

apparent injury to the intestines, but portions of the ileum in the neighbourhood of the kidney showed commencing peritonitis. The right kidney was displaced downwards and forwards, and lay in the iliac fossa; behind it was an enormous amount of blood-clots and effused blood, the latter extending along the cellular tissue almost to the middle line of the abdomen in front. There was also a quantity of blood-clots immediately in front of and on the right side of the lumbar vertebræ, overlying the solar plexus and semi-lunar ganglion; this had apparently spread along the renal plexus of vessels; it did not extend over to the left side of the vertebræ. The peritoneum anterior to the kidney was severely lacerated, and so allowed escape of blood into its cavity. The upper half of the kidney was literally smashed into a pulp, but more so on the anterior surface than the posterior, extending down to the pelvis of the kidney. There were several large branches of the renal artery laid open. We could detect no wound of the trunk artery or vein. There was also a small deep jagged wound in the lower half of the kidney on the posterior surface, which looked as if a rough object had been driven into it. The ureter appeared to be completely blocked by a blood-clot. Bladder empty and healthy; left kidney and ureter healthy. There was no evidence of the lower ribs having been driven through the abdominal walls.

*Remarks.*—The noteworthy feature of this case is how such an extensive injury to the kidney should have been caused without fracture of any ribs. The sudden cessation of hæmaturia was apparently due to clots in the ureter. The rapidly-increasing anæmia, together with the hæmaturia and fulness of the iliac region, pointed presumably to hæmorrhage from the kidney; accordingly, astringents were given. Mr. H. A. Reeves, F.R.C.S., in a case published by him in THE LANCET of Oct. 4th, 1884, says that as soon as it is found that hæmorrhage is not controllable after trial of every known means, a lumbar incision should be made over the kidney, and all clots and blood removed, and the kidney also, if necessary. It occurred to me, if it would have been justifiable to cut down and remove the kidney as soon as it became evident that hæmorrhage was profuse, obviously in such cases to wait the effect of a lengthy trial of astringents means waiting till too late. I do not feel competent to give an opinion as to the actual cause of this injury; but remembering the fact that the boy was crushed beneath a great mass of coal, it occurred to me that the kidney may have been suddenly dislocated, as it were, by the force of the blow, and at the same time caught between the vertebræ and the suddenly compressed ribs; and what makes this idea more tenable is the fact that the boy was small and very thin for his age, and that the anterior portion of the kidney was the most severely damaged.

Kettering.

#### ON A

### FATAL CASE OF ACUTE DELIRIOUS MANIA COMPLICATED WITH PAROTITIS.

By JAMES M. WILLIAMSON, M.D. EDIN.,

HONORARY SURGEON TO THE ROYAL NATIONAL HOSPITAL FOR CONSUMPTION, VENTNOR, ETC.

THE patient in this case was an American lady, aged forty, but looking older. She was a highly educated and talented woman, and was the principal of a large educational establishment. Overwork had brought on nervous prostration and insomnia, for which Dr. Hammond, of New York, ordered rest from work and change of scene. For twelve months the patient followed this advice, travelling in England, but without much benefit. During April, 1885, while at Bournemouth, she had a throat attack, suspected to have been diphtheritic, and accompanied by what she called "delirium." The patient came to Ventnor early in the next month (May), and consulted me on the 10th for insomnia. Her catamenia, regular as yet, began on the 12th, and brought on increased restlessness and irritability, upon which chloral and the bromides made no impression. On the 14th she was in bed, her mind excited and wandering. The pulse was rapid, but the temperature not elevated. The tongue was dry; the breath offensive; appetite absent; but the bowels were not confined, and the urine was freely voided. In two days more

she was deliriously insane, howling, laughing, incessantly talking, struggling, and trying to bite. She spat out food and saliva, and urine and fæces were passed into the bed, which had been made up on the floor. Morphia, given hypodermically, increased the excitement; but chloral—administered with much difficulty—somewhat lessened it. On the 21st she was seen with me by Dr. Blandford of London, who confirmed the diagnosis. As the heart had begun to intermit, the chloral was abandoned, and paraldehyde ordered instead. The food was limited to eggs and milk. From this time slight improvement took place until the 24th, when swelling of the left parotid gland was observed. The swelling had taken place rapidly during the night, and extended to the malar bone and behind the angle of the jaw; it was hard and very tender, but free from redness. Two days afterwards the right parotid took on the same action, giving the patient the characteristic aspect of mumps. During gleams of consciousness much complaint was made of pain, and attempts at swallowing were virtually abandoned. Feeding by the nares was impracticable, whilst hæmorrhoids that bled copiously at every touch precluded the use of nutrient enemata. No suppuration took place in the parotids, but from this time the strength swiftly declined. Exhaustion passed into coma, and death took place on the 29th, which was the sixteenth day of the illness.

*Remarks.*—It is to the occurrence of the parotitis in this case that attention is drawn, and it is worth noting because it really turned the balance against the patient at the critical point in her illness. Without referring to the difficulties it threw in the way of treatment, the question of causation is full of interest. It was clearly not a case of idiopathic parotitis. Anyone who had for the first time seen the patient when both parotids were swollen would assuredly have thought of mumps and meningitis; but even had there been no history the delirium could not have been mistaken for that of meningitis. The condition was symptomatic, and not idiopathic. A great deal is heard now of the sympathy between the parotids and affections of the generative organs; in this case, however, although the approaching menopause may have had some share in inducing the maniacal attack, so far as could be ascertained there was nothing wrong with the external or internal organs of generation, or with the mammæ. The case ranks with those similar affections of the parotid which have long been known to occur towards the termination of fevers. Some have held that in these circumstances the parotitis results from a spread of the specific poison of the fever. Since the condition has been seen in pneumonia, however, others have ascribed it to the extension of oral inflammation. The present instance confirms the latter view. The mucous membrane of the mouth was dry and parched and covered with dead epithelium; possibly the milk that was retained in the mouth helped to increase the oral inflammation; but no aphthæ were seen. The incessant action of the jaw and the retention of saliva in the parotid may have been contributing agents. So far as I can gather, this parotid complication, well-known in some severe diseases, does not appear to have been much recognised in connexion with acute delirious mania.

Ventnor, Isle of Wight.

### ON SOME OF THE PROPOSED CHANGES IN THE LUNACY ACTS.

By JAMES ADAM, M.D.,

RESIDENT PHYSICIAN, &C., WEST MALLING ASYLUM; LATE MEDICAL SUPERINTENDENT, CRICHTON ROYAL INSTITUTION, SOUTHERN COUNTIES ASYLUM, AND CATERHAM ASYLUM, SURREY.

THE measure introduced by Lord Selborne is already familiarly known to the public and the medical profession. It was presented to the House of Lords during the last session of the last Parliament, and was ordered to be printed on March 26th, 1885. It met with by no means unanimous approval, and some of its provisions were so much objected to that they led to the resignation of Lord Shaftesbury as chairman of the Board of Commissioners in Lunacy; but it was hailed with satisfaction by others, and it came at last to be accepted on the belief that it was necessary to do something to allay the public agitation and suspicion which had been strongly aroused on the subject. The Bill passed through

the House of Lords, and as amended in committee was ordered to be printed on May 30th, 1885; but, owing to the change of Government occurring about that time and the rapid winding up of the session, it became a dropped order, and did not reach the House of Commons.

The principal objects sought to be attained by this Bill may shortly be stated as follows:—To furnish safeguards against the improper confinement of persons as lunatics; to give facilities for the medical treatment of persons who desire to submit to treatment; and to enable public asylums to be provided for the reception of lunatics not paupers. It was stated that the Bill adopted in the main the recommendations made by the report of the Select Committee of the House of Commons on Lunacy Law in the year 1878, and that the principle of the Scotch procedure had been adopted. No part of the Bill was more warmly discussed than Section 3, which provided that, except in cases of urgency, a person not a pauper should not be confined as a lunatic without an order of a county court judge, stipendiary magistrate, or justice, to be obtained upon a petition presented, if possible, by a relative, and accompanied by two medical certificates; and it was the retention of this provision in the Bill after protest against it by Lord Shaftesbury which led to his resignation, as already stated. It is perhaps unnecessary to remark that it is on this point also the Scotch procedure differs most essentially from the English; and much has been urged both for and against its adoption in England. In Scotland, except in cases of emergency or voluntary submission to treatment, with the previous assent of the Board of Lunacy, no person of unsound mind can be legally received into an asylum for the insane without the warrant of a sheriff, who is the principal legal functionary in each district. The sheriff grants this warrant upon the petition of a relative of the patient or other person, accompanied by the certificates of any two legally qualified medical practitioners resident in Scotland; but it is distinctly and clearly understood, and even stated by sheriffs, that they look upon their functions in this respect as “purely ministerial”; they consider their duty simply to consist in examining the various documents put before them, and if they are found accurately filled in the warrant is granted without further question; the alleged lunatic is neither seen nor examined by the sheriff personally, or those acting under him.

Now, it may be asked, where is the actual and real safeguard to the liberty of the subject here which does not already exist in the English Acts? In each country there is the same intervention of a relative or other person and of two medical practitioners. In England the “ministerial” act of the sheriff alone is wanting; but in place of this is substituted, and admirably substituted, the vigilant supervision of the Commissioners in Lunacy, for within twenty-four hours of the admission of a patient into an English asylum, a copy of the order of the relative or other person, who takes the place of the petitioner in Scotland, and the two medical certificates, must under penalties be submitted to the Commissioners in Lunacy. There is no “merely ministerial” performance of duty here; the slightest omission, flaw, or inaccuracy calls for amendment. Within a given time, or if the facts indicating insanity stated are vague or not sufficiently strong, a further statement of facts will certainly be called for, and if not forthcoming the patient may be summarily discharged. The framers of the Bill of last year seem, while adopting the Scotch procedure in the main, to have been fully alive to the weakness of the “merely ministerial” function assigned to the sheriff in Scotland, for it is expressly stated in the Bill that in order to give the county court judge, magistrate, or justice in England something more than “merely ministerial” functions in cases which require investigation, he is empowered, if he considers the statements in the medical certificates unsatisfactory, to make inquiries, and, if he thinks it necessary, to *visit* the alleged lunatic. The wisdom of the provision giving these increased powers to the civic authorities has been much contested by those who have had the best opportunities of watching the practical working of the Lunacy Acts. At a meeting of the Medico-Psychological Association, held at Bethlem Hospital in May last, this question was fully discussed, and the general feeling elicited during the discussion was that magisterial interference was not desirable in England, but if its adoption by the Legislature should prove unavoidable and unpreventable, that the evil should be minimised to the utmost extent. A resolution was finally agreed upon in this event, as follows: That the function of the magistrate to visit and examine a patient

ought to be omitted from the Bill; that the power of the magistrate should be purely “ministerial”; and that, when any doubt on medical questions arose, the magistrate should only have power to direct a further medical examination. Thus the argument with regard to the desirability and the usefulness of the introduction of the magistrate &c. revolves in a circle.

I have, I think, succeeded in showing that the “ministerially” signed warrant of the sheriff in Scotland is a practically useless document in so far as it gives increased security to the liberty of the subject in that country. This is practically admitted in England, for it is proposed in the Lord Chancellor's Bill to give something more than “merely ministerial” functions; whereupon this proposal to extend magisterial powers in England, as compared with Scotland, is at once met by the almost unanimous opposition of those best qualified to judge of the effects of such magisterial interference upon the patient himself, his relatives, and the privacy of domestic affairs; and we are forced to return to the point in the circle from which we started, and the question once more presents itself—Is it or is it not desirable to alter the existing law at all on this point?

A further and important question, however, still remains open for consideration, which is closely connected with the desirability or otherwise of the introduction of the magistrate, and that is the degree in which protection would or would not be afforded under a warrant issued by a magistrate to members of the medical profession on whom the duty might devolve of signing the certificates. Should the magistrate be introduced in any future Bill, and his duties be defined in it to be “merely ministerial,” possibly more responsibility would thus be thrown upon medical certifiers or witnesses than if the magistrate were empowered to act in his “judicial” capacity. In connexion with this arises the interesting question, What is the present legally protective value to members of the medical profession of the sheriff's warrant in Scotland? An answer to this from high legal authority would be exceedingly useful in solving many existing doubts on the subject. It may be remarked *en passant* that the Lord Chancellor's Bill as amended in committee contained the following clause, which seems to afford adequate protection to medical practitioners; and a similar clause must of necessity find a place in any future Bill if medical men are called upon under it to perform similar duties, otherwise they will probably be declined: “A medical practitioner who in the manner required by this Act signs any certificate that a person is of unsound mind shall not be liable to any civic or criminal proceeding for signing such certificate, or for any act done with the view of enabling the practitioner to sign the certificate, if the certificate is signed and the act is done in good faith.”

No dissentient voice has hitherto been raised to the admirable principle announced of affording facilities for the medical treatment of persons who desire to submit to treatment. Clause 30 provides for voluntary residence in asylums of *any person* who has obtained the previous consent of the commissioners or visitors. This practice has been long in beneficial operation in Scotland, and it is not confined there, as at present it is in England, to persons who have within a period of five years been previously in an asylum under certificate. The same remarks apply to the new certificate of urgency. A clause certainly does already exist in the present English Acts which permits reception of a patient in cases of urgency on one medical certificate, but the steps which require to be taken subsequently neutralise its value. In Scotland the certificate of emergency is frequently used, and it is found very efficacious in enabling dangerous patients to be at once placed under proper care and control for a given period, during which, if necessary, more formal documents can be procured.

Finally, by Clauses 54, 55, and 56 of last year's Bill, power was conferred on justices of county or borough asylums to make such alterations in or additions to the asylum, either by way of detached buildings or blocks of buildings or otherwise, for the purpose of providing accommodation for lunatics not paupers; justices were also empowered to make provision for the reception of pauper and private patients together or in separate asylums, and also to provide separate asylums for patients suffering from any particular class of mental disorder. The powers thus conferred upon justices, although merely permissive, clearly would have enabled them to provide for the poorer classes other than paupers, by annexes &c. to existing county or borough

asylums; but the powers seem vague and ill-defined with regard to the provision to be made by justices for some 3321 patients of the upper and middle classes who are now resident in the metropolitan and provincial houses licensed for their reception by commissioners and county justices, the friends of whom would probably object to their removal from private and domestic surroundings suitable to their stations in life to the precincts of a pauper asylum. In introducing his Bill to the House of Lords, the Lord Chancellor, however, remarked that there was nothing to prevent justices purchasing for a fair value the existing licensed houses in which these patients are now under care, and converting them into public institutions.

## 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. BARTHOLOMEW'S HOSPITAL.

A CASE OF DOUBLE POPLITEAL ANEURYSM; LIGATURE OF BOTH FEMORAL ARTERIES; RECOVERY.

(Under the care of Mr. MORRANT BAKER and Mr. BRUCE CLARKE.)

THE treatment of double popliteal aneurysm would be carried out by the majority of surgeons in a similar manner to that used in the following case. Some still object to the employment of digital compression before ligature, believing that such treatment injures the vessel and leaves the patient in a worse condition if unsuccessful. But when the pressure is properly regulated and skilfully applied, in cases where the artery at the point of pressure is healthy, no local damage arises, and after-ligature is quite satisfactory. As the risk of operation is increased by the simultaneous ligature of the two vessels, few would be inclined to perform it, although it has been done with success.

For the following notes we are indebted to Mr. Frederick H. Wigmore, house-surgeon.

J. P.—, aged thirty-eight, a compositor, was admitted into Darker ward on Dec. 28th, 1885, suffering from double popliteal aneurysm. Three months previously he first noticed in the left popliteal space a pulsating tumour about the size of a walnut, which had gradually increased in dimensions. Two months ago he experienced very considerable pain in the right popliteal space, and his knee-joint was treated as for rheumatism. There was no history of individual injury or family history of aneurysm, but there was a distinct account of syphilis ten years ago.

On admission the man was pale and badly nourished, with numerous pits of small-pox on his face. In the left ham, and situated just behind the knee-joint, was a pulsating swelling about the size of a hen's egg. The whole tumour was very soft, and could be made almost completely to disappear by slight pressure when the common femoral was controlled by the finger; and if, while the sac was still compressed, the common femoral was allowed to go free the aneurysm was found to fill by gradually increasing leaps and bounds, three pulsations at least being required to distend it to its usual limits. The pulsation was expansile, and synchronous with the heart's beat. There was no thrill to be felt by the hand placed upon it, or bruit when the stethoscope was applied. The pulse in the tibial arteries was feeble. In the right leg there was a large and feebly pulsating tumour as large as a man's clenched fist, extending from between the hamstring tendons under the inner hamstrings as far round in front as the inner border of the rectus muscle, and on the outer side to the tendon of the biceps. There was a distinct thrill to be felt and bruit to be heard in the tumour, which was very painful. The patient had been losing flesh, and was manifestly very weak. His appetite was bad. The temperature was just above normal. The bowels were rather confined.

The pulse at the wrist was strong, but intermittent. Urine: sp. gr. 1020; acid; contains phosphates, but no albumen or sugar. Both radial and tibial arteries were hard. An examination of the chest and abdomen disclosed the following physical signs:—Movements fairly good; vocal vibrations increased at right apex; no thrill to be felt. Heart's dulness normal. Right apex slightly impaired to percussion. A somewhat flatter note to be obtained in the second right intercostal space near sternum and over aorta. On auscultation expiration at right apex was found to be prolonged and tubular; vocal resonance increased over same area. Heart sounds: first sound thumping at apex; second pulmonary and second aortic sounds loud and forcible; aortic sounds conducted some distance from sternum; first aortic sound soft and altered, but not a murmur. Posteriorly the physical signs corresponded with those in front of the chest. No crepitant sounds anywhere. Liver and spleen not felt. Pulsations of abdominal aorta forcible and pronounced.

Since pressure upon the common femorals easily controlled the pulsations in the aneurysms, it was determined to try the effect of such pressure before resorting to ligature of the artery. Accordingly, at 3.30 P.M. on Jan. 2nd, a Holden's shot-bag containing 9 lb. was applied (a finger intervening) to the right common femoral, high up. The pulsations were readily controlled, and there was an increase in hardness of the sac. At 6.45 P.M. the patient was much exhausted, and the pressure was discontinued. The pulsation was almost checked, and the sac was very hard. The pulsation recommenced, however, in a very short time.

Jan. 3rd.—Pressure was applied from 9 A.M. to 1 P.M. and from 3 to 7 P.M. The result was not satisfactory, the pulsations being as strong as ever. Complaints of some pain in the right tumour. Pulse 100; temperature subnormal.

5th.—On the right side the aneurysm seems to have extended a little up the limb, and pulsation appears to be strong over a wider area. Complaints of some numbness.

6th.—2 P.M.: A discoloured patch observed on the skin over the right aneurysm. Œdema behind ankle. The aneurysm has extended slightly up the thigh. The patient was consequently taken down to the operating theatre, and, he having been placed under ether, the right femoral artery was tied by Mr. Morrantly Baker at the apex of Scarpa's triangle. The artery was tied in two places with kangaroo-tendon ligatures and divided between, there being an interval of about three-quarters of an inch between the two ligatures. A small drainage-tube was inserted, and the wound, having been cleansed with warm carbolic lotion, was closed with silver sutures. The whole was dressed with sanitas oil (1 in 30 of olive oil), lint, and antiseptic gauze. The limb was carefully wrapped in cotton-wool, and hot bottles were placed in the bed.

7th.—Passed a good night. Has taken food well. Limb warm; no pulsation to be detected in the aneurysm. The tumour on the left side remains the same.

8th.—Toes warm and moist; blush returns after pressure. Temperature normal.

9th.—Aneurysm pulsates; has diminished in girth three quarters of an inch since the operation; wound dressed and looking well; sensation of limb unimpaired. The aneurysm of the left leg seems to have extended upwards and downwards in the popliteal space. No discolouration of the skin or œdema of the leg. Girth, 12½ in.

11th.—Wound dressed and doing well. No change in left aneurysm.

12th.—Drainage-tube withdrawn, and not replaced. Left aneurysm appears to have extended, and the skin over it is slightly discoloured. Temperature subnormal. On account of the rather sudden alteration in the aneurysm, the left femoral artery was, in the absence of Mr. Baker, tied by Mr. Bruce Clarke near the apex of Scarpa's triangle in two places, and divided between. Kangaroo tendons were used as ligatures. A drainage-tube was inserted, and a dressing of moist carbolic gauze was applied.

14th.—The right wound shows some signs of slight discharge from the track of the drainage-tube; elsewhere it is healed. The left wound had its drainage-tube removed. The temperature has gone up to 101.5°; pulse 120.

15th.—Right wound looking exceedingly well; left wound appears healthy; no pulse in either aneurysm; sensation not impaired, and toes warm. Feels comfortable.

19th.—Right wound quite healed, and dressing discontinued.

20th.—Left wound is breaking down; pus discharging;