

and there had been no bad smell about the discharge." On examination I found the patient looking terribly ill, dorsal decubitus, knees not being drawn up; she was more or less delirious. Skin moist, tongue thickly furred. Temperature 104°; pulse 140; respiration 40 per minute. Abdomen was not swollen, and there was not the least tenderness on pressure above the pubes. The lochia were not offensive, but the condition of the bedclothes was not so clean as one could wish. This I saw remedied, ordered her the usual diet (milk and meat broth), and ordered a mixture containing ten grains of salicylate of soda with two minims of tincture of aconite every two hours, promising to call again in the evening. At 7.30 P.M. I found her in much the same condition. She had been delirious through the day, but had taken freely of nourishment without vomiting. Had passed two copious and offensive motions. Temperature 105°; pulse 160; tongue dry. I syringed her with diluted Condy and ordered an ounce of brandy every four hours. On the 9th I visited her twice. The temperature at 11 A.M. was 105°; at 8 P.M. 104°. Her general condition was much the same. The breasts were soft and contained very little milk. The lochia had ceased. There was no swelling of the abdomen or tenderness. She had taken nourishment freely, and the bowels had not been moved. She had not vomited. Had dozed at times, and been less delirious during the later part of the day. She was syringed morning and evening. On the 10th, at 11 A.M., she expressed herself as feeling much better, and certainly looked so. She had taken plenty of nourishment without vomiting, and had slept fairly well during the night. Temperature 102°; pulse 108. I syringed her as before, and gave a mixture containing five grains of quinine every three hours, and promised to call the following morning. On the 11th I was sent for at 8 A.M., and found her condition as follows: Face anxious; slightly jaundiced tint; lips bluish; skin moist; dry tongue, with sordes about the teeth. She was quite conscious, and complained of cough and of pain about the wrists, elbows, and knees, which were slightly swollen. The abdomen was much swollen. There had been some diarrhoea, but no vomiting, through the night. The nourishment had been taken freely. Temperature 102°; pulse 130; respiration 40 per minute. The sputa were brownish, and on percussion and auscultation there were well-marked signs of pneumonia in both lungs. From this time onward she went from bad to worse, and died on Sept. 14th at 11.30 A.M.

I have seen many cases of puerperal fever during the time I have been practising, and in all previous to this my experience has accorded with what is stated in the works I possess on Midwifery. That the initial rigor in this case did not take place until the ninth day I cannot doubt, as the patient told me she had never felt better than she did until the morning of Sept. 8th. Information gained from those who had seen her on the 6th and 7th tended to corroborate this. No doubt the exciting cause of the disease was lack of cleanliness; and I imagine, as the woman was very stout and flabby, the reparative process was more slowly accomplished, and thereby the susceptibility to septic influences unduly prolonged. So good an authority as Lusk<sup>1</sup> writes:—"The third day is the one upon which ordinarily the beginning of the fever is to be anticipated. After the fifth day an attack is rare, and at the end of a week patients may be regarded as having reached the point of safety." Other authors I have at hand take much the same view, and although they agree in saying that the disease may occur later, I fancy a case in which it commenced on the ninth day is sufficiently rare to make it worthy of record.

Learmonth, Victoria, Australia.

<sup>1</sup> The Science and Art of Midwifery, by Wm. Thompson Lusk, M.A., M.B.; 1st edition, p. 620.

**THE ROYAL SURREY COUNTY HOSPITAL.**—The annual report for 1890 is satisfactory. The continued generous support received has relieved the committee from present financial anxiety. The receipts on current account—£4204 17s.—have been adequate to discharge the disbursements and leave a balance of £84 8s. 1d. in hand. The house surgeon's report showed that the in-patients numbered 774. The home patients on the books were 409 and visits made 1395. The total of out-patients was 4640 and attendances 11,006. The proposal to abolish the attendance of the house surgeon on home patients residing within a mile of the Town Hall, Guildford, has been referred to a committee to consider and report to a special meeting of the governors.

## 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.

### EASTERN FEVER HOSPITAL, HOMERTON.

A CASE OF PURPURA FULMINANS; NECROPSY; REMARKS.  
(Under the care of Dr. COLLIE.)

PURPURA of the severity exhibited in the case of this patient is fortunately of very rare occurrence in this country, and the resemblance which it bears to the cases described by Dr. Henoch is pointed out by Dr. Collie in his remarks. A more recent contribution to the literature of the disease will be found in the *Archives of Pediatrics* for December of last year by Dr. Jackson, of Boston, U.S.A. His communication was founded on the observations of the case of a boy aged five, who had died under his care on the fifth day of the disease. The patient had suffered from severe hæmorrhages from the mucous membranes (epistaxis, hæmatemesis, melæna, and hæmaturia), as well as from large subcutaneous extravasations of blood. The following account is from notes by Miss Fleury, assistant medical officer.

F. B. D— was admitted into the hospital about 9 P.M. on Nov. 11th last. About Oct. 20th he had an attack of scarlet fever, which he appeared to be passing safely through when the "eruption" which is about to be described was observed on Nov. 10th, about three weeks from the commencement of the scarlet fever. On admission the patient was a pale, thin boy, nine years of age. His expression was placid, and his intelligence remarkably acute. Over the extensor aspect of the left elbow a large ecchymosis extended some way down the forearm. There was an extensive ecchymosis over the right hip, and one on the calf of each leg. The ecchymoses appeared to be recent, and at their margins the extravasated blood was of a bright-red colour. There was extreme tenderness of the skin, but otherwise the patient made no complaint of pain. The tongue was fairly clean, and the gums sound. There was no hæmorrhage into the conjunctiva, and there was none from the mucous membranes. The pulse was fairly good, and the temperature 98.6° F. There was a little branny desquamation on the face. Mind clear. He passed a restless night, but took his nourishment readily, apparently being very thirsty. He complained of "pins and needles" sensation all over, but at 7 A.M. he was reported to have been bright and cheerful. He passed two ounces of urine free of blood during the night, and there was no motion from the bowels. About 8 A.M. violent vomiting came on. He cried much when moved in bed, and complained of pain in the abdomen. At 11 A.M. a new ecchymosis was observed behind the left ear. His face was now very pale, pinched, and drawn, and generally he appeared to be in great distress. It was clear that he was sinking, but his mind continued clear. He died about noon; that is, about sixteen hours after admission, and about forty-eight after the appearance of the "eruption."

*Necropsy, forty-eight hours after death.*—Rigor mortis was very marked. There was a large ecchymosis on the back extending downwards from the right shoulder; also one over the left hip. The patches were somewhat symmetrical. There was some fluid in each pleural cavity, but more in the right than in the left. Lungs were anæmic, but otherwise normal. The heart contained no clots, but the walls were somewhat thin and flabby. The liver and kidneys were anæmic. Spleen not enlarged. Intestines were very anæmic, containing a little feculent matter, walls very thin. There were a few drops of urine in the bladder, no fluid in the peritoneal cavity. Patchy congestion of the tonsils. On examination of the brain, the arachnoid was found to be milky, the convolutions somewhat flattened, and a small quantity of serum in the ventricles. There was no extravasation of blood in any of the internal organs.

*Remarks by Dr. COLLIE.*—The interest of this case is

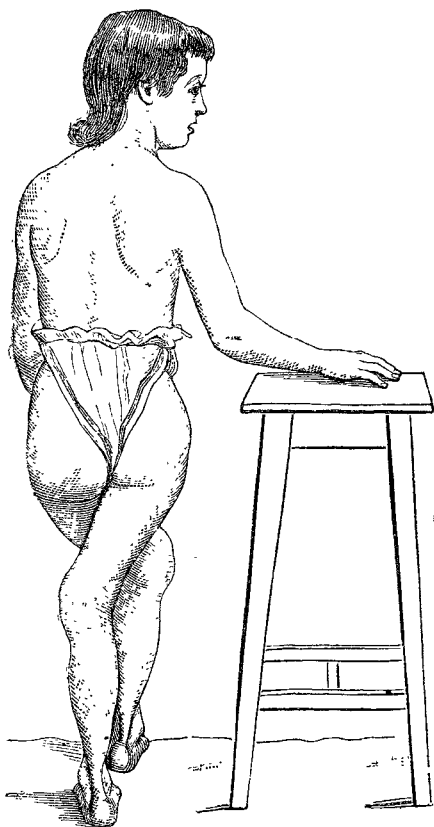
that it appears to be one of a class of rare cases which have been described by Dr. Henoch of Berlin. (For this reference I am indebted to Dr. Donkin.) Henoch says: "In recent years I have seen two cases of extensive hæmorrhage into the skin, both of which were rapidly fatal. I have termed them 'purpura fulminans.' A third case was communicated to me by Dr. Michaelis, and a fourth has been published by Charron. All these cases had this in common—that hæmorrhage from the mucous membranes was wanting, and that extensive ecchymoses, from which within a few hours all the extremities became of a blue-black-red colour and the skin tolerably hard from infiltration of blood, occurred with great rapidity. In two cases there were sero-sanguineous blisters on the skin, which blisters never became gangrenous, or even stank. The course of these cases is very rapid, scarcely twenty-four hours elapsing between the first appearance of the blood spots and death. The longest case lasted four days. There were no complications, and post-mortem examination, with the exception of general anæmia, gave negative results; in particular there was no trace of embolism or thrombosis. The etiology is as obscure. One of my cases showed itself two days after the complete crisis of a pneumonia, the other a week and a half after a very mild scarlatina. For the two other cases no etiology could be suggested."<sup>1</sup> Henoch adds in a footnote that two similar cases have been observed by Ström and Arctander, one of which followed a scarlatina, and according to Heroé three quite similar cases have been published by Guelliot.

## ROYAL INFIRMARY, NEWCASTLE-ON-TYNE.

CROSS-LEGGED DEFORMITY; OPERATION; GOOD RESULT.

(Under the care of Mr. FREDERICK PAGE.)

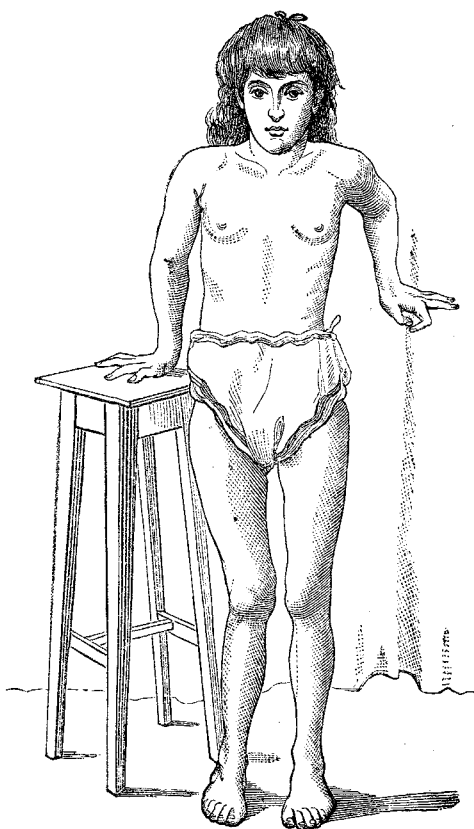
RECORDED examples of the cross- or scissor-legged deformity resulting from ankylosis of the hips in the adducted position are few. The better recognition of the principles of treatment and the increased facilities for obtaining treatment in cases of disease of both hip-joints make it improbable that the deformity will ever be otherwise than rare, disease affecting both hips being of itself a rarity. Most of our readers will remember the account of



the deformity in the patients under the care of Mr. Lucas, who brought the condition to the notice of the profession in 1880,<sup>2</sup> and the description of Dr. Tuson's<sup>3</sup> case published in

the following year. The eversion of the limbs, which was such a marked feature in those cases, does not appear to have been present in the patient whose history is here given. For the notes of this case we are indebted to Mr. J. Hindhaugh, house surgeon.

J. B—, a schoolgirl aged thirteen years, was admitted in August, 1890, suffering from cross-legged deformity due to ankylosis of both hip-joints. Six years ago she was confined to bed for eight months by an attack of acute inflammation of both hip-joints, and during the illness the deformity arose. The engraving fairly represents her condition on admission. The legs could not be separated, and in consequence the child was much inconvenienced. She was in good health. On Aug. 21st the neck of the right femur was subcutaneously divided with Adams' saw, and the leg straightened. The neck of the left femur was similarly divided, but the limb could not be straightened until the origin of the adductor longus was severed. The legs were then secured in a box splint with starched bandages. The wounds healed at once, without any constitutional disturbance. In six weeks the splint was removed for the first time, and the result, as shown by the following engraving, leaves little to be desired.



*Remarks by Mr. PAGE.*—Cross-legged deformity, from ankylosis of both hip-joints, is fortunately rarely met with, and its treatment is not always satisfactory. In this case the patient's condition has been materially improved. She walks less awkwardly and much more readily than she did before the legs were straightened, and in other respects she is in a more satisfactory condition, though the hips are still ankylosed, and there is slight genu valgum on the right side.

## LONDON COUNTY LUNATIC ASYLUM, HANWELL.

A CASE OF SUICIDAL EPILEPSY.

(Under the care of J. PEEKE RICHARDS, M.R.C.S.,  
Medical Superintendent, Female Department.)

THE presence of certain definite coördinate movements which arise while the patient is in a state of epileptic unconsciousness is a point of peculiar interest in this case. She does not continue what she may happen to be doing before the onset of the petit mal, as is usual in such cases, but commences an entirely new act, the whole end and object of which has always been self-injury or destruction. Moreover, these movements are always preceded by a state of muscular relaxation (which sometimes commences with very slight spasm) which invariably renders the patient helpless and

<sup>1</sup> Kinderkrankheiten, fünfte Auflage, p. 810, Berlin, 1890.

<sup>2</sup> THE LANCET, vol. ii. 1880, pp. 696, 1009.

<sup>3</sup> Ibid., vol. i. 1881, p. 700.