

was in less pain and clearer-headed. — 15th: There was indefinite deep fluctuation to be felt between the mastoid process and the occipital spine, while a large quantity of fetid pus was washed out of the tympanic cavity by syringing through the meatus into the pharynx. On June 17th I made an incision under chloroform just above and to the left of the atlas and found the occipital bone denuded. There was profuse suppuration. During the following days the patient was very prostrate. The temperature was hectic in character, occasionally in the evenings reaching 103°, but there were no rigors. These, however, returned on June 24th. There was no discharge to speak of from the internal ear, and no head symptoms; but on the right side of the neck over the glandulæ concatenatæ there was a painful swelling. This I opened on June 26th and found it to be a deep-seated abscess with no communications; several ounces of pus were evacuated. This abscess was evidently of secondary formation.

From this point the temperature was never above normal, and the patient rapidly approached convalescence. Throughout the case he took nourishment freely, but remained extremely emaciated. His chief medical treatment was perchloride of iron and quinine, for which bark and ammonia were substituted when the prostration was very marked. The hypodermic injections of morphine were continued until the last abscess was opened.

The deep suppuration between the mastoid process and the occiput suggests to me the possibility that perforation of the mastoid portion of the temporal bone took place through the digastric fossa, the pus having been conducted backwards (the patient being on his back) by the occipital artery.

Sittingbourne.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NEUROMIMESIS: TWO CASES IN WHICH THE HIP-JOINT HAD BEEN HELD FIXED FOR NINE MONTHS.

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THESE two cases are worthy of note, since for nine months the hip-joint in each was believed to have been seriously injured. Sir James Paget, in his Clinical Lecture on Nervous Mimicry,¹ has described the group to which these patients belong. The first case was that of a strong, healthy sailor, seventeen years of age, who had been thrown down by a lurch of the vessel in the North Sea. He had been treated during nine months as for an injury of the hip-joint by rest and liniments. He expressed himself as very anxious to regain the use of his leg. The other, a young man twenty years of age, was also perfectly healthy. Last August an accidental kick just above the left pubic spine had caused an abrasion followed by an abscess. The place was marked by a superficial scar. He had formed the notion that the left hip had been dislocated by the kick and was still out of joint. These two cases were identical in character. Both patients complained of a fixed hip-joint and of pain along the inner side of the knee. In both the limb was held rigidly extended at the hip, neither rotated in nor out, and neither abducted nor adducted, a position not obtaining in disease or after injury. The length of the affected limb and the great trochanter, in respect to position and touch, corresponded with that of the opposite side. Firm pressure over the front of the joint caused no pain. Sufficient nitrous oxide gas was given to the first patient to overcome resistance, and the free motion of the hip-joint was continued as he recovered consciousness. In the second case I diverted the patient's attention for a moment and, having commenced the flexion, carried the limb by main force up to the abdomen. The head of the bone moved freely in the joint, and both patients were able to stand on the other leg and flex the affected limb to less than a right angle with the trunk. After this

free movement both seemed convinced that there was nothing wrong with the joint—at least I have not seen them again.

Brook-street, Grosvenor-square, W.

HARELIP SUTURES.

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IN operating upon the most severe forms of harelip I have found that there is far more difficulty in obtaining a satisfactory result in respect to the nose than as regards the lip. In fact, the nose is as a rule the weak part of the operation; for I have seen in my own cases, and also in those of other surgeons, results that, so far as the lip was concerned, were all that could be desired, but the slight falling away of the ala of the nostril on the affected side has spoilt what would otherwise have been an excellent result. I refer only to the more severe forms of harelip, where the cleft passes through the nostril and palate. In this class of case there is before operation a very marked flattening of the nostril on the affected side, and although by well freeing the ala and adjacent part of the lip one can bring the nostril into good position it is not always an easy matter to keep it there, and the object of this communication is to suggest a means of overcoming this difficulty. The method of operating I almost invariably adopt is much the same as that described by Mr. Edmund Owen in his Lettsomian lectures of 1890. After thoroughly freeing both sides of the lip I take a transverse flap from the better side, remove the mucous membrane on the opposite side from the nose to the angle of the mouth, making a point of paring the mucous membrane well into the nostril so as to secure two broad raw surfaces for apposition. For sutures I use green gut and horsehair, never having used harelip pins. All the stitches being tied, I complete the operation by compressing the ala of the nostril on the affected side against the nasal septum by means of a button suture. This suture consists of two small discs of lead slightly convex on one side (the side which is applied next to the skin), with two holes about their centre. One of these is threaded with silver wire armed with a large needle, the wire being twisted into a single coil to the estimated thickness of the septum and ala. I pass the needle through the nasal septum well within the nostril and out through the junction of the ala and cheek, cut the needle free of the wire, thread the other disc, press the two discs together, and fix them by twisting the wire. I leave the button suture in for a longer time than the other stitches, taking it out about the end of a week. On removing it the nostril on that side remains compressed for a day or so, but it soon rights itself. I have not found that the sutures leave any appreciable mark or cause any deviation of the septum. I have used this form of suture in my last twenty cases and have found it so satisfactory that I trust other surgeons may be induced to give it a trial, for not only does it ensure a good result as regards the nose, but it also steadies the whole lip and so guards against any pull upon the lip sutures when the child cries. In cases of double harelip I pass the wire from the ala nasi on one side, through the septum, and out through the ala on the opposite side, and when tightened the discs compress both ala against the septum. I do not for a moment wish it to be thought that I believe it impossible to obtain a good result in hare lip operations unless the button suture is used, for of course this is not the case; but I do say that if the button suture is used in the way I have described it very materially increases the probability of obtaining a satisfactory result.

Liverpool.

VICTORIA HOSPITAL FOR CHILDREN, CHELSEA.—

The medical report of this institution states that during the past year 1120 patients have been admitted into the hospital, a larger number than on any previous year. Of these 817 were discharged cured or relieved; 107 left the hospital *in statu quo*; and 69 remained in at the close of the year. 127 cases terminated fatally, but of these a large proportion were infants brought to the hospital in a hopeless condition. The admissions to the convalescent home at Broadstairs numbered 430, an increase of 135 on those of the preceding year. The number of new patients in the out-patient department treated was 17,173, and there were 34,431 visits from old cases, thus bringing up the total number of attendances to 51,604, a total exceeding that of last year by 2410.

¹ Clinical Lectures and Essays, second edition, 1879, p. 210.

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.

UNIVERSITY COLLEGE HOSPITAL.

A CASE OF INSENSIBILITY SUDDENLY SUPERVENING ON
EXTREME MUSCULAR EXERTION.

(Under the care of Dr. G. V. POORE.)

WE do not often have the opportunity of seeing cases such as this in our London hospitals, and it constitutes an important contribution to our literature on the subject of "over-work." It is not necessary to add anything to the remarks of Dr. Poore, but we should like to draw attention to the work on Bodily Exercise by Lagrange which is mentioned by him; it is very instructive and worthy of a place in most libraries. For the notes of the case we are indebted to Mr. T. Streatfeild, house physician.

On Feb. 25th a strongly-built man twenty-one years of age was brought to the hospital in an unconscious and irritable condition with the following history. The previous day, Feb. 24th, he had come up to London, a distance of 120 miles, to take part in a cross-country ten mile race, for which he had been in training for some time previously. At 6.30 A.M. on that day he had for breakfast two eggs, a few pieces of toast, and two cups of tea. This was the last time he had anything to drink until after the race. He had lunch in London about midday. This consisted only of a chop and dry toast. The race commenced at 4.30 P.M., and the course, which was partly through plough land, taken as a whole, was extremely heavy owing to recent rain. The patient said that he felt out of sorts before the race began, but he finished well up, doing the ten miles in sixty-six and a half minutes. During the race he did not perspire as much as he ought to have done, and afterwards when he went to the dressing-room he felt very thirsty and drank off about a pint and a half of cold water. After this he became ill, did not recollect dressing himself, and, in fact, remembered nothing more until he found himself in the hospital next evening. His friends state that the race was finished about 5.45 P.M., and after this the patient dressed himself with very little assistance, but he did not seem well; he appeared "over-run." Just after leaving the dressing-room with his friends he "fainted." They gave him some brandy, but, as he became unconscious and helpless, they carried him to a neighbouring house and laid him down on the floor. Here he lay quite still, with semi-closed eyes, occasionally groaning as though in pain. His breathing was stertorous, and his pupils are said to have been dilated equally and his teeth clenched. He continued thus until 7 P.M., when he began to have convulsions, which appear to have been epileptiform in character. They came on with intervals of one or two minutes, in which the breathing was stertorous and the patient was quite quiet. A considerable quantity of saliva ran from his mouth, but he did not bite his tongue. At 8 P.M. the convulsions became so violent that it was found necessary to restrain the patient, and at 11 P.M. he was given a hypodermic injection of morphia. This controlled the fits, and he lay quiet during the rest of the night, but was quite unconscious. All next day, Feb. 25th, he remained in the same condition, and in the evening was brought up to University College Hospital.

Condition on admission.—The patient lies on the couch in a curled-up position, with his legs flexed on to his abdomen and his arms crossed over his chest. He is in a state of extreme cerebral irritation and resists all attempts to examine him. If his eyelids are opened to look at his eyes, he closes them tightly and rolls over on the couch with his face to the wall. He lies quite still, except that occasionally he puts his hand to his head and rolls over on the couch, especially when any attempt is made to examine him. His pupils are equal and semi-dilated; the conjunctivæ are suffused. He will not say anything in answer to a question, but only opens his eyes and stares vaguely about. He will not put out his tongue. The

breath is foul. Pulse regular, full, and bounding. No paralysis can be made out anywhere; knee-jerks equal on both sides. Except that he at times passes his hand across his forehead he does not seem to suffer any pain. Urine, obtained later, found quite normal in every respect. At 11 P.M., as the patient has had no food for the last twenty-four hours, preparations were made to feed him nasally. The passage of the tube caused such violence on the part of the patient that the tube was taken out. He then sat up in bed, seemed quite rational, drank about a pint and a half of milk, and took three grains of calomel.

During the night the patient was restless, but quite conscious, and took his food well. The next day, Feb. 26th, he complained of some headache, but was quite sensible and took interest in what was going on. The headache disappeared towards the end of the day. Examination of the patient revealed nothing abnormal. He left the hospital on March 4th, no bad symptoms having developed in the interval.

Clinical remarks by Dr. POORE.—Prolonged insensibility resulting from, or determined by, excessive muscular exertion is sufficiently rare to merit rather special attention. It would, to say the least, be rash to conclude that an insensible and semi-comatose condition betokened any coarse lesion of the brain. There was abundant evidence that such a condition was common without any cerebral lesion whatever. What, indeed, is sleep—that daily recurring attack of insensibility from which, happily, we all suffer—but the physiological prototype of the more intense pathological conditions? Sleep might be light or heavy, sound or disturbed, and accompanied by mutterings, dreams, nightmares, or movements, but it was very seldom that any of these morbid complications of normal sleep were attributable to any definite brain lesions. Sleep was probably brought about by the action of waste products circulating in the blood, and it was said to be generally accompanied by contraction of the cerebral vessels. We have lately had in the ward a case of so-called "uræmic coma" and another case of "diabetic coma," and I would remind you that in both these cases the cause of the coma was to be looked for in the deranged composition of the blood and not in any definite lesion of the brain or its membranes. On the other hand, we have now in the ward a patient suffering from profound and complete right-sided hemiplegia, in which the lesion in the brain is certainly very extensive, and yet there has never been so much as a cloud over the man's intellect, and he has astonished us all by his singular quickness, accuracy, and volubility. These cases all point to the fact that the connexion between insensibility and brain lesions is by no means constant. The patient under consideration has never manifested any symptoms which warrant us in concluding that there has been any lesion of the brain or its membrane. He has been insensible, he has had fits; but in the absence of any localising symptoms we should be wrong to regard them as "cerebral" or "meningeal" in origin. It is certain that forty-eight hours after the onset of his trouble a careful examination of the patient failed to reveal anything amiss with any organ of the body. What, then, was the cause of the attack? The answer which is most probably correct is that the patient was poisoned by his waste products. We must remember that ten miles across a heavy country and over obstacles represents a prodigious amount of work, and that this heavy work was concentrated in a very short period of time. If the products of tissue metabolism, as must have been the case, were excessive, and if their eliminations did not keep pace with their formation, then we have a condition distinctly analogous to uræmia or diabetes, and we cannot wonder that symptoms such as insensibility and convulsions should supervene. But, it will be urged, "this man is a trained athlete, well accustomed to such work, and no similar accident has befallen him on any previous occasion." This is doubtless true, and it behoves us to review the history which is given by the patient and his friends, and try to discover what were the exceptional circumstances (if any) which led to such an exceptional result. First, we have the statement of the patient that he felt "out of sorts" when he started for the race. This is a sufficiently indefinite statement, but we shall not be wrong in insisting that the functions of our bodies are not so well performed when we are "out of sorts" as when we are "fit." Next we have the statement that he did not perspire as much as is usual with him in such contests. His statement to me on this point was very definite; he said he "scarcely perspired at all," and "nothing like as much