

wall. From the abdominal aorta through the left common iliac, external iliac, and femoral artery the coats of the vessels were separated by a thin layer of coagulum, but no palpable thickening of the arteries was so produced. In the lower part of the aneurysm the dissection of the arterial coats did not extend much more than half-way around the circumference of the vessels.

The microscopic sections which I exhibit are from the left common iliac artery and they show that the blood is effused in the substance of the middle tissue of the artery, so that the external wall of the aneurysmal canal is composed of the outer strata of the media together with the adventitia. The dissection was carried along the coats of the right renal artery, which was also occluded by a thrombus. The lumbar arteries were cut across and their orifices likewise contained thrombi. A large coagulum was adherent to the posterior wall of the aorta at the level of the renal and lumbar arteries. I have not been able to satisfy myself as to the position of the internal rupture of the aorta. There are many degenerated spots in the inner coat of the vessel through which it might have occurred, or possibly it took place at the origin of one of the primary branches of the aorta. The capsule of the left kidney was adherent, the organ being cirrhotic; the right kidney was in a similar condition and was, in addition, cystic; it was extremely engorged with blood and the microscopic sections (which were prepared by Dr. Dargan in Dr. MacWeeney's laboratory) show that a universal hæmorrhagic infarction was present. There was no hæmorrhage in the spinal cord or its membranes. In the light of the necropsy it is not difficult to account for the symptoms of this case. As predisposing causes of dissecting aneurysm the patient had extensive atheroma of the inner coats of his aorta, which was consequently unduly lacerable, and in addition he had hypertrophy of the left ventricle with high arterial tension. The intense pain at the onset of the symptoms was due to the primary rupture and separation of the coats of the aorta by the blood. The paraplegia was caused by the interference with the arterial supply to the lumbar region of the cord, partly from thrombi in, partly from rupture of, the origin of the lumbar arteries. The sudden death ensued on the rupture of the external wall of the aneurysm and the consequent escape of blood into the right pleural cavity. It is rather remarkable that the urine contained no blood and that the amount passed was not noticeably diminished, for the functions of the right kidney must have been completely arrested.

Other cases of dissecting aneurysm have been recorded in which a remarkable series of symptoms was due to the arrest of vascular supply to the brain, kidneys, or cord. Tessier's²⁰ patient died with symptoms of apoplexy, and a dissecting aneurysm was found extending from the arch of the aorta along the innominate artery and its branches to the internal carotid. Todd's case²¹ was characterised by hemiplegia and suppression of urine, and the post-mortem examination showed softening of the brain due to obstruction in the carotids, and the renal arteries were also obstructed. Sainet²² records a case in which the patient became rapidly paraplegic. In Dickenson's²³ case a policeman after seven hours on his beat was seized with loss of power over his lower extremities, followed by pain, collapse, and death in twenty-four hours. Swaine's²⁴ case was diagnosed during life, the patient having been suddenly seized with pain in his chest followed by paraplegia. Where the symptoms are liable to such variation it is evident that the diagnosis of dissecting aneurysm must be always difficult and uncertain. In reference to treatment Walshe²⁵ remarks: "Were the practitioner fortunate enough to divine the occurrence of acute separation of the coats of the aorta it does not appear that, in the present state of our knowledge, the management of the case would be materially improved by his sagacity. Did he fail to diagnose the occurrence, his aim would be to restore the patient from the first shock of the accident, control excited arterial action, and relieve the symptoms as they arose. And it does not appear that art could do more than this were the anatomical nature of the affection understood from the first."

Dublin.

²⁰ Giornale della Scienza Medice, 1842.

²¹ Todd: Transactions of the Royal Medical and Chirurgical Society, vol. xxvii., 1844.

²² Bulletin de la Société d'Anatomie, 1851.

²³ Transactions of the Pathological Society of London, vol. xiii.

²⁴ Ibid., vol. vii.

²⁵ Diseases of the Heart.

A CASE OF DOUBLE LOBAR PNEUMONIA COMPLICATING INFLUENZA DURING THE COURSE OF ACUTE MANIA.

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THE following is a case of some interest, showing as it does the possibility of recovery from double pneumonia complicating influenza under conditions of such special difficulty as to render the prognosis almost certainly fatal.

The patient, a woman, aged thirty-seven years, was admitted into the Coppice Hospital, Nottingham, on March 18th, 1898, suffering from acute mania of three weeks' duration, her leading mental symptoms being extreme restlessness, hallucinations of sight and hearing, and obstinate refusal of food. She professed inability to walk and had to be carried to her room. On examination there were no signs of organic disease except at the apex of the right lung, where there was evidence of consolidation, which from the history was presumably tuberculous in character. The pulse was 84 and the respirations were 22 per minute, while the temperature was normal. The pupils were equal and reacted (though somewhat sluggishly) to light. The muscular power generally was fair, but the knee-jerks were greatly exaggerated. The patient was said to be of a highly excitable disposition and for several years had been subject to attacks of *petit mal*. After admission she was very troublesome in the matter of food, being only induced to take it after much persuasion, while the use of the nasal tube was necessary on one or two occasions. On the 22nd the patient had a slight cough and on the following evening the temperature was found to be 101.4° F., but the rate of respiration was not accelerated; the pulse was 92 per minute and no abnormal signs were found in the lungs apart from the condition at the right apex. On the following morning the temperature had fallen to 99.4° and in the evening it was normal; during the night, however, the breathing became very rapid and the face cyanosed, and the night nurse, becoming alarmed at the patient's condition, sent for the medical officer, when the respiration was found to be 60 per minute, the temperature 103.4°, and the pulse very rapid (160 per minute) and of so feeble a quality that a hypodermic injection of 15 minims of ether with $\frac{1}{16}$ gr. strychnine was given, upon which the patient rallied a little. She was then put on strychnine ($\frac{1}{16}$ gr. hypodermically every six hours) and fed four times daily through the nasal tube as it was impossible to get her to take food otherwise and the bowels were acting so frequently that rectal feeding would have been useless. At 6 P.M. the temperature had risen to 105° and the pulse was 168. Signs of consolidation were now observed over the lower hand's breadth of the right lung behind, the previous examination having given negative results. The patient's condition now appeared to be very grave and death was looked upon as imminent. She was fed, however, and 10 gr. of quinine were given with the food, the temperature dropping in the course of an hour to 103.2°, while the pulse had greatly improved. During the whole of the day the patient had been trying to throw the bedclothes off and had passed urine and fæces under her. On the 25th the temperature at 8 A.M. was 102.4°, and at 6 P.M. was 105.4°. The same treatment was adopted as on the previous day and the result was similar. On the 26th there was evidence of consolidation over the whole of the right lower lobe and a patch of a similar character at the left base. The temperature rose as on the last two evenings and fell under the influence of the same treatment. 5 gr. of quinine were now ordered three times a day. The feeding and injections of strychnine were to be continued as before. On the 27th signs of improvement began to manifest themselves, the temperature being 101.4° at 8 A.M. and 103° at 6 P.M. The case now progressed favourably, the injections of strychnine being discontinued on the 29th and the temperature falling to normal for the first time on the 30th. A slight recrudescence of fever which occurred on April 4th was attributed to the regurgitation and inhalation of a portion of her food during her feeding on the previous evening. After this the temperature dropped steadily to normal, the recovery being uninterrupted, while the signs of consolidation which had involved the whole of

the two lower lobes had cleared up almost completely on April 10th. The patient is now much stouter than on admission and is in a condition of obstinate melancholia, refusing her food and having to be fed four times daily with the nasal tube.

The main point of interest in this case is the apparent proximity of death and the recovery under particularly unfavourable conditions. The patient was very much exhausted by her maniacal attack and added to our difficulties by her refusal of food, constant attempts to get out of bed, uncleanly habits, and violent resistance to anything done for her benefit or comfort. The irregularity of the temperature and the absence of a definite crisis are probably due to the pneumonia occurring as a complication of influenza. The effect of the strychnine injections upon the pulse was very marked as was also that of the quinine upon the high temperature. It is remarkable considering the severity of the fever that the patient was able to retain so large a quantity of food as was administered on each occasion through the nasal tube, the amount given altogether in the twenty-four hours consisting of 4 pints of milk, 6 eggs, and 6 ounces of brandy. To this somewhat unusual power of digestion the recovery of the patient is, no doubt, in great part due.

I am indebted to Dr. Tate for permission to publish this case.

Nottingham.

A CASE OF TEMPORO-SPHENOIDAL ABSCESS; TREPHINING; RECOVERY.¹

By HERBERT J. ROPER, M.R.C.S. ENG., L.R.C.P. LOND.;
AND
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A GIRL, aged fourteen years, had had a purulent discharge, which latterly had been offensive, from the left ear for two years. She came of an unhealthy stock, her father and mother being distinctly delicate and her grandmother showing scars all over her body the result of necrosis of bone, probably syphilitic. On June 11th, 1897, she complained of severe pain in the left ear and corresponding side of the head, which nothing appeared to alleviate. On the 13th the headache was still intense, but the earache had ceased. There was only a slight rise of temperature—generally about 101° F. On the 14th she was practically free from pain and on the following three days it was noticed that her memory was defective for common objects in the room. She was unable to name a spoon, fork, knife, chair, &c. As soon as the word was mentioned she recognised it and could pronounce it, but she forgot it again almost immediately. A slow pulse (50) and occasional vomiting were her other symptoms. On the 23rd her temperature was 101°, her pulse was 50, and her respirations were 12. She was drowsy and wished to be let alone. When roused she was childish in her manner and voice, quite different from her usual condition. She remembered dates well, but could not tell the name of any of the surrounding objects in the room. She had taken a dislike to many people of whom she had previously been fond and would have nothing to do with them. There was no disturbance of sensation or power of movement on either side. Optic neuritis was present on both sides. The ear was being carefully syringed with an antiseptic lotion and there was no discharge perceptible. The next day, however, the ear began to “run,” but she was more drowsy than the day before, and the vomiting persisted and grew worse. On the 25th the temperature was normal, the pulse was still slow, but she was not so drowsy. During the day, though, the drowsiness increased and became more and more pronounced during the following three days until it resolved itself into coma. She took nourishment fairly well, retaining some. On the 27th and 28th she passed urine and fæces into the bed. The temperature continued normal. During the 29th the right arm became strongly flexed and remained motionless in that condition. On the 30th she was comatose but still able to swallow liquids; the right arm was paralysed and

the right leg was much weaker than the left. I strongly advised operation at this stage, to which the parents readily consented. Mr. Littlewood at my request performed the operation. I administered ether, of which very little was required. Mr. Littlewood, assisted by Mr. F. E. Taylor, first exposed the mastoid process by a semilunar incision down to the bone and by chiselling opened the antrum until there was a free communication with the external auditory meatus. Some purulent material was found and the cavity was cleansed. He next dissected back a large semicircular flap and then proceeded to trephine over the petrous portion of the temporal bone. On pressing aside the dura mater the anterior surface of the petrous bone was well exposed but nothing was found here. The dura mater was perfectly healthy. Mr. Littlewood then proceeded to remove bone in a backward direction with Hoffmann's cutting forceps until he had exposed the membranes over the temporo-sphenoidal lobe. He then opened the dura mater and exposed the brain, which bulged out and did not pulsate. With a large trocar (Macewen's) he punctured the brain and immediately very offensive, thin, yellowish-green pus, with thick flakes of lymph floating in it, rushed out. The trocar was withdrawn and Mr. Littlewood plugged the opening with his finger in order to allow the pus to escape slowly, so that the intracranial pressure might not be too rapidly reduced. When the pus had all escaped the cavity began at once to shrink. This was then well washed out with boiled water by means of a syphon. Several large flakes of lymph came away with the water which returned. The large scalp-flap, which had become soiled by the discharge, was well washed with boiled water and afterwards with weak carbolic lotion. A drainage-tube was inserted into the abscess cavity and the flap was stitched up with silk sutures. The antrum was packed with iodoform gauze and a dressing of boric wool was applied over the whole. The condition of the patient at the end of the operation was wonderfully good; the extremities were warm and the pulse was 120 and fairly full. Before we left the house she moved her right arm. At 9.30 the patient was asking for food. Milk and soda-water in small quantities were given. On July 1st she had had a fairly good night. She moved her arm quite well and her mental condition was distinctly improved. Her temperature was normal and her pulse was 120. There was no pain. She asked for solid food. The dressing was changed. She had been asking her mother if the knocking had ceased, which appeared to refer to the chiselling. On the 2nd the temperature was subnormal. The patient was bright and cheerful but still amnesic. She took nourishment well. Hernia cerebri had formed. On the 4th the tube was removed and the scalp wound had nearly healed. The hernia continued to increase in size for some days until it was of the size of a Tangerine orange, when it slowly began to shrink. On the 22nd she sat up for a short time daily and was able to read and remember names of objects much better, though she still made mistakes. The antrum was filling up. Pressure was applied to the hernia after a time by means of a piece of thin sheet lead shaped to the hernial protrusion. After this it rapidly decreased in size and towards the end of September disappeared altogether and the wound healed over. The patient's memory gradually improved and now is almost normal. At the present date (March 10th, 1898) she is remarkably well in every respect.

Leeds

THREE CASES OF MYOMATA OF THE UTERUS COMPLICATING PREGNANCY;

PAN-HYSTERECTOMY PERFORMED IN TWO CASES AND SUBPERITONEAL HYSTERECTOMY IN THE THIRD; RECOVERY IN EACH CASE.

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I VENTURE to record these three cases because cases of myomata of the uterus complicating pregnancy are of comparatively rare occurrence and when met with, owing to the rapid growth which the myomata take and the symptoms they produce, are a source of grave anxiety to the medical

¹ A paper read before the Leeds and West Riding Medico-Chirurgical Society on Feb. 4th, 1898.