

longer taught to speak new words his condition remains the same, and all improvement seems to have ceased. He still, however, refuses operation.

I have been able to obtain the following cases of aphasia resulting from injury. The case of Mr. Jalland and that of Surgeon Basu most nearly resemble mine:—H. Campbell Pope, M.D., and Rickman Godlee, M.S.: "A case of punctured wound of the left orbit, followed by aphasia; recovery." (THE LANCET, June 19th, 1886.) Professor Fraser: "Aphasia from injury; subsequent hemiplegia; trephining; death; necropsy." (THE LANCET, Feb. 27th, 1886.) Mr. Morgan: "Compound depressed fracture of skull, with loss of cerebral substance; aphasia." (*British Medical Journal*, vol. i. 1885, p. 1155.) Mr. Verrall: "Aphasia after injury." Read at the Brighton and Sussex Medico-Chirurgical Society. (*British Medical Journal*, Sept. 1884.) Kast: "Aphasia, with loss of ear for music." (Mentioned in THE LANCET of Nov. 6th, 1886, p. 878.) Basu: "Compound depressed fracture of skull; aphasia; right hemiplegia." (*Indian Medical Gazette*, Calcutta, 1880, vol. xv., p. 99.) Mr. Jalland: "Compound fracture of skull; elevation; aphasia." (*British Medical Journal*, vol. ii. 1881, p. 706.) Rex: "Fracture of skull; hernia cerebri; aphasia; hemiplegia." (Oregon Medical Society, Portland, 1882, vol. ix., p. 40.) Lloyd: "Compound depressed fracture of skull; eight square inches of bone removed; wound of longitudinal sinus; secondary aphasia; embolic pneumonia; complete recovery." (THE LANCET, vol. ii. 1885, p. 892.)

Mr. Verrall's case was one of several attacks of aphasia, lasting for twenty-four hours and upwards, following a blow on the occiput. There was some slight right hemiplegia. Complete recovery took place in five weeks' time.

The case of Mr. Morgan of Sunderland was one of aphasia following a compound depressed fracture of the left parietal bone, in which elevation was practised. A wound of the superior longitudinal sinus occurred, and hernia cerebri followed. The aphasia came on thirteen days after the operation, and was permanent. There was also permanent right hemiplegia.

In Professor Fraser's case, although the aphasia followed a blow on the left side of the forehead, it was found on post-mortem examination to be due to a glioma involving the temporo-sphenoidal lobe and Broca's convolution.

In Mr. Jalland's case there was a compound comminuted depressed fracture a little above the left ear and temple; dura mater uninjured. Elevation of depressed portion of bone was practised. Subsequent aphasia was discovered on the patient recovering consciousness; slight left facial paralysis; deafness for ten days; unable to repeat from memory; broke down at fifth letter of alphabet, fourth word of Lord's Prayer, &c.; could not write from dictation, &c. Recovered completely in all respects in less than two months. This case more closely resembles the one I have related than any of the others.

In Mr. Lloyd's case the patient was conscious, but could not speak, Broca's convolutions being compressed by blood-clot, which was subsequently removed. There was an almost complete disappearance the following morning of the hemiplegia and aphasia, pointing to absence of gross lesion of the brain tissue itself. These symptoms returned, however, on the fourth day, and subsequently somewhat rapidly disappeared.

Surgeon Basu's case was that of a Hindoo struck on the head with a "lathi." Insensible for two days. Right upper limb completely paralysed. On recovering his senses he was found to be aphasic, answering "Yaam" to all questions. He understood fairly, and expressed his desires by hints and gestures. He had a contused wound in front of, and internal to, the left parietal protuberance; at the bottom of this was a depressed fracture of the skull, said to be one-fifth of an inch deep. The aphasia got well first, and then the paralysis of the arm. It should have been mentioned that on admission his tongue pointed to the left when protruded.

Dr. Charlton Bastian, who saw my case at the Clinical Society, kindly showed me a photograph of a man who had a depression on the right side of his head. "This man was not aphasic at all, though he was partially hemiplegic on the left, and subject to unilateral convulsions on this side; the depression in his case was more uniform, and, I think, a trifle deeper than in yours." The above is an extract from a letter of Dr. Bastian to me.

THE SURGICAL TREATMENT OF ACUTE ABDOMINAL DISEASE.

By WILLIAM COATES, M.R.C.S. ENG., L.R.C.P. ED.

THE contributions that have recently appeared in THE LANCET on the above subject are full of interest and information, especially those by Mr. Lawson Tait and Dr. Wade, which must engage the particular attention of the profession. As it is suggested that some diseases which have hitherto been left to the resources of medicine can be more successfully treated by the surgeon, it is clearly a duty that any case which bears at all upon the subject should be placed upon record. Such being so, perhaps the narrative of the following two cases may be considered worthy of perusal.

CASE 1.¹—*Perforation of a small stone through the vermiform appendix, followed by acute faecal abscess and general peritonitis; operation; death.*—H. F—, aged eighteen, a young woman, came under observation on Jan. 11th. She was a member of a healthy family, and had never been seriously ill. Five days before coming under my care, whilst in service, she was suddenly seized with acute general abdominal pains, which were the most severe on the right side, and continued for about six hours. She was free from pain and slept well during the night, and, though feeling a little soreness, resumed her duties on the following morning. During the afternoon the pain returned in the right side of the abdomen; it gradually spread all over the bowels, which became constipated, and she began to vomit. Purgatives were administered, but, becoming worse day by day, she was sent home in a cab, a distance of several miles. When first seen on the evening of the above date she was exhausted after the journey and very ill. Her face was pinched and expression anxious; tongue dry and furred; temperature 103°; pulse 130, small, quick, and thready; chest healthy; knees drawn up; and she complained of acute abdominal pain and vomiting. The abdomen was distended, tympanitic, and painful. The pain was severest in the caecal region, but no swelling or resistance was detected. The rectum, loaded with faeces, was relieved by simple enema, opium administered, and poultices locally employed. On the 12th her condition was unaltered. On the 13th there was abdominal distension, and the pain on pressure over the caecal region and the general signs of peritonitis were decidedly increased. On the 14th the temperature was 103.2°, the pulse 120, and the vomiting and abdominal pain more severe. There was a decided sense of deep-seated resistance in the caecal region, where pressure produced much pain. No swelling could be felt per rectum. There was retention of urine. On the 15th the temperature remained high, the pulse rapid and small, and the vomiting was exhausting her. The abdomen was more distended, and in the caecal region, covered by tympanitic bowel, in a position where pressure was most resisted, an obscure swelling could be felt. Under chloroform the swelling was more defined, apparently deep seated in the iliac region. It could not be felt per vaginam. On introducing the aspirating cannula into the swelling a few drops of offensive pus oozed out, but nothing was drawn into the aspirator. An exploratory incision about three inches in length was made, beginning a quarter of an inch above the middle of Poupart's ligament and extending obliquely upwards and outwards above the anterior iliac spine, and a dissection made upon the swelling. Out of it about five ounces of offensive faecal pus were evacuated. On introducing a finger, it entered into a large irregular cavity around the caecum, from which a small stone about a quarter of an inch in length was removed. This was oval in shape, and composed of faecal matter arranged in a laminated manner, and surrounded by a hard, dense phosphatic layer. There was a small opening into the peritoneal cavity, which possibly was made during the dissection upon the swelling. As no post-mortem examination was allowed, the exact condition was never determined, but the distended bowel immediately over the swelling appeared to greatly increase the risks of wounding the peritoneum. The patient's condition appeared too critical to permit any extension of the operation, so the cavity was washed out with carbolic solution, drainage-tubes intro-

¹ This case was mentioned before the Manchester Medical Society on Feb. 3rd.

duced, and the wound dressed. After the operation the patient rallied, her symptoms having been decidedly relieved; but after a time the vomiting returned, and she gradually sank, dying in twenty-four hours.

CASE 2. *Obscure abdominal symptoms and death, caused by localised enteritis set up by a fish-bone.*—M. W.—, aged seventy-one, the subject of chronic bronchitis, was as well as usual until Feb. 5th, when she complained of indefinite pains. These becoming worse, she was first seen on the 7th. Defective articulation made it difficult for her to describe her symptoms; but she was suffering from pains in the abdomen, which region, however, was neither distended nor very tender. The temperature was 98.4°, the pulse 100, and the tongue a little furred. A calomel purge, sedative mixture, and hot fomentations were employed. On the following day the bowels were relieved, but there was slight abdominal distension, with some tenderness. The temperature was normal, but the pulse was 110. On the 9th the abdomen was more painful, vomiting set in, and she died rather suddenly, probably from syncope, ninety hours after the first onset of symptoms. On opening the abdomen post mortem, a discoloured portion of bowel eight inches in length was found at the junction of the jejunum and ileum. The central four inches of this were acutely inflamed and somewhat indurated, but not at all gangrenous. The sharp end of a small fish-bone ($\frac{3}{4}$ in.) was projecting through the wall of the bowel into the peritoneal cavity, and this had originated the mischief. The large intestine was occupied by hard faeces, and in the descending colon a large fish-bone (2½ in.) was discovered travelling safely. The small intestine contained a large quantity of a chymous fluid, which looked very much like pus, but under the microscope it showed vegetable debris—starch granules and stray phosphates. There was no fluid or lymph in the peritoneal cavity, nor other sign of peritonitis, except slight hyperæmia in the immediate neighbourhood of the inflammation.

The age of this patient and the existence of subacute bronchitis precluded the advisability of resorting to operation; but if in a similar case in a younger subject an exploratory operation were performed, the foreign body irritating the bowel might readily be detected and removed, the bowel itself dealt with, and a chance of recovery afforded. It is interesting to note that the fish-bones had escaped digestion, and that the larger bone was travelling safely in the midst of a mass of faeces, whereas the smaller one, happening to be in a portion of the bowels where the contents were fluid, was arrested by contact with the wall of the bowel, exciting local inflammation in and penetrating through it. This fact favours the administration of astringent rather than purgative medicines after the accidental swallowing of foreign bodies.

Referring to Case 1, it is reasonable to suppose that, had its nature been clearly recognised at an early stage, before the occurrence of acute peritonitis, an operation such as the one performed might have been accomplished without further injury to the peritoneum, and with a fair prospect of success; or even at the later stage, when first she came under my care, before the iliac swelling was detected, if the abdomen had been boldly opened, the pus might have been evacuated, the abdomen thoroughly cleansed, free drainage established, and recovery hopefully looked for. But, on the other hand, what would have happened had the surgical treatment been left alone? Could not life have been sustained long enough by nutrient enemata &c. until the near approach of the abscess to the surface allowed a safe incision? Cases of perityphlitis are readily recalled to mind where, after patient waiting, the swelling has made its way to the surface, and a simple incision has ended in recovery. But in these cases the peritoneal complication is usually of a milder type, and so they compare unfairly with the above.

The treatment of acute abdominal disease, now that surgery claims a part in it, is surrounded by difficulties, especially to the general practitioner. The consequence of an unsuccessful operation to him is of much importance; but still no operation must be shirked which promises to relieve suffering and prolong life, and still more should he avoid operation where such is not necessary to recovery. Modern surgery lessens the risks of these great operations, but how must the cases be decided in which it is justifiable to perform them? If an operation be delayed until after the failure of medicine the prospects of successful surgical interference are greatly minimised, whereas if a much larger proportion of the cases are treated surgically many will have

to submit to an operation which would have recovered without. Every week cases of acute abdominal disease come under notice—some mild, others most severe, and the larger proportion by far recover. Even the most violent case is not without hope. That being so, the responsibility of advising an exploratory operation is indeed very great, and the practitioner at present looks in vain for some standard rules to guide him. More accurate and detailed observation of the course and symptoms of these diseases, and the cultivation of the art of more minute diagnosis, must eventually make it possible to differentiate between those cases which will yield to medicine alone and those which demand the assistance of surgery. Meanwhile, it might be a good rule for guidance to imagine ourselves to be the patient, and to operate accordingly. It is hoped that the above cases may be of use to those who are working at the subject.

Manchester.

NOTES ON ENTERIC AND TYPHO-MALARIAL FEVER.

By SURGEON-MAJOR H. JAGOE, M.S.

THE discussion at the Medical and Chirurgical Society on enteric fever at Suakim, reported in THE LANCET of Feb. 13th, 1886, induces me to forward this communication, with the hope that it may prove interesting.

The cases and necropsies which I give are from notes taken in Zululand, Afghanistan, and India, and the temperature charts attached to elucidate the cases are two out of a very large number that I took to try to clear up the distinction between enteric and what is called typho-malarial fever. I agree with Dr. Squire that the large majority are as clear and distinct cases of enteric fever as those seen in this country, but I doubt very much the advantage of the term "typho-malarial" to express a fever which, to my thinking, is far more fairly expressed by the name "bilious-remittent." As Dr. Broadbent stated, there is nothing typhoid about it, "nothing in common with enteric fever, if we except the fact of a protracted high fever with some intermissions." There is a protracted fever of about forty-six days, with an interval of eleven days, during which there is a total absence of any rise of temperature; or in its course there may be two intermissions. It has been suggested that these are mild cases of typhoid with relapses, but there is not a single symptom of enteric fever about them; on the contrary, they seem to be more of a bilious-remittent type. There is frequently yellow tinging of the skin and conjunctivæ, often vomiting, and the tongue pale, clean, sometimes coated with a yellow fur, and frequently large and indented by the teeth; at no time is there any degree of the red³ irritable, and contracted tongue of enteric fever, or any other mild characteristic symptom of the disease. These are the class of cases that I understand it is proposed to call, or have been called, "typho-malarial." I have never seen a death caused by them, if I except one patient who died during the last march into Candahar on Sept. 18th, 1879. Chart 1 shows the last nine days of the fever; the previous eight days had been spent under the care of the regimental surgeon. The patient was very much in the condition described above when admitted into the field hospital. There was diarrhoea; the upper surfaces of the conjunctivæ were slightly jaundiced; there had been some vomiting; and the pulse was small and weak (about 86); the tongue was moist, large, and indented by the teeth. The man was perfectly sensible and intelligent up to half an hour before his death. In Candahar I could only make a very hurried necropsy, but I found the lower part of the ileum perfectly healthy, not even congested; the liver and spleen were enlarged, but I had no means of weighing them.

The cases above referred to are very different from that shown in Chart 2, which may appropriately be termed "typho-malarial," or, without using this compound, is fully accounted for by Trousseau when he states that enteric fever in its early stage may simulate malarial fever. Here, at all events, was a case of enteric fever in which the morning temperature was normal on the ninth, tenth, and eleventh days of the disease, while in the second week the variation between the morning and evening temperature ran from three to four degrees. The stools were not considered to be like those of typhoid, but on the fifteenth day spots, both rose and blue,