

fresh attacks, the patient being never entirely free. Pregnancy seemed to cause exacerbation during the first three months, after which psoriasis would fade almost entirely till suckling when a fresh attack came on. Patches were subjected to a liberal application nightly of the following ointment: 15 minims of strong solution of iodine, 15 minims of solution of carbolic acid, and one ounce of boric acid ointment, and they disappeared within a fortnight. Papules were gently pricked with a sterilised needle until they bled slightly, when a drop or two of liquor epispaeticus were insinuated into each papule and also applied over its surface. This process was repeated every second night until three or four applications had been made. A small blister was the result in the case of each papule so treated, which, when left alone, went through the usual stages of healing attendant on any other form of simple blister. In other words, the papules were aborted and the areas of skin implicated again became normal.

CASE 2. Psoriasis of 15 years' standing.—The patient was a woman, aged 23 years. She had twice suffered from erysipelas of the right side of the face at a spot where psoriasis had subsequently broken out from time to time. The patient was chlorotic. April and October brought fresh exacerbations; the menstrual periods made no difference. The treatment adopted was the same as in Case 1. The papules disappeared entirely. Pricking followed by the application of liquor epispaeticus and liquor acidi carbolicum on alternate nights or carbolic acid alone checked the development of patches from the papular stage in the ratio of 3 or 4 to 1.

CASE 3. Psoriasis of 37 years' standing.—The patient was a man, aged 43 years. An uncle and a niece suffered from psoriasis; his wife and family were free. The nails were deformed on several occasions. One patch on the outside of the right leg measured 13 inches long. The skin was extremely thin; on lifting a fold of it between the forefinger and the thumb it seemed to be no thicker than silk or ordinary writing paper. Treatment with salicylate of sodium made a good impression; many of the larger patches instead of involuting in the centre cleared up along the natural furrows, clear lines of healthy skin appearing as valleys bounded on each side by psoriatic hills. This drug seemed to produce also an excellent crop of hair. Salicylism caused a cessation of this treatment. Myelocene (50 per cent.) was then tried for 14 days and full strength for other 14 days but it failed to make any impression. On Jan. 29th two papules and one small psoriatic patch were present on the right side of the face. These were well painted with liquor epispaeticus without previous pricking, as was also a patch of the size of half-a-crown on the back of the wrist. On Jan. 31st the four affected areas were energetically blistered afresh. On Feb. 18th the papules and patch on the face disappeared entirely. On the 28th the patch on the wrist disappeared and left no mark.

These three cases illustrate the efficacy of the blistering method of local treatment and, therefore, if one could get rid of a present attack of psoriasis a succeeding one might be checked and aborted by the timely use of the method briefly indicated above. Other agents, such as strong nitric and glacial acids, seem to have an effect similar to that of liquor epispaeticus.

During the past year only five cases of molluscum contagiosum came under my notice. Four of these occurred in female fishworkers and may therefore have resulted originally from the materials used in curing fish or from the fish themselves, as the areas of skin affected were the areas exposed whilst at work. Pricking and blistering produced a cure in each of the four cases. The fifth case occurred in a miner's wife and is at present under similar treatment.

Bedlington, Northumberland.

A CASE OF INFLUENZA IN ADVANCED LIFE.

BY HUBERT M. EARLE, M.R.C.S. ENG., L.R.C.P. LOND.,
CAPTAIN, I.M.S.

THE following case seems to be worthy of record by reason of recovery occurring after very severe prostration, marked cardiac weakness, and extensive respiratory affection in an elderly person.

The patient was an Englishwoman, 74 years of age, and had been nursing her son, who was suffering from influenza.

She was herself first attacked with the same disease on May 3rd, 1902. Her initial symptoms were typical. Severe prostration and cardiac weakness were present from the first and became accentuated after a few days. Coryza was followed by catarrh of the upper respiratory passages, which gradually spread, leading subsequently to broncho-pneumonia of almost the entire right lung with slight similar affection of the left apex. Slight pleurisy of the right side was found to have developed on the 7th. There was no rise of temperature until the 6th and it never rose above 101° F., the fever being of a remittent type. Defervescence occurred by lysis, normal temperature being reached on the ninth day of the illness. During the period of defervescence the heart and nervous system showed gradual and marked signs of improvement.

The treatment consisted chiefly of careful nursing, free ventilation, and frequent administration of light nourishment and stimulants. Medicinally stimulating expectorants were given and in the treatment of the heart weakness much benefit was derived from the administration of digitalis and spirit of nitrous ether. When the acute stage was over quinine and strychnia were given.

Bakloh, Punjab.

NOTE ON A COMPLICATION IN SEVERAL CASES OF PNEUMONIA.

BY J. H. PORTEUS GRAHAM, M.R.C.S. ENG., L.R.C.P. LOND.,
SURGEON-CAPTAIN, ARMY MEDICAL RESERVE.

DURING the past 12 months five cases of pneumonia (acute lobar) that have been under my care have presented a somewhat unusual feature during the earlier days of the disease—namely, acute gastro-intestinal disturbance evidenced by vomiting and severe diarrhoea. The patients were adult males previously healthy serving in three home stations widely remote. In each case the signs and symptoms were typical of acute lobar pneumonia limited to the base of one lung. Crisis is sometimes preceded by diarrhoea but the gastro-intestinal disturbance in these cases came on with the onset of the pneumonia and persisted during the first four days of the disease. Four patients recovered and one died; the fatal event took place on the sixth day of the illness and was due to cedema of the lungs. The patient who died did not suffer more severely from the complication than those who recovered.

The explanation of the complication is not evident unless it was due to a coincident influenza, of which there were strong indications, and acute gastro-intestinal disturbance is not an infrequent feature in influenza. The gastro-intestinal phenomena might have raised a suspicion of commencing enterica.

Station Hospital, Warrington.

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. v., Proœmium.

ST. THOMAS'S HOSPITAL.

A CASE OF RECOVERY AFTER ACUTE DILATATION OF THE STOMACH AND INTESTINES.

(Under the care of Dr. C. R. BOX and Mr. W. H. BATTLE.)

A WOMAN, aged 27 years, was admitted to St. Thomas's Hospital under the care of Mr. Battle on Nov. 7th, 1901, and left the hospital on August 12th, 1902. The patient was admitted for the removal of an abdominal tumour which had been noticed for a period of about nine years. She was a strong healthy-looking woman with a good family and personal history and beyond the presence of a large multilocular ovarian tumour nothing abnormal was

discovered on examination. The tumour was removed in the usual manner on Nov. 12th, the operation being carried out aseptically and the wound being dressed with cyanide gauze. Two silk ligatures were required for the pedicle. Very little sponging was necessary. A continuous silk suture was used for the peritoneum, interrupted sutures of the same material for the fibrous structures, and interrupted sutures of fishgut for the skin.

During the two days following the operation her condition was as follows. The pulse varied from 104 to 108; the respiration from 18 to 32, and the temperature from 101° to 103° F. The abdomen became distended, the bowels were constipated, and an enema with castor oil had no effect. Pain was not severe. On the third day after the operation (Nov. 15th) another enema was given and five grains of calomel were administered by the mouth, but without effect. The temperature was 98°, the pulse was 112, and the respirations were 24. In the evening the abdominal distension was more marked and caused much discomfort but there was no vomiting. The pulse had risen to 140. The dressings were changed but the incision looked healthy; no dulness or unusual resistance was present but some tenderness was noted in the left iliac region. Calomel was again given without result. On the evening of the 16th a turpentine enema opened the bowels and relieved the distension. On the fifth night after operation (Nov. 17th) the temperature was 100.2° and a hard brawny swelling with much tenderness was noticed in the left iliac region extending into the left labium; this was incised on the following night (the 18th); it was superficial to the aponeurosis of the external oblique muscle. The pus had not extended to the median incision, which still appeared to be quite healthy but became infected three days later, so that a drainage-tube was passed between the lateral incision and the lower part of the operation wound. The distension of the upper abdomen became even greater, was very distressing to the patient, and was little relieved by medicine. On the 22nd the abdominal distension was extreme and diarrhoea had been present for four days. The tongue was red, cracked, and dry. The pulse was 136, the respirations were 28, and the temperature was 101°.

Dr. Box saw the patient with Mr. Battle on Nov. 21st. The stomach was then evidently much dilated, the epigastrium being very prominent, and a ringing coin sound was obtained from the region of the left nipple across to the right hypochondrium. On palpation a sensation of fluid resistance was appreciable. There was no vomiting. It was therefore decided to use gastric lavage twice a day and to alter the position of the patient, so she was turned on her right side semi-prone instead of being kept in the recumbent position, and the foot of the bed was raised. Hypodermic injections of liquor strychninæ (three minims) were given every six hours and the amount of fluid given by the mouth was restricted. By these means the gastric distension was much relieved, but the diarrhoea persisted and became the predominant feature with considerable bodily weakness and emaciation. On the 28th it was noted that the diarrhoea was getting worse and that now the patient had some loss of control. The stomach when tested by "coin" percussion extended to the highest point of the iliac crest and as high as the apex beat. The patient was very thirsty before lavage was commenced but was not so now. On turning well to the right side gurgling in the region of the pylorus was heard. There was no succussion splash. The strychnine was stopped and opium was resorted to, both by the mouth and as an enema in order to check the diarrhoea, but with very little effect. The temperature chart had assumed a septicæmic type. This condition was further complicated on Dec. 8th (26 days after the operation) by an attack of acute inflammation of the right parotid gland. Glycerine and belladonna were applied and on the following evening two leeches gave much relief. On the 10th 10 cubic centimetres of anti-streptococcic serum twice a day were tried and apparently produced a favourable effect on the parotid inflammation for in two days' time the swelling and tenderness were less. The temperature was still irregular but not so high. No improvement took place in the diarrhoea, from six to ten motions a day being passed. That benefit was derived from the position of the patient was proved by the patient's statement that after lying on her back for a time she became somewhat distended and uncomfortable in the region of the stomach. On the 17th there was an irritable

red rash about the upper part of the abdomen which was ascribed to the serum injections; it spread all over the body but had passed away by the 23rd. On the 30th the serum was discontinued as it appeared to be producing little effect on the general state. Two days later parotitis began again on the right side of the face. On Jan. 3rd the serum was again employed and by the 7th the inflammation had subsided. This treatment was continued for ten days. On the 30th two abscesses were opened in the abdominal wall to the right of the wound; they were the result of injections. On Feb. 22nd the legs were œdematous half-way up the calf, diarrhoea continued, there being from eight to ten motions daily (once 14), and the temperature was still irregular, being frequently 103° in the evening. About this time the wound in the left groin healed. During this month a course of sulphate of magnesia in large doses failed to check the diarrhoea. Rectal injections of sulphate of copper in four-grain doses also failed. On March 1st she had two rigors without apparent cause. During the second the temperature rose to 104.2°. On the 3rd the abdomen below the umbilicus was noted as distended, tympanitic, and tender. There was no evidence of a dilated stomach in the epigastric or left hypochondriac region. On the 7th there was another rigor, the temperature again rising to 104°. On the 9th izar was given internally and the diarrhoea began to improve, the number of actions of the bowel falling to four or five in the 24 hours, and it was evident that the patient was gaining strength. An improvement in the diet, however, gave rise to an increase in the temperature and fluid nourishment had to be resumed. On April 5th the right parotid region was for the third time slightly swollen and hard but since March 25th the temperature had not exceeded 99.4°, and now the bowels only acted once or twice daily. The lower extremities were, however, œdematous up to the hips and on the 23rd the flanks were also œdematous, whilst the abdomen continued very tense. On May 1st the condition was as follows. The abdomen was prominent, moderately tense, and glazed. The superficial veins were enlarged and extended upwards to the thorax. The blood flow in them was upwards. Occasionally peristalsis became evident in the epigastric region and was accompanied by gurgling sounds; the direction of the peristaltic movement was not definite. The stomach resonance extended up as high as the fourth costal cartilage on the left side, but it was impossible to say how much of the abdominal distension was caused by the stomach. A fluid thrill was obtained both in front and in the flanks, but more easily in the former position. The feet, legs, and thighs were highly œdematous and this œdema extended over the abdomen to the lower costal margin and some distance over the ribs posteriorly. The specific gravity of the urine was 1025; it was acid with a trace of albumin. Diarrhoea had ceased. On June 13th she could stand and walk without help, but was, of course, much emaciated. On the 30th peristalsis was still visible above the umbilicus. The abdomen was prominent and resonant. The outline of the stomach could not be made out but the "coin" sound was still widely diffused. On the 13th electrical treatment was commenced and continued for the remainder of the patient's stay in hospital. The veins of the surface were less prominent on August 7th, the stomach was still as low as the umbilicus and splashed a little. The swelling of the legs which had almost gone reappeared after she had been up for a short time. The general improvement was considerable before she left the hospital on the 12th. The patient presented herself for re-examination in January, 1903. There was then no evidence of gastric dilatation even after inflation. The lower part of the abdomen was rather prominent and the legs still showed a slight tendency to swell. The superficial veins of the lower extremities and abdomen were generally enlarged and tortuous, this enlargement disappearing in the lower costal regions. She was able to work most of the day without fatigue and had gained two stones in weight.

Remarks by Dr. Box and Mr. Battle.—The occurrence of recovery after such extreme post-operative distension of the stomach, and possibly also of the colon, seems sufficient justification for the publication of this case. Such recovery must be very exceptional and, indeed, the complication itself in a marked and obtrusive form is a rare one. It is possible that a minor degree of gastric distension after operation is often overlooked, and it is noteworthy that

surgeons have long recognised the beneficial influence of stomach washing in some cases where distension and vomiting occur after abdominal operations. There can be little doubt that this complication followed septic infection of the wound. During the operation it was noticed that the left side was being too vigorously retracted and pressed upon, and the result was shown in the localised suppuration.

There are several points worthy of comment in the case recorded above. The gastric dilatation at the time when it was recognised was already very extreme, for the stomach area as mapped out by the "coin" sound extended from the region of the cardiac impulse to a line joining the highest points of the iliac crests and stretched laterally from the left mid-axillary to the right mid-Poupart line. At the same time vomiting, although present, was quite insignificant in amount. The semi-prone position was adopted in accordance with the theory already enunciated by one of us¹ that the dilated stomach after a time obstructs the exit of its own contents by exercising considerable pressure on the terminal portions of the duodenum in front of, and by the side of, the vertebral column. So soon as the proper position was adopted by our patient gurgling sounds were plainly audible in the pyloric region of the abdomen. Gradually increasing distension of the abdomen was noticed for a week before the diarrhoea set

in and during this week the bowels were obstinately constipated. During the later part of the illness the gastric dilatation was less obtrusive and diarrhoea and great prostration were prominent symptoms. Attention is particularly drawn to this sequence of events because one theory attributes acute dilatation of the stomach to traction of the superior mesenteric vessels over the transverse portion of the duodenum and consequent obstructive compression of the bowel at this spot. This traction is attributed to a primary collapse of the coils of small bowel such as might conceivably accompany or follow severe diarrhoea. In our case, then, the evidence seems to negative this method of obstruction and we believe that the case belongs primarily to that class in which a dilatation results from wound infection and is later rendered extreme by stomach pressure on the duodenum. The small amount of albumin present in the urine after the operation may have been due to the infective process which was evidently at work, but it is also possible for the distended stomach to exercise pressure on the left renal vein. There was no albumin in the urine before the operation. The oedema of the legs and lower part of the trunk with dilatation of the superficial veins points to thrombosis in the inferior vena cava. This possibly originated in the pelvic or iliac veins and extended in the upward direction.

HULL ROYAL INFIRMARY.

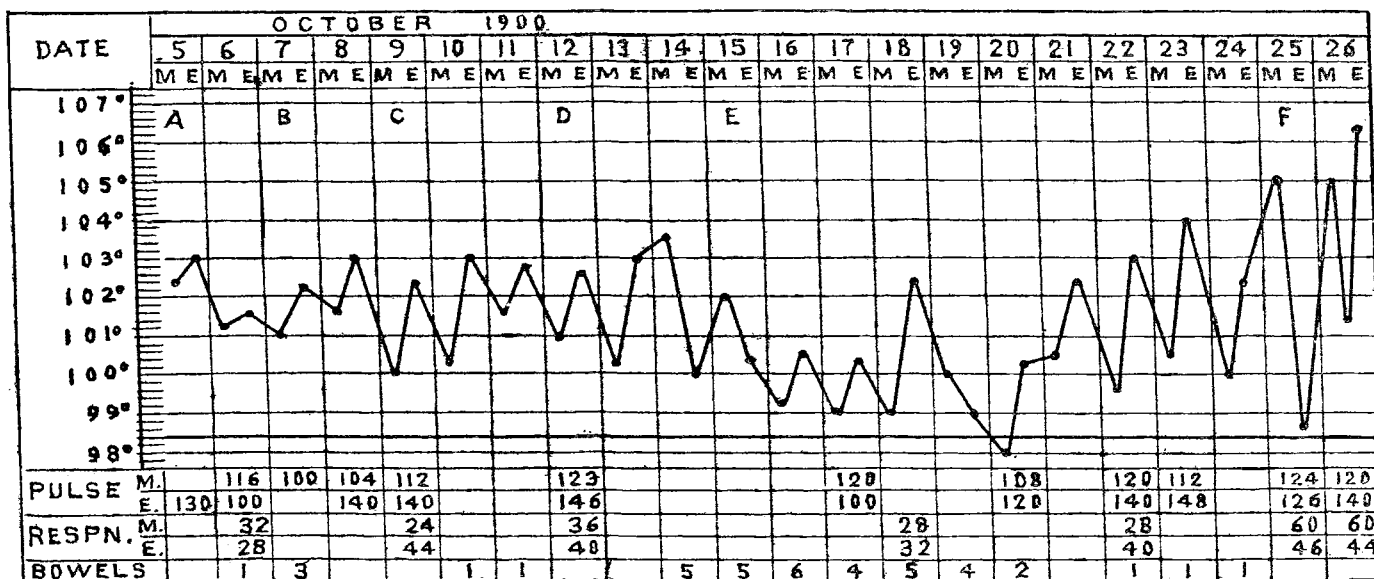
A CASE OF SPINAL RHEUMATISM.

(Under the care of Dr. FRANK NICHOLSON.)

FOR the notes of the case we are indebted to Dr. Hunter, house physician.

The patient, a male, aged 33 years, was admitted into the Hull Infirmary under the care of Dr. Nicholson on Oct. 5th, 1900, and died on the 26th. He had been strong and healthy till five days before admission, with the exception of an attack of influenza two years previously, from which he had long entirely recovered. For 12 years he had acted as an out-porter for hotels and during that period had averaged

extremities were free from pain unless passive movement was attempted. 12 hours later the right leg similarly lost power and on the next morning the left leg could not be moved. Three days before admission the patient could not move hand or foot, but there was no pain unless the limbs were moved. Sleep was not disturbed and there were no rigors. The bladder and rectum were intact. For two days he could not feed himself in the least. A certain amount of movement was possible in the right leg two days before admission and the upper extremities began to recover at the same time. On admission he was bed-ridden. The urine was amber-coloured and acid with a trace of albumin; it had a specific gravity of 1013. The lungs were normal. The heart was somewhat enlarged. The first sound at the apex (best heard in the fourth inter-space in the middle line) was loud and sharp, with a



A, One drachm of compound powder of jalap. B, 20 grains of sodium salicylate every two hours; 30 grains of potassium bromide and 20 grains of chloral every six hours. C, 20 grains of sodium salicylate every six hours. D, Injection of $\frac{1}{2}$ th of a grain of strychnia *pro re nata*. E, 30 grains of carbonate of bismuth *pro re nata*. F, 10 grains of quinine three times a day.

two or three pints of beer daily but rarely anything else. Five days before admission he was feeling quite well till the evening, when suddenly in the hotel, "discussing a pint of beer and a pipe," his left upper extremity "dropped" down close to his side and the forearm flexed at right angles to his arm—the forearm being previously flexed at an acute angle to the arm. He tried to move the arm but could not, nor could he even move the fingers. There was no pain, loss of consciousness, vertigo, or faintness. About 12 hours later the patient awoke from sleep to find that his right arm was now quite useless. Both upper

localised systolic bruit; the second sound at the base was rather impure. The pulse was regular, being about 100, of small volume and good tension. The arteries were rather degenerated. The abdomen was normal. The splenic area of dulness was a little increased but the organ was not palpable. Liver dulness was normal. The pupils were equal and of medium size and reacted to light and to accommodation. There was no nystagmus and extra ocular movements were free. There was no palsy of any cranial nerves. The visceral reflexes were normal. The knee-jerks were active on both sides and there was no clonus. The wrist and elbow-jerks were not elicited. The plantar reflexes were active. The cremasteric, abdominal, and thoracic reflexes

¹ THE LANCET, Nov. 9th, 1901, p. 1259.