

a very severe pain which he has experienced in his perineum and supra-pubic region. Patient, who is a strongly-built man, but who is now extremely cachectic, was very healthy until lately, when he began to suffer from the severe pains above described, and from frequency of micturition. His urine, which is turbid on being voided, has a feculent odour, and at times, when the last few drops are being expelled—a process which is accompanied by an excruciating pain—there is an explosion of fetid gas by the urethra. The urine on examination is found to have a sp. gr. of 1016; a thick turbid deposit, which occupies about half of the glass, is found on microscopical examination to be chiefly composed of pus-cells. Patient states that he has never at any time passed urine by the rectum, but it would seem that on one or two occasions after eating some grapes he passed a day or two afterwards a few of the seeds by the urethra. These he kept and showed to us. The introduction of a catheter into the bladder by Mr. Rigby was followed by an exacerbation of the symptoms, and it would appear that at the entrance into the bladder some difficulty was experienced to the progression of the instrument. An examination of the rectum by the finger and the speculum gave negative results.

On visiting this patient a few days after the above notes were recorded, we elicited the fact of his having had gonorrhœa twenty years ago, and that for the last four or five years he has had slight difficulty in micturating. He has never had any fever, but has complained lately of being chilly. The rectum was on this occasion explored with the hand, but, beyond a slight bulging in the region of the prostate, which was painful on pressure, nothing could be detected. The sufferings of this man were most intense. Relief from pain and a little sleep could only be obtained by the free use of opiates and the frequent employment of morphia suppositories.

The patient soon afterwards removed into the country, where we lost sight of him, until I was asked by Mr. Rigby to make a post-mortem examination on March 31st, 1877.

Autopsy, twenty-eight hours after death.—A plump body; rigor mortis well developed. There is a cyst about the size of a pigeon's egg just above Poupart's ligament on the left side; it is very superficial, and on being punctured very fetid gas escaped.—Chest: The heart is normal; valves and aorta healthy. The right lung is slightly emphysematous at the apex; otherwise it is normal. The left lung is hyperæmic, and somewhat œdematous at the base.—Abdomen: The abdominal wall contains a good thick layer of fat. Fat is freely distributed over the omentum. Peritoneum healthy, with the exception of that which is in the neighbourhood of the pelvis. The liver is very much enlarged; it is pale and friable. The left lobe is much increased in size. A few white spots are seen on the surface of the right lobe, and these when cut into are found to be collections of pus. Numerous and somewhat larger abscesses are met with in the interior of the organ, which seemed to be very definite in their distribution; they are arranged along both sides of the portal vessels. These collections of pus are only met with in the right lobe. The spleen is enlarged and soft, but otherwise healthy. Kidneys normal in situation. With its ordinary coverings upon it, the right kidney feels like an emphysematous lung. On being cut into, it is found to be a dilated, sacculated pouch, the covering of which is the thickened capsule, and the interior of which is lined by a delicate layer of what looks like softened renal tissue. The ureter is normal, and can be traced amid adhesions to the brim of the bony pelvis. The left kidney is in a state somewhat similar to the right. It is a distended sac, with exceedingly soft and flabby walls. Its pelvis is much dilated, and the ureter is dilated to about twice its normal size. The left ureter is traced with difficulty through some firm adhesions to the brim of the bony pelvis, and in its course we find it firmly bound down to the internal iliac artery. The stomach is healthy. On examining the intestines it is found that the colon is enormously distended, and filled with soft fecal matter. Lying across the brim of the pelvis, we find the terminal portion of the ileum, and from it there pass to the peritoneum in front and adjacent structures bands of lymph of a soft and friable nature. The surface of this portion of the intestine for about four inches in length is of dark-blue colour. Lying a little to the left and somewhat to the front is a portion of the sigmoid flexure. The bladder, the portion of the ileum above mentioned, and the sigmoid flexure are all matted closely together; and on slightly raising the terminal portion of the small intestine there wells out from underneath it a few ounces of a dark-green fetid

fluid of pretty thick consistency. The whole of the intestine, with the exception of those portions which are adherent by bands of lymph to the bladder, were removed, and we are now able to trace a line of communication of pus extending from the depot of dark fluid already described, through the inner wall of the abdomen just above the left Poupart's ligament, into a large abscess, whose contents are similar to the fluid just described. This collection of pus has undermined the abdominal wall in various directions. By one channel it can be traced up as far as the crest of the left iliac bone. By another canal this intra-parietal abscess can be traced towards, and is found to be in communication with, a large collection of pus lying in front of the psoas and iliacus muscles, and bounded in front by thickened peritoneum. The anterior crural nerve is much thickened. From a small portion of the fourth lumbar vertebra the periosteum has disappeared, and the body of that bone is undergoing softening. The pelvic viscera were removed *en masse*, and the bladder when cut into is found to be somewhat reddened towards its base; the vessels are injected. The entrance of the ureters is somewhat contracted. Towards the middle, and especially in the upper third of the posterior wall of the bladder, are five or six small perforations, each of which is surrounded by a ring of slaty pigmentation. These small foramina are seen to pass directly into a large ragged space, from which exuded the dark fetid pus already noted. Immediately behind this abscess lies the terminal portion of the ileum; in fact, the surface of the gut forms the posterior wall of the abscess. The intestinal wall for about four inches is in a state of deep pigmentation, and tears like blotting paper. It is pierced at one spot by an opening large enough to admit a penholder. Around this opening there is a ring of inflammation. Direct communication, therefore, exists between the lowest portion of the small intestine and the bladder through the intervening collection of pus. The sigmoid flexure and rectum are normal.

This case is of interest partly from its rarity and partly from the absence of any definable cause to account for the inflammation of the cellular tissue behind the bladder. In the discharge of his duties it is more than probable that the patient was a good deal exposed to the combined action of wet and cold. Whatever its onset the whole progress of the case was one seemingly subacute in character, and differing from those attacks of cellulitis in the neighbourhood of the rectum which have been met with in people who are intemperate in eating and drinking. The development of double hydronephrosis from partial occlusion of the ureters is a point worth noting, as is also the association of pyæmic abscesses in the liver, with the suppuration already described.

A CASE OF FRACTURED SKULL, WITH SYMPTOMS SIMULATING DRUNKENNESS.

By G. A. WRIGHT, F.R.C.S.

A. M.—, a healthy man of twenty-eight, was brought to the Manchester Royal Infirmary at 12.50 on the afternoon of March 12th, 1880. While engaged in loading hay upon a cart he was standing upon the top of the load pulling a rope to bind the hay to the cart when the rope broke, and he fell upon his head upon a stone pavement. He was brought to the hospital in less than half an hour after the accident.

On examination, an extensive scalp wound was found over the right fronto-parietal region, laying bare the bone for a space of about one square inch. No fracture could be detected. There had been some bleeding from the nose, and blood was effused into the upper eyelid of the right side. There was no paralysis of any part. The man was perfectly conscious; he walked into the accident room, but his manner was peculiar; he was noisy and irritable, resisting examination of the wound and application of dressings, and complaining much of pain in the back of the neck, where, however, no lesion could be found. His condition much resembled that of a drunken man, but the peculiar irritability and restlessness of his behaviour were not quite like the manners of one intoxicated, and this, in spite of the absence of any history of insensibility, induced further inquiry into his state. After some difficulty it was ascer-

tained that he had drunk in the course of the morning about a quarter of a pint of spirits, but this had not been taken at one time, and had not produced any symptoms of intoxication. On asking the man himself if he had been unconscious after the fall, he replied, "What fall?" and evidently was unaware of what had caused the injury; this answer, as showing that he had been insensible as well as the peculiar state of irritability above described, led to the diagnosis of some more serious injury than was apparent externally, and the man was therefore admitted into the hospital.

A few hours after admission he gradually became unconscious, the right pupil became dilated and slight facial paralysis on the right side set in. There had been no bleeding from the ear. His breathing became stertorous, and he was soon totally unconscious. In the evening his temperature rose to 103.2° , and his pulse, which on admission showed no peculiarity, became rather slow, 56, full and bounding in character, and between midnight and one o'clock rose to 170; at this time there was some rigidity of his limbs.

He remained in much the same state throughout the 13th; his pulse, however, became weaker, and he sweated profusely, and died at 9.50 P.M.

The onset of these symptoms soon after his admission naturally led to the diagnosis of fracture of the anterior and middle fossæ of the base of the skull.

Post-mortem examination. — A fracture, without any depression or other displacement, was found running through the frontal bone on the right side of the middle line, but to the left of the portion of bone exposed in the wound, so that it could not be discovered until the scalp was more fully separated from the bone. The fracture ran through the right side of the cribriform plate, and from it another fissure extended outwards through the lesser wing of the sphenoid and across the anterior inferior angle of the parietal, where the middle meningeal artery was torn across, and a large clot of blood was found compressing and deeply indenting the middle lobe and lower part of the frontal lobe of the brain. On the left side some bruising by *contre coup* of the middle lobe was found over a small area. There was some laceration and contusion of the muscles at the back of the neck.

Remarks. — There did not appear during life to be sufficient evidence of any benefit likely to be obtained by operation; and indeed the only indication at all would have been to trephine over the middle meningeal on the chance of the injury being localised. The symptoms, however, pointed more markedly to hæmorrhage at the base than anywhere else, and the extent of the hæmorrhage, together with the other lesions, found post mortem, did not encourage the belief that operation would have done much good.

The case is particularly interesting as an instance of the caution necessary in deciding whether such symptoms as the patient presented were due to drink or injury; and when the man was first seen considerable hesitation was felt as to the source of his peculiar manner; this was, however, clearly due to the surface irritation of the brain by the blood which was at that time being effused upon it, and hæmorrhage increasing soon gave rise to the ordinary symptoms of compression. The case was under the care of Mr. Bradley, by whose kind permission I am enabled to publish it.

Manchester.

BEQUESTS ETC. TO MEDICAL CHARITIES. — Mrs. Townend, of Puckrup Hall, has given £2000 for the erection of a new wing to the Tewkesbury Rural Hospital. Mr. Robert Barr bequeathed £500 to the National Institution for Imbecile Children at Ladbroke, £500 to the Edinburgh Royal Infirmary, and £250 to the Edinburgh Royal Hospital for Sick Children. Mr. Joseph Gurney Barclay has given £500, additional, to the North Eastern Hospital for Children. The Great Northern Hospital has received £450 under the will of Miss Dobson. The Clothworkers' Company have given one hundred guineas to the Earlswood Asylum for Idiots. The Grocers' Company have given £50, additional, to the Victoria Hospital for Sick Children. Miss Anne Allison, of Glasgow, bequeathed £100 and a proportionate share of the residue of her estate, each, to the Glasgow Royal Infirmary and the Archibald Colquhoun Bequest for Relief of Incurable Poor. The Mercers' Company have given one hundred guineas to the Hospital for Consumption, Brompton, and fifty guineas to the Royal Infirmary for Children and Women.

A Mirror

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. GEORGE'S HOSPITAL.

CASE OF STRANGULATED VERMIFORM APPENDIX; OPERATION; DEATH; REMARKS.

(Under the care of Mr. PICK.)

THIS case, in which the vermiform appendix of the cæcum had descended into the sac of a hernia and had there become so tightly strangulated as to produce very severe symptoms, necessitating operation and terminating in speedy death, appears to be worthy of being placed on record on account of its rarity.

Robert E —, aged fifty-four, painter, was admitted into the hospital on Feb. 21st. He stated that he had ruptured himself twelve years previously, but that his hernia, which he had always been able to return, had never given him any trouble nor prevented him following his occupation. He had therefore paid no attention to it, and had never worn a truss. Five days before admission his rupture came down, and he was unable to push it back again. Soon he began to suffer great pain in the part, and it became much swollen. His bowels had not acted since the descent, and he had been constantly sick, the vomit latterly having been of a very offensive nature. The day before admission a medical man made a prolonged attempt by taxis to reduce the hernia, but without success. The proceeding caused him great pain.

When admitted he was in a state of collapse. The surface of the body was cold and covered with a clammy sweat; the pulse was scarcely to be felt, and very quick; the tongue was coated with a white fur; the abdomen was tympanitic, but not rigid. In the right inguinal region and lower part of the abdomen, extending nearly to a level with the umbilicus, the tissues were swollen and cedematous, and the skin was red. Just below and internal to the abdominal ring was a tense, hard swelling, which occupied the upper part of the scrotum and extended up into the inguinal canal, along which considerable fulness and hardness could be felt. There was no impulse on coughing, and the patient did not complain of much pain during the examination.

He was at once placed under the influence of ether, and a vertical incision was made over the external abdominal ring. Upon cutting into the subcutaneous tissue a large quantity of serum escaped. The various coverings of the sac were then divided. They were much infiltrated, and adhered to each other. The sac, having been exposed, was opened, and a large quantity of thick fetid pus escaped. The sac wall was very much thickened, and was coated on its internal surface by flakes of lymph. After the fluid contents of the sac had been carefully sponged away, the sac was found to contain only the vermiform appendix. This portion of intestine was much thickened and congested, and, like the interior of the sac, was covered with flaky lymph. The stricture, which was so tight that it was with difficulty divided, was situated at the neck of the sac. After the division of the stricture the finger could be passed freely up into the abdominal cavity. The vermiform appendix, which was not perforated, was now carefully cleansed, and returned just within the opening into the abdomen. As the sac was in a state of acute suppuration, it was dissected out from the tissues with which it was in contact and removed; the external wound was then closed. The operation was performed with strict antiseptic precautions. During the operation the patient was very faint and collapsed, and required brandy. He never rallied after his removal to bed, and died in about five hours.

Necropsy. — There was a wound some three inches long over the right inguinal canal, closed by silver suture. The wound being opened gave access to a small sac communicating directly with the peritoneal cavity by its neck, which was about one-third of an inch in diameter. At the upper part of the sac was the extremity of the appendix cæci,