

of the attendants. This closer watch soon told, as by the 14th the pulsation was obviously lessened in both tumours. On the 15th the treatment was supplemented by digital compression for an hour, and this was continued for a few minutes daily. On the 18th the pulsation was noticed to have entirely ceased. Subsequently a narrow channel corresponding to a part of the area of the popliteal pulsated, but the tumour presented no trace whatever of pulsation and has since increased in solidity and diminished in size daily. I kept on the instruments for a few days longer and enjoined quiet for a couple of weeks. The patient's heart was not sound, but otherwise he was free from organic disease. His habits had been good, and he had never suffered from any grave disease. He had noticed the tumour only some two months before. I may add in conclusion that the Esmarch's bandage was twice tried without any result prior to May 9th, as was also a flexure of the knee-joint. The successful result in this case was due to instrumental compression rigorously applied and continuously maintained.

Cashel.

COEXISTENCE OF INFECTIVE DISEASE IN THE SAME INDIVIDUAL.

BY GUSTAVUS G. GIDLEY, L.R.C.P. LOND.,
M.R.C.S. ENG., &c.

ADVERTING to Dr. Carmichael's notes on the above in THE LANCET of May 19th, I am tempted to record the following case, which I think may be of interest.

A boy six years of age developed scarlet fever in July of last year. I first saw him on the second day of the attack. It was a typical case and, though not severe, was of more than average vigour. The temperature rose to 104° F., and there was some slight delirium during the second night. By the sixth day his temperature had sunk to 99°, and desquamation had commenced on the chest. He was happy and comfortable, sat up in bed and played with his toys, and seemed to be making satisfactory progress. During the week his bowels had acted freely about once a day. Next day, however, he was not so well, being thirsty, peevish, and uninterested in his toys. His nose had bled in the night, and his bowels had acted two or three times. His temperature was between 99° and 100°. On the following—i.e., eighth—day he was no better. By the fourteenth day there was no doubt that it was a case of enteric fever. There was diarrhoea from four to six times, or even more, in the twenty-four hours, the motions being characteristic in odour, colour, and consistence. The temperature ranged from 102° to 104°. There was enlarged spleen and cæcal tenderness. During the following week the affection progressed, the child got much weaker, his tongue was dry, brown, and cracked, and the diarrhoea continued. On one occasion the bowels acted about every hour and a half for a day and a night, the abdomen became tympanitic and distended, and the temperature rose above 105°. The cause, I found subsequently, of this might have been accounted for in the fact that, he having cried "two whole hours" for sponge cakes on the previous day, a couple were accordingly smuggled, liberally interspersed with currants, into his hands—and he ate them. As one may expect, he got worse after this, and his entry into his third week of the typhoid fever was very unpromising, his emaciation being very pronounced; he was apathetic, delirious at times, and did not care to drink or be moved. Happily, as the week wore on, he improved; the diarrhoea became less frequent, and the temperature came down slowly, so that by the thirtieth day there was every hope of recovery. He made a good convalescence.

The peculiarities of the case were that there were no spots or rash after onset of the enteric symptoms, and that during this time the temperature was one or two degrees higher each morning than in the evening of the same day. The desquamation ceased immediately on the appearance of bowel trouble, but reappeared when the temperature had gone back to normal, and went on vigorously all over for a fortnight or more. As to causation, I found that the patient had been away shortly before his attack, and that another inmate of the house in which he had stayed also developed typhoid fever. Scarlet fever was epidemic here at the time. The means of isolation were very complete, and no other case of either affection appeared in the house, or, I believe, of typhoid fever in the town.

Cullumpton.

¹ I kept a chart, but have mislaid it, and so quote from memory.

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.

THE EASTERN FEVER HOSPITAL, HOMERTON.

AN UNUSUAL CASE OF PERFORATION IN ENTERIC FEVER.

(Under the care of Dr. E. W. GOODALL, Medical Superintendent.)

WE have considered this case worthy of publication for the reasons mentioned by Dr. Goodall in the remarks. As regards the situation of the perforation in some cases examined, Murchison¹ wrote: "In the majority of cases the perforation is in the ileum, more rarely it is in the appendix vermiformis or in the colon. Of ten cases collected by Louis the opening was in the lower part of the ileum in all. Of thirty-nine cases in which I have noted the situation of the perforation it was in the ileum in thirty-four, in the appendix vermiformis in one, and in the colon in four. Morin in his memoir has tabulated sixty-four cases collected from different sources with somewhat different results. Of the sixty-four cases the perforation was in the jejunum in two, in the ileum in thirty-six, in the appendix vermiformis in twelve, and in the colon in fourteen. Of my thirty-four cases where the perforation was in the ileum, in twenty-seven it was within twelve inches of the ileo-cæcal valve, in six it was between twelve and twenty-four inches above the valve, and in one it was thirty inches above the valve. I have never met with a perforation higher than this; but Bartlett mentions a case where it was as high as forty-four inches and Bristowe another where it was seventy-two inches above the valve, while Morin cites two instances of enteric fever—one on the authority of Lebert—in which the perforation was found in the jejunum."

A married woman aged thirty-nine was admitted into the Eastern Fever Hospital on March 2nd, 1894. Her husband, three sons, and a daughter were also inmates of the hospital at about the same time. The husband suffered from a slight febrile attack, having none of the symptoms of enteric fever, but the children all had severe attacks of enteric fever, and one of the boys died from the effects of prostration and peritonitis. Her husband said she had been ill for ten days before she was brought to the hospital. On admission she was found to be suffering from a well-marked, but not then severe, attack of enteric fever; during the next few days she became worse. The temperature, which up to the morning of March 6th had never reached 103° F., began steadily to rise on that day, so that on the 8th it was above 104°, and on the 9th it reached 105°. On the 10th it varied from 102·6° to 104·6°; there was on this day slight abdominal pain and distension; pulse 124 per minute, regular, soft. On the morning of the 11th the temperature dropped to 101°, rising again in the evening to 104·2°. On the 12th the temperature was only once below 104° (103·4°). On the 11th, 12th, and 13th there was still abdominal pain, and the patient also complained of a sensation of flatulence and was occasionally sick; the abdomen was only slightly distended. Up to the 12th there had been no action of the bowels except after an enema, but on that day there were six light and loose stools. On the 15th the temperature varied from 101·6° to 103·8°, and the patient was occasionally delirious; pulse 132; there had been no further action of the bowels; the abdomen was flaccid, and there was no distension and no abdominal pain. The patient remained in much the same state up to March 31st; the pulse-rate was usually about 130 per minute, the temperature varying from 101·2° to 103·2° and no new symptom appearing. On the 21st she was troubled with coughing, which continued for some three or four days. On the morning of the 23rd the temperature fell to 99°, but rose to 103·4° in the evening, falling to 99·6° the next morning; on this day, the 24th, the pulse-rate went up in the morning to 140. The patient was

¹ Continued Fevers, p. 628.

better next day and continued to improve, though slowly, up to April 2nd; the temperature during this period was, on the whole, lower than it had been before, ranging from 99·2° in the morning to 102° in the evening. On the evening of April 2nd the patient appeared to be as well as on any occasion since her admission; at 10 P.M. the temperature was 102°, at 2 A.M. on the 3rd it was 100°, and at 6 A.M. 100·8°; during the night the patient's condition showed no alteration; suddenly, at 8.50 A.M., she complained of severe pain in the abdomen and vomited; she very quickly became collapsed and within ten minutes was dead.

A necropsy was made at 5 P.M. on the same day. The body was found to be well nourished; there was no peritonitis; there was a considerable amount of faecal material in the pelvis; a perforation was discovered in the small intestine before the bowel was opened; the loop of gut in which the perforation was found was situated at the back of the brim of the pelvis, at about the middle line; the hole was large enough to admit a No. 5 catheter. On slitting up the intestines the perforation was found to have taken place in an ulcer three and a half feet above the ileo-cæcal valve. Ulcers were seen to have occurred over a large portion of the small intestine; the first was met with seven feet four inches above the valve; the ulcers situated furthest from the valve still had sloughs adherent to their bases; the nearer the valve was approached the more had the sloughs separated, while quite near the valve some of the ulcers were entirely healed. There was one healed ulcer at the commencement of the ascending colon. The spleen was enlarged and weighed twenty-one ounces. Except for a small infarct in the upper lobe of the left lung, the other organs appeared normal.

Remarks by Dr. GOODALL.—I have thought this case worthy of being put on record, firstly, because of the extreme rapidity with which death followed the first symptom of perforation—less than ten minutes; and, secondly, because of the situation of the perforation—three feet and a half above the valve. The suddenness with which death took place was, I suppose, due to the effects of the shock that is so often seen in cases of perforation, occurring in a patient who had been ill about six weeks with a severe attack of typhoid fever. I am not aware of any case in which death took place in less time than a few hours, nor do I remember to have read of any case in which the perforation was situated at so great a distance above the valve. Usually perforation occurs within the lowest two feet of the small intestine, though Murchison recorded one case in which an ulcer two and a half feet from the valve had given way.

CITY OF GLASGOW FEVER HOSPITAL, BELVIDERE.

A CASE ILLUSTRATING THE RECURRENCE OF DIPHTHERITIC INFECTION.

(Under the care of Dr. WATSON.)

DR ISAMBERT has recorded a case of diphtheria where the patient for some months after recovery continued to discharge pieces of membrane from his nose, and Dr. Greswell has demonstrated that it is possible for a person to communicate diphtheria to others even long after he has recovered from an acute attack of that disease. The report of the Clinical Society¹ also includes the account of cases in which the individual who infected others was either convalescent or was supposed to have completely recovered (he is not known to have presented any symptoms whatever). The following notes of a case, therefore, may be of interest from their adding testimony to both of these statements.

On Feb. 15th of this year a child two years of age was admitted to the City of Glasgow Fever Hospital suffering from a typical and rather severe attack of diphtheria. His tonsils were enlarged, congested, and covered with membrane. The breathing was croupy and laboured. The urine was albuminous. The tonsils were excised, equal parts of pure carbolic acid and glycerine being applied to the wounds. The next day it was noted that the congestion was less and that no membrane had re-formed. The breathing continuing difficult, poultices had been applied to the neck during the night. It was reported on the 17th that his progress was good, no membrane having reappeared since the removal of the tonsils; and next day, the throat being quite clean,

all local treatment was stopped. The throat was noted as remaining clean on each of the succeeding days, but on account of the presence of a slight amount of albumen in the urine the patient was kept in bed until Feb. 26th. The urine having cleared, the child was then allowed up, and on March 10th he was dismissed well, having for a week previously been out of doors daily. An examination of the throat made just before dismissal revealed a perfectly normal state of the tissues. Cough was noted as having been absent since Feb. 19th, and his voice had not been croupy since Feb. 20th. Apparently he had caught cold on the way home, for next night he was restless and coughing. On the following night (March 12th) he, after a fit of coughing, expectorated what his mother described as skin-like stuff about one inch square, of a greyish appearance, blood-streaked on both sides, and capable of being torn into shreds. He continued to cough up this material at some days' interval, the last being seen on April 1st. During this time he did not seem to be at all ill, and continued at play with the other children. Not being under medical observation all this time his urine was not examined. While he was in hospital his parents for safety had removed to another house, taking with them the three other members of the family. On his return all the children played together from the first, and were seen to kiss each other. Nine days after the patient's return home another child, aged four, who had been occupying the same bedroom as his brothers became ill, and was admitted to Belvidere Hospital. He had a malignant attack of diphtheria and died there. On April 2nd another member of the family was reported as having diphtheria, and, unfortunately, his attack also proved fatal.

Medical Societies.

OPHTHALMOLOGICAL SOCIETY.

Optic Neuritis in its Relation to Cerebral Tumour and Trephining.—Some Points in the Histology of Trachoma.—Osteoma of Orbit.—Congenital Serous Cysts of the Eyelids associated with Anophthalmos or Microphthalmos.

AN ordinary meeting of this society was held on Thursday, June 14th, the Vice-President, Mr. GEORGE LAWSON, F.R.C.S., in the chair.

Dr. JAMES TAYLOR read a paper on Optic Neuritis in relation to Cerebral Tumour and Trephining. He alluded to the fact to which Mr. Horsley had some time ago called attention—namely, the subsidence of optic neuritis after operation undertaken with a view to the removal of cerebral tumour, even when the tumour was not removed. Similar observations had been recorded by Bruns and Erb, and in this paper it was intended to emphasise the fact that not only in cases in which tumour was removed from the brain did the optic neuritis subside and the discs resume a normal appearance; but even in other cases of tumour in which the skull was opened, but the tumour not removed or interfered with further, a similar subsidence of the swelling of the discs took place. Three cases of optic neuritis associated with intracranial tumour were first related, in which the tumour was removed and the optic neuritis subsided. Another group of three cases was next detailed. In all of these there were the usual symptoms of intracranial tumour. All were trephined, and in two of them the tumour was visible at the operation, but was not removed or even incised. Yet the neuritis in one entirely disappeared, although the patient subsequently died and tumour was present; in the second the swelling had diminished by one millimetre, although the tumour, as was apparent from the symptoms, continued to grow, and the patient died soon after passing from observation. In the third case of this group the symptoms pointed to cerebellar growth, probably tuberculous, though no tumour could be found at the operation; but the swelling of the discs which was present disappeared, although slight impairment of vision remained in one eye. A third group of cases was next described, consisting also of three. The first was that of a patient from whom a cerebral tumour was removed, and the neuritis, which was present in only one eye, disappeared. He subsequently died, and a cyst was found occupying the site of the tumour which had been removed. There was no recurrence of the neuritis when he

¹ On Incubation and Contagion. 1893.