

5th. To-day and yesterday the pulse was very much quickened towards evening, and at the same time there were present some of the other symptoms of fever. A small fungus was observed protruding from the wound. No constipation.

6th. Fungus much larger, and is distinctly seen to pulsate. Pulse 48.

7th. In the evening of to-day the fungus grew enormously; the patient displaying more mental hebetude than I have yet noticed.

9th. Fungus has begun to slough.

11th. Fungus has disappeared; general condition of patient good. A nutritious diet and tonics prescribed. Bowels have to be moved artificially.

14th. The tumour seems to be reappearing. Urine had to be drawn off.

27th. The fungus is now about the size of an English walnut. There is no paralysis, but some twitching of the muscles about the mouth. Pupils are very much dilated.

5th. Fungus again sloughing; dressed with a weak solution of chlorinated soda.

7th. Sat out in the yard for a long time this morning. His gait is slow and somewhat unsteady, but not remarkably so. There is also a slight twitching of the muscles of left arm. Bowels are generally constipated.

14th. Pupils are no longer dilated. Wound now dressed with a very weak solution of chloride of zinc.

18th. Several small pieces of bone came away to-day.

August 30. From the date of the last note his convalescence has been rapid, being protracted only by an attack of diarrhœa.

He remained in the hospital long after the end of August, but I find no note made worthy of transcribing. He continued up to the date of his discharge very silly and flighty, but his previous history, and the answers he made to our questions when admitted, led us to suppose that this was not a condition induced by the accident, but was with him the usual one. He was lately seen by one of the nurses of the hospital, who said that his mental condition remained the same. We have not discovered whether he had ever done anything for a livelihood.

1863. Oct. 28. *Fibro-Plastic Tumour of the Dura Mater.*—Dr. H. C. Wood, Jr., exhibited the specimen, and read the following history of the case from which it was derived:—

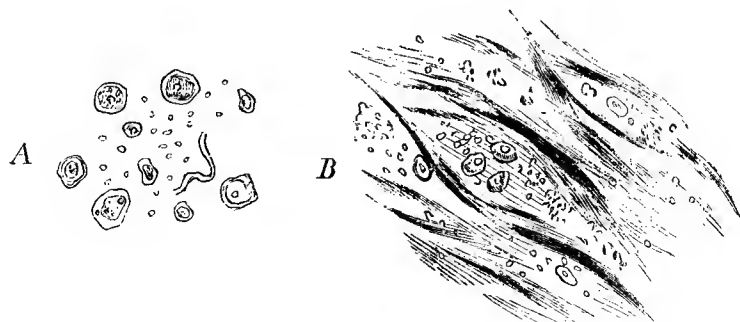
J. R., a native of Scotland, æt. 53, came into the medical wards of Pennsylvania Hospital May 27th, 1863, with the following history. About eight weeks previously, whilst living at service, she arose one morning before light, and on going down stairs fell and hurt herself considerably, but got up immediately. She then went across a room but fell again on the stairs, and there lay unconscious until assistance was attracted by her moaning. Before this accident, she had been perfectly well and bright. She had not had any symptom of brain disease. No headache, loss of memory, or alteration of disposition. On these points I carefully and repeatedly questioned both herself and friends. She had been subject for at least ten years to violent pain, her employers said, in her right arm.

After her fall she was subject to agonizing pain in the head, constant, or nearly so, but with paroxysmal exacerbations. She had also loss of memory and unnatural irritability of temper combined with a failing of the physical powers. At the time of her entrance into the hospital her condition was as follows: She had marked paralysis of the whole of the left side including the face. It was more pronounced in the upper than

lower extremity. Sensation was not very much diminished. She complained greatly of pain in her head. Her bowels were costive. She was ordered ten grains of iodide of potash three times a day, and improved until the 5th of June, when she was attacked with excessive headache, and in a few hours became deeply comatose with stertorous breathing. Cold was applied to her head and a blister to the back of her neck; she was also freely purged. The following day she was less unconscious and rapidly improved, so that on the 10th she walked up stairs to the clinic. After this attack the paralysis of the face was for awhile very marked, and persisted after that of her extremities.

Her intellect continued much enfeebled and her muscular power below par, but she was completely free from pain, was cheerful and walking about until July 5th; on that day she was seized with an agonizing headache, and soon began to lose power in her limbs. By the 17th she was semi-comatose and perfectly helpless, passing her feces and urine in the bed. On the 27th she began again to rally, and in the course of a week or two was about the wards again. Her intellect was more feeble than before her second exacerbation; she was more childish, as well as physically weaker. In the latter part of August she had another similar but less severe attack. From this she entirely recovered; but on the 27th of September had a convulsion, limited, however, to the muscles of the head and neck on the right side. From this time she was evidently failing, and on the 9th or 10th of October a rapid change took place in her. She lost all power over her limbs and sphincters, and was unable even to protrude her tongue; but, strangely enough, there was no marked facial paralysis. She was almost entirely unconscious until her death, which took place on the 19th, unaccompanied by convulsions. During her illness she never was troubled with vomiting or nausea. Her limbs were soft, the flaccid muscles never indicating irritation of the brain.

*Autopsy.*—Cadaver rather fat. Brain substance very slightly congested. An effusion of bloody serum at base of brain amounting probably to half a gill. Meninges brightly injected, closely adherent to the anterior portion of the right hemisphere. There was situated just anterior to the fissure of Sylvius an irregularly ovoidal and lobulated tumour. This was of considerable firmness, but did not creak under the knife, and was surrounded by a very delicate fibrous tunic. It measured one and a half inches in length by one and a quarter in breadth, and three-quarters in depth. The



dura mater coalesced with it so closely that it probably sprang from that membrane. The brain was softened all around the mass, but more especially

posteriorly to it, where its consistency was destroyed for about an inch and a half. There could not be found any indications of apoplectic clots either old or recent. The tumour juice contained numerous irregularly ovoidal cells, mostly containing another nucleated cell (Fig. B). No multipolar or fusiform cells could be found. On section the tumour was seen to be composed of fibrous elements with apparently amorphous material, amongst which were numerous cells and granules similar to those seen in the juice (Fig. A). All the viscera of the thorax and abdomen were examined and found to be healthy.

*Apoplexy Following Railroad Injury of Head. Death, Autopsy, etc.*

Dr. JOHN ASHHURST, Jr., read the following report of this case:—

O. H. S., aged about 40, was received into the Episcopal Hospital about 3 o'clock on the afternoon of October 16th, 1863, having fallen in attempting to get off from the cars of the New York line, on the morning of the same day. He had a deep cut through the buccinator and masseter muscles on the right side, penetrating to the bone. He was then (about six hours after the injury) in a state approaching coma, unable to articulate or swallow, but restless and uneasy. I saw him about 10 A. M. on the morning of the 17th, when his condition was as follows: Skin rather cool and clammy, and in the face very dusky, in some places almost blue. Pupil of left eye rather more dilated than on right side, and both apparently insensible to light. Mouth slightly distorted; all the left side of the face seemed flabby and relaxed. The jaw was dropped, and the tongue, which could not be protruded, stiff and very dry; breathing stertorous. When first admitted some bleeding occurred from the right ear, but had now ceased. Slight palpebral but no orbital ecchymosis. Urine had been passed without aid of a catheter.

From the symptoms and history of the case I suspected fracture at the base of the skull; the autopsy, however, proved this to be incorrect.

No marked change occurred until the patient's death, which took place about 8 A. M. of the 18th, nearly forty-eight hours after the injury.

*An autopsy* was made seven hours after death with the following results:

*Rigor mortis* strongly marked; no external injury apparent except the wound of the face above referred to.

*On opening the skull* a considerable quantity of fluid blood escaped, and between the membranes and the brain, pressing on the base of the latter on the right side and posteriorly, was a clot the size of a pigeon's egg or larger.

There was also much uncoagulated blood bathing the base of the brain, and the membranes were exceedingly congested. Altogether not less than four to six ounces of fluid blood had been poured out upon the brain.

*The thoracic viscera* appeared healthy; some old adhesions existed in the right pleural cavity. A long fibrinous clot occupied the right ventricle of the heart, extending into the pulmonary artery.

*The liver* was enlarged, and gave evidence of fatty degeneration; this, with the fact of a whiskey bottle having been found in the patient's pocket, made it probable that he had been a drinking man. *The gall-bladder* was distended. *The spleen* was lobulated but healthy. *The right kidney* enlarged and congested; the left of the usual size and healthy.

No other abnormal appearances were observed.