis; has been ill three years. Eighteen months ago he had general anasarca, which has just left him. In the spring of 1871 he had a febrile attack, lasting six weeks. He lost the partial use of his left side two years ago. Has had occasional attacks of apparently *petit mal* whilst working; during which he lets the tools fall from his hands, but does not entirely lose consciousness. He is sometimes seized in this way whilst walking, and would fall did he not lay hold of something to support him. The attacks are generally preceded by a feeling of tingling, cold, or numbness, especially in the hands and face.

Feb. 25th.—Whilst standing by the ward fire this afternoon he suddenly twisted quite round three or four times. The nurse asked him what he meant. He said he could not help it; it was his head. He did not fall, but quietly sat down in his chair. He says this attack was preceded by tingling commencing in the fingers of the right hand, and gradually spreading up his arms, and when it reached his head the attack came on. For some minutes after he seemed very drowsy.

March 1st.—Yesterday, whilst sitting by the fire, he fainted. To-day he cannot walk across the ward without assistance. Complains of tingling all over his limbs, and giddiness; eats well, but his meat has to be cut up for him. Conjunctiva more tinged with bile. Not so much pain in the region of the spleen.

4th.—About 2 A.M. the house-physician was called to him, as he was very restless. About ten minutes after the patient suddenly became very furious, flung himself out of bed, kicked, and tried to bite. By the united efforts of five persons he was lifted, or rather forced, into bed, and there held whilst his wrists and ankles were strapped to the bed. He was unconscious; pupils widely dilated, but contracted slightly under the influence of light. The eyes were not fixed, nor did he twitch his face or bite his tongue; both sides of the body were convulsed evenly. The attack lasted about an hour. He was very wild and excitable during the next twelve hours, struggling and shrieking. About 11 A.M. he was quiet, and said he did not know he was making a noise, and could not help it. He complained of a severe pain in the hypogastric region, and on placing the hand there the bladder was found much distended. A catheter was passed, and three pints of dark-coloured urine were drawn off. This was repeated at 10 P.M.

On the 5th the patient seemed better, and passed his urine naturally. Body and conjunctiva rather more tinged. Bowels confined; ordered a purge.

He had another slight attack on the night of the 7th, but was not so violent. Urine contained more bile, and a small quantity of albumen.

On the 12th, as he had been very noisy and violent the

night before, he was removed into the strong room in the casualty ward.

He seemed to improve for a few days, and his hands became less shaky; but on the 21st his face and nose looked puffy, and on the next morning his features were almost entirely obliterated by a reddish-white brawny swelling. Both eyes were closed; face dusky; bowels confined; tongue dry, brown, cracked; skin yellow. Temperature 101.4° F.; pulse 108.

22nd.—Pulse 132; temperature 104.2°. Tongue swollen; skin perspiring profusely; quite sensible. Collodion painted over the face. To take half a drachm of tincture of perchloride of iron every two hours. — 10.30 P.M.: Pulse 132; temperature 103.6°; breathing semi-stertorous; bowels freely opened at 5 P.M.; still perspiring; lips brown and dry. To have one ounce of brandy every hour.

23rd.—Pulse 100; temperature 98.6°; respiration 28. Face not so much swollen. Venous pulsation was noticed yesterday, even in the superficial veins on the back of the hands. — 10 P.M.: Pulse 108; temperature 102.2°; respiration 36. He has not been able to open his eyes since the commencement of the erysipelas. One ounce of brandy every two hours.

25th.—Numerous bullæ, which had formed on the left side of the face, were punctured, and gave exit to a large quantity of serum. Pulse 108; temperature 101°. One ounce of brandy every four hours.

26th.—Face and neck much less swollen; the erysipelas is spreading down the chest. Temperature 99.7°; pulse 96.

28th.—Face and neck nearly of the natural size. The rash has extended down the back as far as the loins. There is a small bed-sore on the sacrum. Nose bled freely this morning. At 10 P.M. the patient began to hiccup. He was ordered an injection of one-third of a grain of acetate of morphia. Pulse 84; temperature 100°.

29th.—The hiccup continued all night. The rash has spread down to the umbilicus. Numerous red ecchymotic spots exist on the right side of the body as far as the iliac spine. Temperature 101.6°; pulse 84.—10 P.M.: He is quite sensible; hiccup every fourth inspiration.

30th.—Temperature 100°; pulse 96. Bowels very much relaxed; motions horribly offensive, dark-coloured from altered blood, and containing a small quantity of bright-red blood.—10 P.M.: Purging still continued; he has begun to vomit large quantities of blackish material, apparently altered blood.

The patient died at 8.30 A.M. on the 31st. He was quite sensible to within half an hour of his death.

*Autopsy, thirty-eight hours after death.*—Body universally jaundiced, but not deeply so. Ecchymoses on many parts of the skin, on the arms, neck, and legs. Brain and membranes healthy. Pericardium and heart natural, excepting some hypertrophy of the left ventricle. Much œdema of the bases of the lungs. Pleuræ healthy. Liver small, weighing 39 oz.; right lobe especially shrunken, so as not to be much bigger than the left; surface very nodular; on section tough, traversed in all directions by fibrous bands; no iodine reaction. Spleen large, soft, and weighing 1 lb. 5 oz. Stomach full of blood; not much changed; mucous membrane everywhere intact, but stained deeply black by the iron administered; the tissues black, the staining not being merely superficial. The small intestines contained blood wellnigh throughout; mucous membrane dark, but less so than that of the stomach. Large intestines natural. Kidneys large; capsule adherent—tears away tissue; surface quite smooth; on section pale; cortical substance broader than natural. No scar discovered on penis.

### CHARING-CROSS HOSPITAL.

#### HYSTERICAL PTOSIS.

(Under the care of Dr. SILVER.)

THERE has lately been under treatment at this hospital a young woman suffering from hysterical ptosis of the left eyelid. The patient has been cured in a somewhat novel manner by Dr. Poore, who is at present in charge of Dr. Silver's wards. She was told that if her right eyelid was closed at once the left would be raised; then Dr. Poore drew down the right eyelid, and the woman at the same time opened the left eye. Dr. Poore then said that all

that was needed to perfect the cure was, that the right eye should be kept closed for a short time, and proceeded to do so with a strip of plaster and a bandage. After a few days the dressing was removed. The patient has not complained since of the drooping of her left eyelid.

#### A MODE OF INTENSIFYING HEART-SOUNDS.

(Under the care of Dr. POORE.)

In the out-patient room we also witnessed, among Dr. Poore's patients, a novel application of acoustic principles for the rendering of sounds made in the chest audible to those standing near the patient. The subject of this experiment was a man of middle age with a very loud basic diastolic cardiac murmur. The murmur was one of the loudest we have ever heard. The patient, being stripped, was made to lie flat on his back on a long wooden bench, or couch, without cushions. Dr. Poore then borrowed a walking-stick from one of the students and placed the lower end of it on the sternum between the third costal cartilages. On the opposite end was balanced the sounding box of a guitar, the aperture being directed towards the thorax of the patient. The cardiac sound became immediately audible to everybody standing round (some nine or ten persons) provided the ear was kept below the level of the guitar. The patient himself became extremely conscious of his murmur, and seemed very much amused with the experiment. There was a considerable amount of cardiac thrill, the vibration of which was felt by everybody on placing a finger on the guitar or the walking-stick. Dr. Poore merely regards the experiment as a curiosity, and does not believe that an apparatus similar to the one he extemporised would be of any use for purposes of diagnosis.

#### CENTRAL LONDON OPHTHALMIC HOSPITAL.

AN INTRA-ORBITAR DERMOID CYST, RESULTING IN ABSCESS; THE CYST REMOVED SUBSEQUENTLY; SATISFACTORY RESULT.

(Under the care of Mr. W. SPENCER WATSON.)

A. S—, aged twelve years, came to the hospital with the upper eyelid and the orbital cellular tissue enormously swollen and inflamed, the eyeball being protruded and thrust downwards. Immediately under the external angular process of the frontal bone, a roundish mass was felt, occupying the centre of the swelling; and growing out of a minute orifice in the skin at this point were three or four short hairs. These had been noticed by his mother ever since his birth, and a serous discharge had, till quite recently, escaped from the opening. Now, however, a probe penetrated only one-sixteenth of an inch into the sinus. There being considerable pain and pyrexia, on Feb. 13th an incision was made into the abscess, and about half a drachm of thin pus let out; the pain after this gradually subsided, though it had before been almost constant, with occasional paroxysmal exacerbations. The eyeball remained displaced, and there was diplopia for several days.

Feb. 28th.—Pain and swelling gone; no diplopia; no discharge; a hard circumscribed nodule occupies the site of the abscess.

April 18th.—The hard nodule, though smaller, remains *in situ*, and though causing no present inconvenience, was thought likely to occasion subsequent troubles. Mr. Watson, therefore, dissected it out from the orbital cellular tissue, through a semilunar incision in the upper eyelid parallel with the eyebrow. It extended as a hard round cord to a depth of about three-quarters of an inch under the orbital ridge, and its removal was much facilitated by passing a small probe from its cutaneous orifice into its cavity during the dissection. The wound was closed by stitches, cotton-wool, and collodion. The crust formed by the dressings above mentioned remained attached to the wound till April 29th, when they were removed, and the wound was found to have healed entirely, without any indication of suppuration, the line of the cicatrix being scarcely distinguishable from the skin on each side. A small collection of pus, of the size of a split-pea, immediately below the line of incision, was opened, and found to be unconnected, or at least not communicating with the original wound.

May 17th.—A small nodule remains in the site of the cyst, which is probably a shrinking cicatricial induration, but giving no trouble to the patient.

The cyst, when removed and cut open, had the usual mucoid lining, with hairs growing from it, so frequently seen in dermoid cysts in this region.

*Remarks*—These cysts, though very commonly found external to the orbital margin, seldom invade the cavity of the orbit, but when they do are very liable to cause trouble, either by their increase in size and consequent displacement of the eyeball, or, as in this case, by accidental suppuration taking place in or around them. The desirability of an early removal of such cysts is strikingly illustrated by the progress of the disease in this instance. The dry dressings here employed offer many advantages in the treatment of any similar wounds the skin edges of which can be accurately adjusted. 1. They give a fair chance of immediate union by favouring close adaptation. 2. If the union by first intention is not obtained they may still be left attached provided no deep suppuration takes place; and by renewing the collodion (or still better Dr. Richardson's styptic colloid), we may avoid any disturbance of the edges of the wound until a healing action has been set up. 3. In either case the pain and discomfort of changing the dressings, of which patients complain so bitterly, are entirely avoided. 4. Even if deep suppuration should occur it will not be always necessary to remove the crust of colloid or collodion, provided an opening be left sufficient for the escape of discharges. The wound in such a case is only in the position of an abscess with a small valvular opening, instead of being an open sore, and it must often be preferable to have the former condition. 5. The saving of time and trouble to the surgeon is very great. In this case the dressings were not touched (except on one occasion for the purpose of reapplying the collodion) for eleven days, and were then removed altogether.

#### LIVERPOOL NORTHERN HOSPITAL.

CASES OF SEVERE INJURY TO THE HEAD.

(Under the care of Mr. LOWNDES.)

CASE 1. *Compound fracture of skull and great laceration of the brain.*—E. G—, aged twenty-two, a sailor, was admitted on December 20th, 1871. He had fallen a considerable height on shipboard from a spar on to the deck. He was insensible, and much collapsed. There was a very large scalp wound, and part of the left parietal and temporal bones was completely smashed, and portions were driven into the brain. The pieces of bone that were quite detached were removed, but a large portion of the squamous part of the temporal bone, which was quite loose and driven into the brain, but not completely detached, was simply raised into position; much brain-matter escaped. Wet lint was loosely applied. To have six ounces of brandy.

Dec. 21st.—There have been convulsive twitchings of the mouth all night. He has taken a little fluid nourishment; a calomel purge was ordered.

23rd.—He is better; is sensible and makes signs, but cannot speak.

25th.—Great discharge from head; to be dressed with oakum poultices.

January 2nd.—Still speechless; the whole of the right side is now paralysed.

11th.—The wound is healing well, but there is a large piece of bone bare. When he is asked any question he seems to understand, and answers by moving his lips, but makes no sound. He now eats well, and his tongue, which he cannot protrude, is clean. All the right side, both face and limbs, is paralysed.

12th.—He speaks a little to-day.

29th.—He can move his right arm a little, and is able to put his tongue out.

Feb. 5th.—A large piece of dead bone was removed. He now speaks much better, but cannot say "Yes" distinctly. He is sitting up and eating well.

From this time he gradually improved; the wound healed; the paralysis of the face and limbs gradually disappeared, and the speech improved, though he still articulated badly, and there were many words he could not pro-