

or diminished light, to induce sufficient oscillation to demonstrate the case to a medical friend who was present.

CASE 3.—Jacob S—, of Kimberley, aged forty-four, came under my care in November, 1872, complaining of dimness of vision, so great that he had been obliged to give up his work. He said that on fixing his lamp in order to break up coal the light began to dance about; he turned giddy; objects seemed enveloped in a mist; and he was obliged to desist. On examination with the ophthalmoscope in a light room, the peculiar fanning motion was at once developed, and the nature of the complaint made manifest. No disease of the optic discs or eyeballs was to be detected, and his health was otherwise good. He was ordered to give up working in twilight or by artificial light, to wear blue glasses, and to take strychnine three times a day. Under this treatment he gradually improved, and in eight months' time he ceased to attend.

It is unnecessary here to reproduce notes of similar cases, for the essential features are the same in all. So far as I can ascertain, this is a new disease; but, however much we may regret the addition of one more malady to our nosological list, I think we may at the same time congratulate ourselves that it is so amenable to treatment, and that the remedy is so simple, easy of application, and generally successful.

Nottingham.

NOTES ON A

CASE OF PYÆMIA IN PRIVATE PRACTICE.

By LEONARD CANE, M.D. & B.S. LOND.

THE following notes of a case of pyæmia present some features of interest, and may be worth recording.

I was called on the 9th of September, 1874, to see a gentleman holding the post of Government contractor. He told me that he had recently come by train several hours' journey when he was seized with a sudden attack of "shortness of breath," caused, as he said, by a lump coming down in his neck from under his jaw. The dyspnoea had been relieved by rubbing his neck briskly with some oil. The only history he then gave of his illness was that he had got very wet in a rough sea passage, and believed he had caught cold and that it had settled in his throat.

On examination I found a large swelling, about the size of a hen's egg, below the jaw on the right side, occupying the situation of the submaxillary gland. The swelling was tender, hard, and painful, and appeared to be an inflamed lymphatic gland. The fauces were seen to be red, especially on the right side, and there were some traces of old ulceration. On inquiry, he stated that he had had an ulcerated sore-throat several months previously, and that, though this had got quite well, he did not think he had been right ever since. He had felt "chilly," but had had no distinct rigors. He was perspiring very freely. Pulse 110; temperature 99.4°. Ordered saline mixture, and liniment for his throat.

He improved for a few days. The swelling rapidly increased to the size of an orange, and then, without any other symptom, slowly subsided. He was then able to take solid food, which he had avoided before, owing to the pain it caused him.

On September 12th, feeling much better and being anxious to get home, he went in a cab for a distance of about a mile. On arriving at his destination he felt very "chilly," and at once went to bed. On the next day he was attacked with diarrhoea and vomiting, and his evening temperature ran up to 100.8°. The diarrhoea and sickness soon ceased, and during the next week he seemed to improve slightly. The chief symptoms during that time were debility and a high evening temperature (100° to 101°).

On September 20th (eleventh day of illness) he suffered from one or two severe rigors, followed by profuse sweating. He now for the first time complained of pain in his left hip. There was nothing that could be detected wrong with the hip beyond a little pain in moving the limb. The diarrhoea became very troublesome; and the stools were remarkably

offensive. The urine became highly albuminous (one-third albumen), containing some blood-corpuscles, casts, and epithelium. He now sweated profusely, the perspiration pouring off him and wetting the bedclothes. He was extremely restless, and could not sleep at night. I now gave him two and a half grains of quinine every two or three hours, with a little opium to counteract the diarrhoea, and a chloral draught at night.

At about this date (Sept. 20th) I noticed for the first time a small quantity of blood on the nose; and, on inquiry, found that he had suffered from a discharge from the nose, occasionally of a bloody nature, but usually like ordinary mucus, for several weeks. I accordingly made further inquiries into his history, and learnt the following facts. He stated that he was a native of the West Indies, and that he had yellow fever when about twelve years old. A few years ago he had syphilis, having a sore on the penis. This was followed by a few spots on the leg, one of which caused deep ulceration, and of which the cicatrices still remained. About a year before his present illness he was in a railway accident, but, though he was much bruised at the time, he did not receive any wound.

About ten weeks before his illness he married, and states that a few days after his marriage he suffered from "spasmodic stricture." For this he was obliged to call in a doctor in the middle of the night. The surgeon passed a catheter, and drew off a considerable quantity of bloody urine. He continued to pass small quantities of blood with his urine for several days after this. He now came to live near London, going to the city every day, where he was chiefly employed in tea-tasting, being frequently at the docks. On inquiry, he said that he had seen a great quantity of raw hides, which smelt very badly. He had also been round the surgical wards of a hospital on several occasions. Eight weeks before his illness he had suffered from an ulcerated sore-throat, which he was told was "syphilitic." He said that "one tonsil was nearly eaten away by the disease." Since then he had got much better. He had been over to Ireland, and though he had not felt well there was nothing much the matter with him. He usually noticed that when he blew his nose in the morning he "got rid of a small piece of matter," which he sometimes "spat up." He said that this came from the back of the throat. He continued to do this until I saw him.

On the 21st of September (twelfth day of illness) he suffered from two severe rigors. His morning temperature was 102.4°; evening 103.8°. The diarrhoea was profuse, with most offensive stools. He sweated very much after the rigors. The urine was highly smoky in colour, and contained about one half of albumen. On this day he first complained of pain in the right wrist, which he attributed to having "ricked" it by holding a book. The joint was painful and tender, and there was some slight swelling. On the following day the swelling had increased; there was a blush of redness over the back of the wrist, and also some pitting on pressure. The diarrhoea still continued; the sweating was profuse. Temperature 103.6° in the evening. He now became very sallow, but not distinctly jaundiced. He was very restless, tossing about continually. There was not any sweet hay-like odour of the breath. The liver was enlarged, but not tender.

On Sept. 23rd I met Dr. Wilson Fox in consultation. Dr. Fox found some congestion at the base of the right lung, and also a basic murmur of the heart. Dr. Fox advised a continuance of the quinine with the addition of some digitalis. The next day there was but little change. On Sept. 25th he had another rigor and felt severe pain in the left knee, which began to swell. The swelling advanced rapidly, and in a few hours the knee was double the normal size. This was followed by oedema of the whole of the left leg and thigh. The right arm was also much swollen, and there appeared to be some fluctuation in the wrist-joint. On the following day (26th) he appeared to be much lower, the respiration became very frequent (35), and there was consolidation of the bases of both lungs. He had a frequent dry cough, but did not expectorate.

Tympanites now set in, and was very troublesome. Dr. Hollings, who saw the case with me for the last few days, advised an enema of assafoetida and of starch and opium. This produced some relief. During the next two or three days the chief symptoms were connected with the lungs. The respiration rose to 44; pulse 130; temperature 104° F.

The respiration became worse, and he sank on Oct. 1st, three weeks after the commencement of symptoms.

During the whole time he took nourishment freely, which consisted of strong beef-tea, eggs and milk, broth, &c. &c.; also a fair amount of stimulants, in the shape of brandy, wine, &c. Unfortunately no post-mortem could be made.

Peterborough.

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.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.

AN UNUSUAL CASE OF URÆMIC POISONING; EPILEPTIC CONVULSIONS, FOLLOWED BY COMA; ULTIMATE RECOVERY, WITH TOTAL LOSS OF SIGHT.

(Under the care of Mr. JABEZ HOGG.)

FOR the following notes we are indebted to Mr. G. E. Alford, house-surgeon.

Jane F—, aged nineteen, a servant, was admitted on the 8th December, 1874, said to be suffering from sympathetic ophthalmia of the right eye. The left, it was stated, was lost when she was five years old, a pair of scissors having been thrown at her, which penetrated the globe. Her right eye had become affected only a few days previously. She brought with her a note from an eminent surgeon recommending its immediate extirpation, but giving no history of the case. She had been an inmate of the House of Charity, Soho-square, for some days; and previously—about four months ago—had been under treatment at a West-end hospital. This, however, was not mentioned at the time of admission, nor was it discovered until after extirpation of the eyeball. She appeared to be rather stupid, and little information concerning her could be obtained.

Mr. Hogg saw her, and, not having been made aware of any previous illness, concurred in the operation, which was accordingly performed whilst under the influence of chloroform. She took the anæsthetic very badly, her pulse being considerably affected and her respiration very shallow and irregular. Her complexion was rather dusky, and became much more so during the operation. There was considerable hæmorrhage from the orbit, which was, however, easily and speedily checked. She quite recovered from the chloroform, and seemed as well as could be expected, sitting up to have some tea, until 6 P.M., when she had a fit, in which she was quite unconscious, ground her teeth, became very cyanotic, and indeed partially asphyxiated. From it she perfectly recovered on the application of cold wet towels to her chest and head. After consciousness returned she said she had never had any fits before. Very shortly she had another similar to the first, and from that time they continued at intervals of less than an hour through the night until noon the following day. After each fit she was increasingly unconscious, until at length she ceased to be at all sensible in the intervals, and lapsed into a state of coma combined with convulsions. The fits were sometimes so severe as to threaten asphyxia, and artificial respiration was resorted to after several.

During the evening a fuller account of her previous history was obtained from her friends. They stated that neither she nor any of the family had ever been subject to epileptic fits; that about four months ago she had been an in-patient at a general hospital, suffering from cedema of the legs, together with some ascites; that she had never quite recovered; and that during the last few days she had appeared to be very dull and stupid, complaining a great deal of her right eye and her head. There was no history of scarlatina. Her mother and a sister had both died of Bright's disease.

(On making a microscopic examination of the extirpated eye it was found to be completely disorganised; small nodules of calcareous matter were everywhere firmly at-

tached to the choroid, bearing a certain relation to the choroidal vessels. The retina was detached, and simply existed as a thickened fibrillated cone from the optic nerve.)

Dec. 9th.—Fits less frequent; but coma more complete. The right eye was now examined with the ophthalmoscope, and found to have the white and opaque spots distributed over the fundus diagnostic of retinitis albuminurica. She passed ten ounces of urine during the night; but, as many hours had passed since, it was deemed necessary to use a catheter, of which she seemed to be quite unconscious. Urine: sp. gr. 1015, acid; albumen two-thirds. Ordered six ounces of brandy and some beef-tea, which she swallowed by teaspoonfuls without much difficulty. The fits became gradually less frequent, and there was none after 3 P.M. Catheter again passed in the evening, and a pint of urine drawn off; albumen one-half.

10th.—No fits during the night; passed no water; unconsciousness incomplete. Nineteen ounces of urine were drawn off by catheter, containing rather less albumen. Six ounces of gin were ordered in place of the brandy. In the evening a pint of urine was drawn off. Yawns a great deal and seems very drowsy, but is becoming much more sensible. Will not take beef-tea; milk given instead. Ordered one drachm of the solution of acetate of ammonia, and five grains of bicarbonate of potash, every four hours.

11th.—Passing no urine. On introducing a catheter thirty ounces were drawn off; albumen one quarter. She has spoken several words, and seems partly to understand what is said to her, but is very drowsy, and will not answer. She took two quarts of milk during the day; no beef-tea.—11 P.M.: Has passed plenty of urine naturally this evening, and now talks a good deal.

12th.—Slept most of the night; talked at intervals. Urine light-coloured; sp. gr. 1010; neutral; albumen one-sixth. Has passed two pints of urine since it was last drawn off, yesterday morning. She occasionally talks; is quite conscious. Takes less milk; ordered eggs beaten up in brandy. In the afternoon she was very excited, talking and laughing; tongue very furred. Ordered three ounces each of brandy, gin, and sherry, and eggs beaten up. Very restless in the evening, but quite sensible.

13th.—Slept more quietly. Passed some of her water under her. Slight tremors down the affected side (left) this morning. Complains of pain across her forehead and the back of her head. Right eye very sensitive and painful. Urine: sp. gr. 1011; slightly acid; albumen one-third; quantity unknown, as some was found in the bed.

14th.—Slept well; does not hold all her water; has taken little else than brandy and eggs. Urine: light-coloured; sp. gr. 1010; acid; albumen nearly one half; cellular casts; scaly and spheroidal epithelial cells. By means of the ophthalmoscope the fundus was seen to be quite white. Her left side twitches occasionally. Talks and laughs a great deal; very sharp in answering questions. At 3 P.M. all stimulants were withdrawn, and at 7 P.M. she was much more rational. Impulse of heart is felt over a very large area, and is powerful. Precordial dulness extends from the third left costal cartilage to the sixth, and from the right side of the sternum to four inches beyond its left margin, at the level of the fourth intercostal space. Sounds very distinct, tumultuous, rapid; no bruit.—Evening: Pulse 120; temperature 98.4°; respiration 30.

15th.—Slept quietly. Two ounces of sherry allowed. Fainted for a few minutes in the morning. Bowels opened freely. Urine: albumen one quarter. Ordered ten grains of citrate of ammonia and iron, with the acetate of ammonia. Fainted twice in the afternoon. More stimulants ordered. Very drowsy; pain in head and eyes.—7.30 P.M.: Temperature 98.4°; pulse 120; respiration 22. Constant tremors over whole body; moderately sensible, but does not speak; face very dusky.—10 P.M.: More rational; retches a good deal.

16th.—At 5.30 A.M. had another fit; face dusky; respiration rapid, short, and shallow; heart tumultuous. She came round in about fifteen minutes; complained of much pain in eye and over heart. Belladonna fomentations to former, and linseed poultice to latter. During the day the lids became very cedematous, and there was much chemosis. Urine: albumen one quarter. In the evening she was sick several times, and unable to take milk. She kept down eggs beaten up in brandy until later in the evening, when that also was brought up. Pulse 124, weak and compressible.