

again at 1 A.M. screaming and passed about an ounce of bloody mucus per rectum. At 9 A.M. he vomited again, and after screaming loudly and straining passed more blood. At 12 noon he vomited again. Temperature 99° F.; pulse 120; respiration 52. Upon abdominal palpation I discovered a small movable tumour to the right of the umbilicus, about an inch long. Nothing was discovered upon rectal examination. Having diagnosed the case as one of intussusception, I proceeded to forcibly inject warm water per rectum, with the result that the tumour could not afterwards be felt, and that about one ounce of blood was passed per rectum. During the rest of the day the child seemed much easier, but would not take the breast, so two minims of tincture of opium and two minims of tincture of belladonna were given every four hours. Urine was passed freely and the pupils reacted well. On the 11th at about 1 A.M. the child awoke screaming loudly and passed more blood; the screaming continued in paroxysms about every hour, and all attempts at disengaging the bowel mechanically proved ineffectual, but the parents objected to operative interference. The vomit was feculent; the abdomen was rather tympanitic; temperature 96.5° F. (per rectum); pulse 120; respiration 60. Severe convulsions occurred during the day at short intervals. Two ounces of urine were passed. On the 12th the child was very cold, notwithstanding the application of hot bottles. There were convulsions and screaming about every two hours. There was no vomiting and no melæna. Temperature 96.5° F. (per rectum); pulse 110; respiration 65. About ten ounces of urine were passed. On the 13th convulsions and screaming occurred nearly all day. There was no vomiting and no melæna. About six ounces of urine were passed. Temperature 96° F. (per rectum); pulse 100; respiration 65. The child gradually sank and died at midnight. Post-mortem examination showed an ileo-colic intussusception three inches in length.

Earl's-court-gardens, S.W.

#### EMBOLISM OF THE LEFT AXILLARY ARTERY.

BY T. H. DAVISON, M.B., C.M. EDIN., D.P.H. CAMB.

THE following case is, I think, instructive as showing how large an embolus sometimes accompanies heart lesions.

On Jan. 5th, 1893, I was asked to see a lady, aged seventy-three, who complained of bronchitis of long standing. On physical examination signs of chronic bronchial catarrh, aggravated by a fresh chill, were manifest. The heart sounds—owing to her extreme obesity—were indistinct, but a faint mitral systolic murmur could be detected. Ammonium carbonate and digitalis relieved the urgent symptoms. The patient progressed favourably till Jan. 13th, when I received an urgent message to visit her again, as she was worse. On inquiry the patient said "she had had a stroke" at 4 A.M., as her arm had "dropped" and become powerless. This was accompanied by a fluttering at the heart and sudden pain in the left shoulder. On examination her left arm was found to be numb, cold and pulseless, the forearm slightly flexed, the fingers strongly so; sensibility was absent from the hand to the elbow. From that time symptoms of dry gangrene rapidly appeared as far as the shoulder, death ensuing on Jan. 19th. Embolism of the axillary artery was diagnosed, which was verified at the necropsy. A few hours after death an examination was made, when a large embolus showing signs of organisation was found blocking the axillary artery in its second part; along with this there was complete thrombosis of the first part of the axillary and second and third divisions of the subclavian. The heart was large and flabby; the segments of the mitral valve were short and thickened; no vegetations were present, but in the left auricular appendix there was a large ante-mortem clot, from which without doubt the axillary embolus had originated. There was no atheroma of the vessels.

Newburn-on-Tyne.

#### AN INCISED WOUND, UNDER INTACT CLOTHING.

BY SIDNEY SPOKES, M.R.C.S.

THE case under Mr. Hulke's care, reported in THE LANCET of Jan. 21st, of a man with a lacerated wound simulating a stab, and inflicted through uninjured clothing, recalls to my mind a somewhat analogous instance. Some ten years ago I was, on emergency, called to see a man past middle-age and a widower, who was lying in bed in a cottage. I was told

something was the matter with his genitals, but found the patient very reticent, not to say bashful. Ultimately the bedclothes were turned down, and the right testicle was found outside the scrotum, protruding through the wrinkled integument and contracted dartos which closely surrounded the spermatic cord. The history obtained was that whilst leading a cart horse early the same day the man fell and the animal trod upon him. I therefore examined the corduroy trousers, and, discovering them intact, doubted the patient's statement. He then explained that in his pocket was a purse with a metal border and clasp, and that it was the latter which actually produced the wound and not the horse's shoe. I thereupon examined the pocket, but that was also intact. The edges of the wound were clean-cut and, combined with the man's behaviour, were suggestive of a case of unfinished self-mutilation. Corroboration of the accident was, however, forthcoming.

The testicle was cleansed and with considerable difficulty replaced in the scrotum; as I had no pocket-case with me, the wound was stitched with an ordinary needle and thread obtained from a neighbour, a spirit-and-water dressing was applied and the patient did well. The medico-legal aspect of such peculiar cases may warrant the recording of this one.

Queen Anne-street, W.

#### FRACTURE OF RIB DUE TO COUGH.

BY J. T. CHARLES NASH, M.B., C.M. EDIN.

A PATIENT aged fifty-four, convalescing from influenza with broncho-pneumonia, was sitting up in bed partaking of some fluid nourishment. While in the act of swallowing he was seized with a severe fit of coughing. Suddenly he felt intense pain under the left scapula, which was so severe as to completely arrest his cough and make him dread the slightest movement. On examination I found distinct evidence of a fractured rib under the angle of the scapula. Crepitus could be elicited, and was so distinct as to be heard at a distance of six feet. I immediately strapped the side, and, fortunately, this uncommon accident in no way further interfered with convalescence, though the illness had been a severe one. The points of especial interest are the rarity of the accident and the comparatively early age of the patient, the few recorded cases of a similar accident having occurred in persons of advanced age with diseased or brittle bones.

Beckenham, Kent.

## 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.

#### ROYAL FREE HOSPITAL.

PHOSPHORUS POISONING; NO SYMPTOMS FOR SIX WEEKS; THEN JAUNDICE AND SUDDEN DEATH AFTER SIX DAYS.

(Under the care of Dr. SAMUEL WEST.)

THIS case is an important contribution to toxicology and must attract considerable attention. In it the symptoms of the hepatic degeneration did not commence until six weeks after the last occasion on which phosphorus was known to have been taken, the longest recorded interval. Blyth,<sup>1</sup> from a study of 129 cases of poisoning by phosphorus, says that jaundice was present in 23 cases, and that it developed in one within nine days, in another within eighteen days and in a third within twenty-seven. The changes in the liver frequently induced by phosphorus, and first described by Hauff in 1860, may be advanced within twenty-four hours and prove rapidly fatal. "The jaundice having thoroughly pronounced itself, the system may be considered as not only under the toxic action of phosphorus but as suffering in addition from a the accidents incidental to the retention of the biliary

<sup>1</sup> Poisons: their Effects and Detection, p. 204.