

was in a very bad condition of health, I felt disinclined to submit him to any surgical procedure, and thought I could not do better than follow the treatment so strongly recommended by such a high authority in surgery as Professor Verneuil. The result obtained was in every respect most satisfactory.

A. B—, an American, aged fifty-four, but looking older, was admitted into the Protestant Hospital of Cannes (Asile Evangélique) on February 22nd last, suffering from a large carbuncle involving the whole of the nape of the neck, extending from the sixth cervical vertebra to the occipital protuberance and from one mastoid process to the other. The disease was of eleven days' duration. Beyond poulticing no other treatment had been applied. The whole of the nape of the neck was swollen, hard, and of a dusky livid colour. A few superficial sloughs, through which some sanious pus discharged, had formed in two or three places, but not in the centre of the mass. The pain was intense, totally preventing sleep. The patient was greatly exhausted, very weak, and depressed; there was complete anorexia; the pulse was 120, feeble and compressible; the skin clammy; the temperature on admission 102·3°; the urine scanty, but containing neither albumen nor sugar. Our small hospital possessing no steam spray, I used a large hand spray instead, previously warming the carbolic acid solution; in other respects the treatment as laid down by Prof. Verneuil, was strictly carried out. After the first twenty-four hours the pain lessened and there was an evident arrest in the progress of the disease. On the third day of the treatment a decided improvement set in; the temperature fell to normal; the central portion of the carbuncle—a very oblong centre—was softer; the hard brawny circumference was less infiltrated, and the parts altogether looked more healthy. The parts were still very tender on the slightest pressure, but the pain had mostly disappeared. Laudable pus issued through the largest of the spontaneous openings, and the sloughing process was elsewhere arrested. The further notes of the case are as follows:—March 6th (fourteenth day of treatment): The carbuncle is greatly reduced in size; the surrounding infiltration has disappeared. Some cellular slough was removed through the openings. The general condition is greatly improved, the carbolic acid treatment omitted, and the parts dressed with boracic acid ointment and salicylated cotton wool.—12th: A large cellular slough some five inches in length was removed through the only opening remaining.—21st: The patient takes his meals at the convalescents' table, and walks in the garden when the weather is fine. Some slight discharge through the opening.—29th: A small granular ulcer occupies the site of the spontaneous opening; the parts have otherwise returned to their normal condition. The patient is now quite well, and has gained much in flesh and in strength lately.

GUNSHOT WOUND OF THE PALM.

By SIDNEY THORP, M.R.C.S.

On Feb. 3rd last I was called to a young man who in a careless way and in an unguarded moment discharged one barrel of a five-chambered revolver through the palm of the left hand. The ball passed through the palm between the heads of the third and fourth metacarpal bones. I was called to see him about two hours after the accident and found him suffering more from shock than anything else. There was a darkened look where the ball made its ingress and egress, but scarcely any bleeding. I could find no injury whatever to the heads of the bones; no fracture could be detected. The hand was ordered to be dressed with boracic oil and wadding, and the limb to be kept at rest. He was placed on milk diet and given chloral and morphia at bedtime.—Feb. 4th: Passed a fairly good night. Hand and forearm very red and erysipelatous-looking; both to be well painted with antiseptic paint; wadding to be reapplied. A purge to be taken at once, and morphia and chloral at night.—5th: Passed a good night. Bowels relieved. Looks cheerful. To have a chop for dinner. Swelling in hand and arm much improved. Arm to be kept at rest. Boracic oil to be applied to wounds of ingress and egress. From this date the hand improved greatly, and in a fortnight's time he sailed for Australia.

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.

GUY'S HOSPITAL.

A CASE OF LEUCOCYTHÆMIA, WITH LARGE SUBCUTANEOUS HÆMORRHAGE; NECROPSY.

(Under the care of Dr. HALE WHITE.)

THE chief points to which we would draw attention in the following case are—the absence of any history of ague, the presence of symptoms due to the altered condition of the blood for some time before the enlargement of the abdomen was noticed, and the unusual size of the subcutaneous hæmorrhage, which appears to have hastened the fatal ending. There does not seem to have been any alteration in the condition of the medulla of the bones. For the notes of the case we are indebted to Mr. H. J. Campbell.

J. B—, aged thirty, was admitted on April 23rd for enlarged liver and spleen. The family history was very good, and there was no account of ague. The patient was born in Essex, near Chelmsford, but left there when fifteen years old, and has since lived in London. He has never had ague. He has all his life been exposed to the weather, especially since he came to London, his occupation being that of a carman. For the past five months, the patient has suffered from pains in the head, dimness of vision, buzzing in the right ear, weakness, languor, and shortness of breath. His abdomen has been steadily increasing in size, and latterly has been tender to pressure over both liver and spleen. The symptoms have been rapidly getting worse during the last month. He weighs 21 lb. less than he did nine months ago.

State on admission.—The patient does not look anæmic. Skin bronzed over abdomen, neck, and face. The slightest exertion causes dyspnoea. Headache and vertigo severe. Respiratory system normal. No pleural effusion; no ascites. The liver is very large, and the right lobe extends down to the level of the umbilicus; the left lobe is continuous with the spleen, the latter extending as low as midway between the umbilicus and the pubes, and curving forward to the middle line, the notch being opposite the umbilicus. Liver and spleen tender on pressure. Pulse of low tension, rapid, not running. Blood pale; contains only 40 per cent. of the normal amount of hæmoglobin, one-third of the normal number of red corpuscles, and an average of twelve white corpuscles to every sixteen red. Double optic neuritis is present, but no hæmorrhage can be seen. The lymph glands in the groins and axillæ are slightly enlarged and hard. Urine normal, except for a large deposit of oxalates.

On mercury and iodide of potash and abundant food the patient's condition improved; the red corpuscles increased, and the white diminished. On April 5th he felt stronger, and was able to walk about the ward. The optic neuritis steadily grew more marked, and a small retinal hæmorrhage was seen in the left eye. On the 6th there was some pain in the back, with slight cough, the sputum being streaked with blood, and there was slight epistaxis. On the 8th he was unable to get up, and lost his appetite. In the afternoon he complained of severe pain in the left axilla, and on examination a large hæmatoma was found to occupy the axilla, it being about four inches in antero-posterior measurement, and six inches from above downwards. On inserting a needle pure blood came out. This swelling rapidly spread, and by the 9th extended from the axilla to the sixth rib, and from the nipple to the vertebral groove. There was no pallor or collapse. The pulse was feeble and running. At 9 A.M. on the 9th the patient vomited undigested food, and complained of pain in the abdomen and great thirst; restlessness was not marked, but there was slight delirium. At 11.50 the patient suddenly died. During the whole of the time the temperature showed an evening rise and morning fall ranging from 97° to 102°.

At the necropsy the superior and inferior venæ cavæ were found to be much engorged. The heart was enlarged, and

there was considerable dilatation, with slight hypertrophy. There was a large effusion of blood under the serratus magnus on the left side, containing 24 oz. of imperfectly clotted blood. The liver weighed 193 oz., the spleen 57 oz.; there being some capsulitis of the spleen, with hæmorrhages on the surface. Blood turbid, and of a chocolate colour. No change in marrow of sternum.

HOSPITAL FOR SICK CHILDREN, GREAT ORMOND-STREET.

DIFFUSE OTITIS OF TIBIA.—CHEIRO-POMPHOLYX.

(Under the care of Mr. EDMUND OWEN.)

FOR the notes of the following cases we are indebted to Mr. R. C. Priestley, registrar.

CASE 1. *Diffuse otitis of tibia*.—A boy of twelve years of age has been in the Louise ward since March 20th with general enlargement of the left tibia. His mother had six weeks previously first noticed that the leg was swelling, but the changes must have been going on much longer than that, for at the time of his admission there was not only general thickening of the entire bone, but the bone was greatly bowed forwards, and was increased in length by at least a quarter of an inch. There were slight redness, œdema, and elevation of temperature in the skin over the shin, and the bone was evidently tender. The patient was the youngest of seven children, and was apparently the only unhealthy one in the family. He has suffered from otorrhœa and headaches at various times. He has never hurt the diseased tibia. His father died of some lung disease; his mother has had no miscarriages. The boy certainly had not the characteristic appearance of inherited syphilis, though he did not look healthy. There were delicate white scars of radiating linear ulcerations at the corners of the mouth, and there was a suspicious pegging of the left lateral incisor. In the crescentic notch which its narrowed crown presented, however, there was a small tubercle such as one does not expect to find in a Hutchinsonian tooth. As regards the central incisors of the upper jaw—the “test-teeth,”—all that one can affirm is that their long axes sloped downwards towards each other.

For a week or two the boy was kept in bed, and was watched to see if he would improve without antisyphilitic treatment; but he made no progress until small doses of grey powder were regularly administered. After this the local conditions became considerably improved; there was less tenderness about the bone, whilst the skin was no longer smooth and shining, but its cuticular layer was thrown into delicate wrinkles, showing a general diminution of vascular tension.

Remarks by Mr. OWEN.—Diffuse interstitial osteitis in children is generally the result of hereditary syphilis, but in this case no direct evidence of the congenital disease could be obtained. But the suspicious obliquity of the central incisors, the doubtful notch in the left lateral incisor, and, above all, the radiating linear scars at the angles of the mouth, when taken together, afforded strong circumstantial evidence of the specific nature of the disease. And to all this the improvement under the administration of the small doses of grey powder added further confirmation.

CASE 2. *Cheiro-pompholyx*.—Emily C—, aged ten years, healthy-looking and vigorous, was admitted on March 8th last, with a fairly good family history; at any rate, there was no reason to suspect that she was the subject of any hereditary taint. One Saturday last summer she went for a holiday to Hackney Downs, and, getting very hot, she drank a large quantity of cold water. On her return home she complained of great pain in the feet, and the mother, on examining them, found the soles studded with a crop of blisters of various sizes, which she thought might possibly be due to pressure from the boots. Since then, however, the child has had periodic attacks of blebs upon the palms of the hands as well as on the feet. They last for about a week, and, disappearing, leave the parts extremely tender.

On admission, there was one large bulla containing clear fluid on the plantar surface of the right great toe, and another still larger over the second and third metatarsal bones. There was also a large bleb under the heel, and there were some small ones on other parts of the sole. The blebs were tender, and the surrounding skin was red. A

day or two after admission the child developed a rash of lichen urticatus on the flexor aspect of the legs and arms. She was prescribed liquor arsenicalis, and in due course all her troubles disappeared. As, however, she affirmed that the blebs appeared upon the hands and feet regularly every month, she was, though apparently in excellent health, kept in the hospital for a week or two beyond the month; but her statement was not verified. She is still to be kept under supervision.

Remarks.—Pemphigus of the hands and feet is a sufficiently rare disease, even in childhood, to justify the publication of this typical case. What may have been the cause of the first occurrence of the disease is uncertain. Although the child had been running about all day, the blebs did not appear, merely because she was footsore—the fact of the hands being subsequently implicated is evidence of some general disturbing cause, which probably acted through the nervous system.

BOLTON INFIRMARY.

A CASE OF MULTIPLE SARCOMATA; DEATH; NECROPSY.

(Under the care of Dr. GILLIBRAND.)

FOR the following notes we are indebted to Mr. E. C. Kingsford.

Rebecca R—, aged forty-five, was admitted on Jan. 9th, 1888, for persistent vomiting. The family history was unimportant. She has been married fifteen years, and had seven children, six of whom are living; one miscarriage before birth of second child. Menstruation had been regular up to the previous June; she had seen nothing since then, and at the time of admission again commenced to menstruate. She had always enjoyed good health, but at the end of October was seized with frequent vomiting, which was preceded by pain in the left side; this lasted for five days. There was then abatement of symptoms for three weeks, after which they recommenced, and continued with more or less severity up to the time of admission. Previously to October the patient had been comparatively stout, but had since been getting rapidly thinner.

On admission she was much emaciated, with dry shrivelled skin, and some bright petechiæ scattered over the chest; these she had not noticed until her attention was drawn to them. Cardiac sounds normal. Dulness at left apex, with absence of respiratory murmur and vocal fremitus. Temperature normal. No headache. Optic discs normal. No abdominal tumour to be felt. Aortic pulsation quite perceptible. Vaginal examination showed the os to be rather low down, expanded in all directions, and quite smooth. The uterus was freely movable, and the ovaries could not be felt. There was a small impressionable tumour on the upper surface of the left clavicle about its centre, painful on pressure; and a resistant mass in the position of each thyroid lobe, that on the right side being about the size of a large horse bean, and that on the left twice as large; these were not painful on manipulation, and no other such tumours could be found about the body. Vomiting occurred frequently, quite irrespective of the ingestion of food, and was always preceded by a sensation in the throat in the neighbourhood of the thyroid. Urine normal.

The vomiting continued, but varied considerably from day to day, and was always more severe in the early morning. On Jan. 22nd she first complained of headache at the vertex and in the frontal region, and the next day had two epileptic seizures, the left arm being chiefly implicated; she had never been affected with anything like a fit before. On the 24th the right optic disc was found to be slightly blurred, the left being normal, as were also the fundi and vessels. She was allowed to get up on the 31st, not having vomited for a week, but was immediately seized with headache and sickness. From this time onward the headache persisted, being most severe in the upper occipital region; and she was troubled with coughing, hiccup, and vomiting, although she was able to take her food fairly well.—Feb. 9th: Right pupil dilated.—10th: Another epileptiform fit, followed by paresis of the left arm and slight bronzing of the skin, was noted, but it did not increase. Cardiac impulse felt outside the nipple line, and on the 19th it was reported as above the level of the nipple, in a line with the anterior axillary fold. Pulse 136; temperature normal; respiration easy. A few more petechiæ had appeared on the abdomen, and albumen was found in the urine for the first time, but not in any considerable quantity, and after three or four days it disappeared