both incompetent and constricted. The pulmonary, azygos and left femoral veins all appeared to be normal. The right pleural cavity contained twelve ounces of fluid, the left eight ounces. There was extensive pleurisy over the left lung and some over the right. The bases of both lungs were compressed. There was some pus in both tonsils.

Harley-street, W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL AND THERAPEUTICAL.

A CASE OF STRYCHNINE POISONING IN WHICH DEATH OCCURRED AFTER AN UNUSUALLY LONG PERIOD.

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AT 9.35 A.M. on Jan. 27th I was called by the police to see a man aged forty-six. He was said "to have taken strychnine to do away with himself." As he lived close at hand I was with him in five minutes. I found him convulsed about the lower part of the body. He told me he had taken, three-quarters of an hour or so previously, "as much strychnine as would cover a shilling"—probably from seven to ten grains. He had poured it in a dry state on to his palm, tossed it into his mouth and washed it down with water. He had by threats compelled his wife to watch his actions, and then wait until symptoms manifested themselves—a period of from ten to fifteen minutes. He then sent her to a business man in town with a letter he had previously written, detailing his intentions. The woman said she was too frightened to give any alarm, although people lived within twenty yards. She delivered the letter and returned quickly. The recipient of the letter, thinking it might be a serious threat, took it to the police. The latter went to investigate the case and then called me. I adopted the chloral and bromide of potassium treatment, giving large doses of each. I supplemented these by chloroform inhalation occasionally. At first the jaws were free and I was able, by police assistance, to prevent the patient's attempts to bite and got the tube down. I washed the stomach out repeatedly. It was quite devoid of food. He was well aware of the strength and properties of strychnine as he was an experienced dingo poisoner and had over seven ounces of the alkaloid (coloured pink as used in New South Wales) in his possession. To cause more rapid absorption he had refrained from breakfasting and taken a glass of whisky instead. The convulsions were exactly as described in Taylor's and others' works. He complained of great thirst and desired to be placed on his side. About 11 A.M. the symptoms were well marked. I then chloroformed him and he sank into a deep slumber such as chloral would produce, and he remained quiescent and limp till 1 P.M. He then awoke, seemed better, regretted his rash act and even joked. In accordance with the accepted teachings, both of the schools and the text-books, that after three hours a strychnine patient is practically safe, and, considering the patient's condition, I gave a good prognosis. At 2 P.M. he still seemed improving, but twitchings and mild general convulsions occasionally occurred. I then gave more chloral and at 4 P.M. more bromide. At 3 P.M. I had caused him to be removed to the hospital of which I am medical officer. He was carried the distance, about 200 yards, on a police stretcher, and had no convulsions on the way. About 4 P.M., however, convulsions again became more frequent, and he was much exhausted. What I particularly noticed all through was the extremely sudden cessation of the paroxysms. From the climax to complete relaxation was an instantaneous fall. Each lasted from ten to thirty seconds. There was usually an interval of ten to fifteen minutes between each. At 5.45 P.M. he seemed improving under the treatment; but suddenly as I was speaking to him he said, "Here's another coming," and cried out in terror. A dreadful paroxysm bent him back, he became almost black, and when the sudden relaxation occurred I found he was dead—asphyxiated by the intensity of the seizure. His pulse continued beating for a few seconds after the respiration stopped.

What I desire to particularly draw attention to is the length of time he lived—eight and three-quarter hours—after the onset of symptoms, or nine clear hours after the dose. Taylor (11th edition, edited by Dr. Stevenson) gives six hours as the longest recorded period for a fatal issue, and other works state the same. I think it highly important that it should be known by general practitioners that exceptions may occur, in order that no relaxation of treatment may be permitted from a false sense of security.

Warialda, New South Wales.

SACRO-ILIAC DISEASE, WITH NOTES ON ITS TREATMENT.

BY PEYTON T. B. BEALE, F.R.C.S. ENG., L.R.C.P. LOND.,
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SEVERAL points of interest in sacro-iliac disease have been recently brought forward in the discussions arising at various societies, and I should like to draw attention to a few facts which seem to show that the disease is often accompanied by tuberculous disease involving the anterior surface of the sacrum. Brief notes of a case which was recently under my care illustrate this point.

A man aged thirty, with a strong tuberculous history, was admitted into the Great Northern Central Hospital in the early part of 1892 suffering from well-marked sacro-iliac disease. The disease was of about twelve months' standing, and the patient had undergone the usual treatment—that of opening abscesses and scraping out sinuses—several times. There was complete ankylosis of the left hip, with considerable flexion, dating from the time when the patient was four years of age. When he came under my care there were five or six sinuses in the left gluteal region and over the left sacro-iliac synchondrosis, with the usual signs of tuberculous disease of this part. One sinus discharged thick cheesy pus and, when probed, seemed to lead to the great sacro-sciatic notch. This sinus was laid freely open until the finger could be passed through the notch. A sequestrum was then felt lying against the front of the sacrum; it could not be grasped or withdrawn even after several attempts with different instruments, nor could it be broken up, as it was quite loose and slipped at once out of reach; so a free incision was made over the situation of the great sacro-sciatic notch on the right (sound) side. The left forefinger was inserted and the wound enlarged until the finger passed easily through the notch. By this means the sequestrum was reached, pushed across the front of the sacrum, grasped and broken up by forceps, assisted by the right forefinger in the wound on the left side, and the fragments were removed. The other existing sinuses led down to the same region and were laid open, scraped and drained. The shape of the sequestrum showed it to consist of the greater part of the sacro-vertebral articulation and it would appear that the disease had originated in this situation and that the presence of the sequestrum at the front of the sacrum had caused the continuance of the symptoms. In support of this view I may state that Professor Rose had a similar case under his care in King's College Hospital some months ago, where he removed a sequestrum from the front of the sacrum, and other cases have been published where necrosis in this region was described in conjunction with sacro-iliac disease.

Mr. Makins has recently recorded three cases, in one of which there was ankylosis of the hip on the affected side. This and the presence of cervical caries seem to be fairly commonly associated with sacro-iliac disease and both are due to tuberculous affection. The man, whose case I have briefly described improved rapidly after the operation and was able to walk, but he is now suffering from general tuberculosis. I therefore venture to think that in cases of sacro-iliac disease it is of the utmost importance to examine the front of the sacrum through the sacro-sciatic notch, and there is much evidence in recorded cases to show that the disease does exist there, perhaps primarily.

Grosvenor-street, W.