

abscess cavity containing four ounces of very off-nisive pus was opened. This was swabbed up and washed out with 1 in 40 carbolic lotion and then explored with the finger; the walls were quite smooth and felt as though formed by mucous membrane. The peritoneal cavity was opened next and carefully packed off. The abscess cavity described above was then found to be the inner surface of the fundus of a dilated and gangrenous Meckel's diverticulum, which was adherent to the anterior abdominal wall. It was then carefully separated and the coil of bowel from which it arose was drawn out of the wound. The diverticulum arose from the ileum, about 12 inches from the ileo-cæcal valve; its proximal portion was stenosed and its distal portion or fundus was gangrenous and dilated (as far as could be judged, for it had contained four ounces of pus) to the size of a Tangerine orange. The pathological condition was on a par with the "appendicitis with stenosis, empyema" classified by Mr. C. B. Lockwood. The diverticulum was removed in the same way as an appendix and the stump was tucked in, the wall of the intestine being brought together over it with Lembert's sutures. The displacement of the cæcum was due to the mesentery of the ileum being adherent to the meso-cæcum and meso-colon, and to slight adhesion of the omentum to the outer and posterior wall of the cæcum. These were separated and all bleeding points secured. A drainage-tube was placed in the whole length of the wound in the middle line and brought out at its lower extremity, and the abdominal walls were brought together over it with one layer of sutures, a separate layer for the peritoneum not being practicable owing to its friability. The wound in the iliac region was closed in separate layers.

The after history of the case was as follows. The patient did not suffer from shock, though the operation lasted about one and a quarter hours. His condition gave rise to some anxiety for the first 36 hours, owing to the difficulty of overcoming the paralytic distension of the bowel, but this was effected by calomel and enemata, and the second day after the operation the bowels opened naturally and the hiccough, which had been rather persistent, stopped and the pulse-rate dropped from 120 to 98. Convalescence was uninterrupted and the wound in the iliac region healed by first intention. There was a fair amount of discharge from the tube in the other wound, but at the end of a week this had stopped and the wound soundly healed in 14 days.

Remarks.—Cases of Meckel's diverticulum are sufficiently uncommon to warrant their publication, and the above case is one of unusual interest from a pathological point of view. Cases in which the diverticulum has caused acute obstruction by strangulating the bowel have been frequently reported, but I have not the literature at my disposal to look up the subject. I should be glad to hear if any cases of a similar nature have come under the notice of any readers of THE LANCET.

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DELIRIUM TREMENS (MANIA E POTU):
STATISTICAL STUDY OF 156 CASES.¹

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I HAVE made a statistical analysis of the hospital records for 156 cases of delirium tremens treated at the Philadelphia Hospital (Blockley) between Jan. 1st, 1904, and March 1st, 1907. In compiling statistics so as to display them in the form of tables it was found that the records of 16 of these cases were incomplete, therefore these have been omitted, and the tables include but 140 of the 156 cases treated. A number of cases that have occurred in my private practice could have been added, but it was deemed advisable to include only cases that had received hospital treatment in order that one might obtain statistics that would be of definite value. An analysis of the 140 case records showed age to be not only a predisposing factor to delirium tremens but also to exercise a decided influence upon the gravity of this condition. The number of cases observed at the different decades, the number of deaths, and percentage of mortality are set forth in Table I.

¹ Published through the courtesy of Dr. Joseph Neff, Director of Public Health and Charities, Philadelphia.

TABLE I.

| Age. | Total number of cases. | Total number of deaths. | Percentage of mortality. |
|-------------------|------------------------|-------------------------|--------------------------|
| 20 to 30 years... | 24 | 8 | 33·3 |
| 30 „ 40 „ ... | 48 | 18 | 37·5 |
| 40 „ 50 „ ... | 41 | 14 | 32·1 |
| 50 „ 60 „ ... | 21 | 9 | 42·3 |
| 60 „ 74 „ ... | 6 | 3 | 50·0 |

Delirium tremens is most common between the ages of 30 and 50, yet the death-rate remains almost the same during the second, third, and fourth decades. The prognosis is decidedly unfavourable in those suffering from this condition after the age of 50 years, and while the above statistics show a mortality of between 42 and 50 per cent. for such patients I am confident that a much higher death-rate is seen in private practice. Many of the cases included in Table I. had had a number of admissions to the delirium tremens wards of the hospital during the past 20 years. The greatest number of admissions for any one patient was 42, while many of the patients had had from six to 15 admissions, from each of which attacks they recovered and had been discharged from the institution as comparatively cured. These facts, though not included in any of my tables, are contradictory to the rather popular belief that those suffering from delirium tremens usually end in death during the second or third attack.

Further analysis with reference to season as a predisposing factor and its influence upon the gravity of the condition is revealed by Table II. :—

TABLE II.

| Month. | Number of cases. | Number of deaths. | Percentage of mortality. |
|------------------|------------------|-------------------|--------------------------|
| January | 14 | 7 | 50·0 |
| February | 15 | 2 | 13·3 |
| March | 11 | 5 | 45·4 |
| April | 10 | 1 | 10·0 |
| May | 14 | 1 | 7·1 |
| June | 5 | 3 | 60·0 |
| July | 7 | 2 | 28·5 |
| August | 28 | 13 | 46·7 |
| September | 10 | 4 | 40·0 |
| October | 7 | 3 | 42·8 |
| November | 8 | 3 | 37·5 |
| December... .. | 11 | 8 | 72·7 |

It will be seen by Table II. that the largest number of cases developed during the month of August when in this climate the heat is extreme. It is further of special interest to note that August gives a death-rate of 46·7 per cent., while the average death-rate is but 37·1 per cent. Extreme cold is not without influence upon the mortality-rate, since December and January gave the correspondingly high death-rate of 72·7 and 50 per cent respectively. During the spring months (May, April) delirium tremens is fairly common but the proportionate number of deaths is low, 7·1 and 10 per cent.

The following table (Table III.) is designed to present the various pre-existing and complicating conditions found to

TABLE III.

| Pre-existing or complicating diseases. | Total number of cases. | Deaths. | Percentage of mortality. |
|-------------------------------------------------|------------------------|---------|--------------------------|
| Cases with pre-existing cardiac disease | 13 | 11 | 84·6 |
| Cases developing cardiac complications | 10 | 8 | 80·0 |
| Cases with pre-existing kidney disease | 11 | 11 | 100· |
| Cases developing renal complications | 4 | 4 | 100·0 |
| Cases with pre-existing lung disease | 11 | 5 | 50·0 |
| Cases developing pulmonary complications | 53 | 35 | 66·0 |

influence materially the mortality in 140 cases of delirium tremens studied, and of which 52 were fatal.

Twenty-two of the cases displayed more than one pre-existing or complicating condition of which ten displayed kidney and lung involvement; seven heart and lung; two kidney and heart; and three heart and stomach. Thirty-eight of the 140 cases were uncomplicated and all of these were followed by recovery. Most striking in connexion with Table III. is that all of the 15 cases showing renal complications terminated fatally. Again, great importance is to be attached to the prognostic significance of pre-existing cardiac disease which gave a mortality-rate of 84·6 per cent.; and acute cardiac complications are of but little less importance as regards the seriousness of the condition in question. Those cases developing acute pulmonary conditions (bronchitis and broncho-pneumonia) gave a death-rate of but 66 per cent.

Philadelphia.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTE ON A CASE OF HERNIA OF THE LUNG.

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OWING to the rarity of the condition the following case seems worthy of record.

In November, 1905, a female, aged 56 years, was admitted into the Salford Union Infirmary suffering from a septic

FIG. 1.



Hernia before reduction.

wound of the wrist and resulting cellulitis of the right axillary region with abscess formation. This was incised very thoroughly in three or four places and when she was

dismissed in April, 1906, all the wounds had healed. About this time the patient noted a swelling at the lower end of the sternum but did not consult a medical man about it. On May 4th, as she was fixing her handkerchief round her neck, she suddenly discovered another swelling near the upper end of the sternum and went to the out-patient department of the Salford Royal Hospital. I saw her in the out-patient room and admitted her into the hospital under the care of Dr. A. M. Edge.

On admission she had two distinct and separate swellings in the region of the sternum, one at the lower end in the middle line and one at the upper end slightly to the right of the middle line. The lower swelling was about 3 inches long by 2 inches wide, tympanitic, soft, and moveable to a certain extent under the skin. There was no impulse on coughing, no breath sounds over it, and it was unaffected by taxis or pressure—evidently a collection of air in the cellular tissue. This gradually disappeared in a month's time. The upper

FIG. 2.



After reduction of hernia.

swelling gradually increased in size and presented all the signs of pneumocele.

The notes at this time were as follows. On inspection it is situated over the upper end of the sternum, 5 inches in length and 3 inches in width. The outline is well defined and smooth and tapering to a blunt point over the first right intercostal space. It moves slightly with re-piration relatively to the chest wall. On palpation it is found to be soft and fluctuating. The skin moves over it and it can be moved a limited amount both up and down and side to side. Vocal fremitus is much increased over it and it has a most marked impulse on coughing which is easily visible as well as palpable. It does not pulse. On percussion it is tympanitic to a marked degree. On auscultation there is bronchial breathing over it, low pitched, and interrupted. Vocal resonance is increased with whispering pectoriloquy. There are no adventitious sounds. When the patient speaks the swelling bulges out and becomes quite tense. There is no pain. The temperature is normal and the pulse is normal.