

water before meals.—10th: No apparent change.—14th: More inclination for food manifest.—16th: Marked increase of appetite; child now quite anxious for food, bowels more regular, and tongue rather cleaner.—20th: Improvement steadily maintained. Orexin stopped, and child put on cod-liver oil with compound syrup of the phosphates, both of which were taken without apparent gastric disturbance.

It would thus appear that orexin is in the loss of appetite concurrent with tubercular disease a valuable stimulant. The power of stimulating absorption of the products of digestion claimed for it seems to be merited, for under its use, as a rule, the tongue became less furred, and the constipation was relieved. Though, so far, these observations cover only a limited field, still the indications are that orexin is worthy of receiving an unbiased trial in suitable cases. It certainly cannot be claimed that the repertory is already too well-stocked with remedies for this special purpose.

Aberdeen.

## DEATH UNDER CHLOROFORM; WITH REMARKS.

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PRISCILLA D—, aged one year and seven months, had been an ailing child since birth, and for many months was treated as an out-patient at the General Hospital, Nottingham. She was admitted to the Children's Hospital under the care of Dr. Marshall on Jan. 31st, 1891, suffering from malnutrition. In the course of a few days noma of the hard palate, which rapidly spread to the upper lip, made its appearance, and on Feb. 7th I was asked by my colleague, Dr. Marshall, to administer chloroform, preparatory to his applying nitric acid to the diseased part. Being aware of the patient's serious condition, I gave the chloroform with extra caution, employing a Guy's mask held about half an inch from the face. The anæsthetic was taken quietly and well, insensibility being produced in four minutes; the pupils were equal and moderately contracted. Just as the nitric acid was about to be applied I noticed that the temporal pulse was more feeble, and immediately the respiration became slower and sighing in character, with slightly increased pallor of the face. Artificial respiration was promptly commenced before the natural breathing had ceased, which, however, occurred in a few seconds. The pulse was by that time imperceptible at the wrist, and remained so to the end. In about ten minutes' time three or four voluntary gasping inspirations were made, followed in a couple of minutes by three or four others. No further efforts to breathe took place. Artificial respiration was carried on uninterruptedly for half an hour; in addition, galvanism, hot fomentations, and elevation and friction of the lower extremities were employed; but all proved futile. No post-mortem examination was made. There was no evidence of cardiac disease during life.

Let me preface my remarks on the above case by saying that for the last six years I have been in the habit of constantly administering anæsthetics—in all nearly 1600 times. Of these 1600 cases it has been necessary to employ artificial respiration on four occasions. The operations were: (1) circumcision, the anæsthetic used being chloroform; (2) vesico-vaginal fistula, chloroform; (3) ankylosis of hip-joint, chloroform; (4) inguinal colotomy, alcohol, ether, and chloroform mixture. All four cases breathed naturally after a few minutes, and in none of them was there any failure of the pulse; thus confirming the opinion of the Scotch medical schools—viz., "that the respiration always fails before the pulse, and that if the breathing is closely watched the pulse may be disregarded." I have lately become convinced that such teaching is at any rate an erroneous one if the chloroform is being administered for the treatment of nævi by electrolysis. During this operation it is a common occurrence for marked enfeeblement of the pulse, with slowing of the respiration, to take place; the effect, however, on the pulse and respiration being in direct proportion to the strength of the electric current employed, but the main effect is usually on the heart. I have noticed the pulse disappear at the wrist,

though the breathing continued. I am indebted to Dr. Marshall for the observation that this danger is most to be feared if the nævus be situated on the scalp. If, then, failure of the heart's action is the thing most to be apprehended during anæsthesia for the electrolysis of nævi, may not such a danger be occasionally the primary one, when anæsthesia is induced for other purposes, the death of the above patient being a case in point? There is little use in publishing an account of a death occurring under anæsthesia unless the case be examined from many aspects. 1. Children suffering from noma occasionally die suddenly. 2. The patient was one whose natural feebleness was much increased by the depressing nature of her complaint. It was improbable that she would have survived more than three days. The arrest of the gangrene was her only chance of recovery. 3. An anæsthetic being necessary, was it right to use chloroform? Knowing the comparative safety of chloroform for children, I elected to use it rather than ether, on the ground that cases of noma usually die from septic pneumonia, and that ether producing a free flow of saliva over the slough, together with the irritation that ether causes to the respiratory track, would increase the tendency to pneumonia. I am conscious that it was an omission not to have given brandy immediately before the operation, but the child had been fed with small quantities of warm nutritious food every half hour. 4. Was the mask employed a suitable one? To this I must answer, Yes. The chloroform was freely diluted with air, the mask not being applied close to the face, and at no time did the child receive an extra dose of chloroform. The mask is one which has been used for many years at the hospital with success. Personally I usually employ a small folded towel or Lister's method, but have also frequently used the mask. It matters little what particular method be adopted if attention be not paid to the essential points of successful administration—viz., a supply of chloroform vapour of constant strength, freely diluted with air, and the quantity regulated according to the depth of the patient's respiration.

Nottingham.

## Clinical Notes:

### MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

#### THE "STERNAL SYMPTOM" IN BREAST CARCINOMA.

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UNDER the above title in THE LANCET of March 7th and 14th last was described a painless and slowly progressive prominence of the sternum between the second costo-sternal articulations, consecutive to carcinoma of the female breast. This is a common physical sign of latent marrow deposit; it is most conspicuous in broad-chested women; after an operation is often the sole objective indication of malignant disease; and, in the end, is invariably followed by other symptoms of "recurrence." It is of considerable practical value as showing that no complete immunity can be hoped for after removal of the affected organ. It is found where there can be no suspicion of any direct infiltration; it rarely gives rise to an actual tumour-formation. The following, however, is one of those exceptional cases in which a distinct new growth eventually appeared at this particular spot after a long interval of seemingly entire freedom from the cancerous malady.

Mrs. — of Cambridge, seen in consultation with Mr. T. Lucas, had her left breast excised for scirrhus by a very eminent local surgeon in 1884. She remained well to all outward appearance till May, 1890, when a prominent tumour grew from the sternum at the situation here indicated. This quickly ulcerated. In November last a round sloughy sore, three inches in diameter, with livid border and elevated edges, occupied a large part of the bone. The former site of the left breast was occupied by a perfectly healthy scar; there had been no reappearance in the soft parts of the chest wall. The left axilla contained a lymph gland slightly enlarged; this deposit was apparently