

The sternal end of the left collar bone was incompletely luxated forwards. Temperature, taken in armpit, was subnormal (97·6° F.), and it continued so during a week. On the fourth day a strong volitional effort produced slight movements of the hand and forearm. This improvement continued, and by December 5th, when he became an out-patient, he could execute with regularity such complete acts with the hand and forearm as were required in dressing and taking his meals. He soon after this returned to work, and when recently seen the only remaining traces of the injury were a slight loss of bulk and slight defect of muscular power of the limb as compared with what he believed to have been its condition previously; and the subluxation of the collar bone, which did not appear to cause any inconvenience.

EVELINA HOSPITAL.

CASE OF RUPTURE OF THE OESOPHAGUS; FRACTURED BASE; NECROPSY.

(Under the care of Mr. HOWSE.)

FOR the following interesting notes we are indebted to Dr. W. H. C. Newnham, resident medical officer.

Edward B—, aged three years, was admitted on Oct. 15th, 1883. On the 15th, at 10 A.M., the child went up to a baker's cart standing in the street, and hanging on the back the cart tipped up. The child fell with his head on the stones, the cart striking his forehead and chest.

On admission there was a very small cut on the back of the head, no bone exposed. There was much bruising of the left eyelids, bleeding from right nostril only. The child appeared drowsy but quite conscious. No paralysis, no convulsions, no vomiting. Pupils equal. Pulse 80, not quite regular. Temperature 96° F. Limbs not drawn up. In the night the child was very sick, bringing up a large quantity of blood.

Oct. 16th.—Pulse 156. Respiration 48. Still conscious, eyelids much more ecchymosed. At 10 P.M. the child began to have convulsive movements of both arms and legs, equal on both sides, some twitching of face also, was not drawn to either side. Temperature 103·2°.—17th: The movements have continued at intervals during the day. The right pupil is much more dilated than the left. No paralysis apparent. Pulse 192; respiration 60.—18th: At 2 A.M. the child died quietly. The treatment was simply to keep the child in bed with an ice-bag applied to the head, and administering a little milk.

Necropsy, thirteen hours and a half after death.—Well-nourished, well-developed child. Rigor mortis present; ecchymosis of both upper eyelids, chiefly left; a small superficial wound of occiput. No other external injury. Head: Meningitis, chiefly of vertex, but slightly at base of brain; lymph becoming yellow in the sulci; opacity of membranes; changes not localised on hemispheres; no bruising of brain substance, or other changes; some excess of fluid; the left speno-frontal suture at the outer end (where the great wing of the sphenoid articulates with the horizontal plate of the frontal) is started, and a fissure extends forwards into the orbital plate of the frontal about an inch and a half; a very slight extravasation of blood at this fracture beneath the dura mater; no other fracture of skull; slight extravasation of blood into the left temporal muscle. Chest: No fracture of ribs or vertebrae, or dislocation of the latter; in left pleural cavity a considerable amount of brown gelatinous matter, chiefly, if not entirely, blood-clot, also some dark blood; in right pleural cavity some dark blood, less in quantity than in left side. Lungs normal; no rupture on pleural surface. Heart normal. Pericardium normal. Oesophagus: On left side, and somewhat posteriorly, is a rent about an inch and a half in length, half an inch above the cardiac orifice, the edges of which, though not ragged, are not sharply cut, and the edges of the mucous and external coats do not quite correspond; it is quite unlike the hole which would result from post-mortem digestion; the coats of the oesophagus in the remainder of its length are normal and healthy-looking; no other lesion discoverable. Stomach contained a little blood. Kidneys, intestines, and spleen normal. Liver healthy in appearance on the surface; and extending into the substance are some yellow patches (gummata?); no other evidence of hereditary syphilis.

SHEFFIELD PUBLIC HOSPITAL.

INTESTINAL OBSTRUCTION; DEATH; REMARKS.

(Under the care of Dr. THOMAS and Mr. THORPE)

FOR the following notes we are indebted to Dr. Sinclair White, house-surgeon:—

Alfred H—, aged twenty-seven, a silver buffer, married, was admitted on October 25th, 1883. He gave the following history: Had inguinal hernia when a child, and wore a truss until he was four years of age. Since then the hernia has not reappeared; has been fairly healthy, and has had no difficulty in regulating the bowels. On Oct. 20th, five days prior to admission, he began to feel pain in the abdomen; the pain was of a "colicky" character. He could assign no cause for the pain, and had been until then in his usual health. On the 21st the pain was worse and the bowels were relaxed, and he vomited for the first time. On the 22nd the pain and vomiting continued, the vomited matter smelt faecal; he had one motion. From this date until admission the pain and vomiting continued, and his medical attendant, Mr. Hargreaves, states it was distinctly stercoraceous; the bowels did not act subsequent to Oct. 22nd.

On admission the abdomen was moderately distended and tympanitic all over except in the left iliac region; here an oblong swelling could be distinctly felt; percussion over this area elicited a dull note, and pressure caused pain; elsewhere over the abdomen pressure was borne without complaint. The patient volunteered the statement, that "the water rolled all over the belly until it came to the left side, where it stopped." The inguinal canals were unduly large, but no hernia could be detected here nor in any of the situations where it may appear. Examination per rectum revealed nothing abnormal. The patient was not suffering much pain, nor were the features pinched; he complained of thirst, but the tongue was fairly clean and moist. The temperature was normal, and the pulse 96 per minute and fairly strong. He passed a considerable amount of urine, which was normal. Shortly after admission, he vomited a small quantity of liquid matter; this did not smell faecal, and was mostly beer, which he had taken prior to admission. The case was diagnosed as one of faecal impaction in the descending colon. Belladonna fomentations were applied to the abdomen, and an enema of castor oil and gruel was thrown up the rectum through a long rectal tube. The man was allowed small quantities of iced milk and beef-tea. The enema did not bring away any faecal matter, but the patient seemed to improve; the vomiting ceased, and the pain subsided considerably. During the night he slept for five consecutive hours. Next morning he was fairly comfortable; there had been no recurrence of the vomiting. The abdomen was softer, and the iliac swelling had entirely disappeared; still, no faecal matter had come away, although the enema had been repeated. The improvement was maintained until the afternoon, when the vomiting recurred, and the pulse went up to 120 per minute; the vomited matter soon became stercoraceous, and the patient got rapidly worse.

A consultation was held, and operative interference decided on. The patient was anaesthetised, and the abdominal cavity opened by means of an incision four inches in length, at the linea alba, between the pubes and umbilicus. The large intestine was first examined, but was found everywhere empty and natural. The small intestine was next traced, and at an inch from the ileo-caecal junction a band was found constricting the ileum; this band was easily torn through on passing the finger beneath it. The protruding portion of intestine was carefully replaced, and the wound in the abdominal wall closed by sutures. The operation was performed under strictly antiseptic precautions. The patient did not rally, and died an hour after the operation was completed. It may be here stated, that in the efforts made to revive him the subcutaneous injection of twenty minims of ether had a remarkable influence on the pulse, causing it for a short time to beat much more strongly; but the gain was not maintained for more than a few minutes. Ether was the anaesthetic used.

Examination after death showed the bowels slightly inflamed and distended with gas. The constricted portion was thickened, and its lumen narrowed but patent; there was some blood effused beneath the peritoneum around it. The large intestine contained no faecal matter.

Remarks.—The case is one of unusual interest and shows