Diphtheria and sore throats are often due to sewer-gas. House No. 12 seems to prove that the poison which generated diphtheria in the child, in the three adults caused bad sore throats. Several cases of death from puerperal fever have occurred, generally in houses which are subject to bad sanitary arrangements, especially as it regards drainage and ventilation. I have had a large number of abscesses in children during the past summer. In nearly every instance there were strong reasons to believe it to be due to sewer-gas. As a rule, if two or more persons in a house are suffering from summer-diarrhoea, or abscesses, we may suspect sewer-gas. Sewer-gas is especially dangerous to children. Older persons may resist its influence; but in them it will probably be the cause of anæmia, nausea, and headache. In the winter, when the decomposition of sewage-matter is far less active than in the summer, I have found that infantile diarrhoea and abscesses are very few when compared with the number of cases occurring in the summer months.

ENTERIC FEVER IN A CHILD FIFTEEN MONTHS OLD.

By A. DUNBAR WALKER, M.D.,

Medical Officer to the North Kensington and Kensal Town Provident Dispensary.

NOVEMBER 1ST. The child looked pale and out of sorts, though nothing particular appeared the matter, with the exception that he had had four motions during the day, which looked healthy.

November 2nd. The little patient was languid and fretful. Four motions were passed in the day.

November 3rd. Symptoms of fever were manifest, and the little patient was disinclined to play with his toys. The bowels were still relaxed. Cerebral disturbance was great; sleep was interrupted by frequent startings of the whole body.

November 4th. The child passed a fair night, but appeared this morning to have no inclination to move, lying in an almost insensible state; from which, however, he could be easily aroused. There was frequent and severe twitching of the muscles of the forearms. The thumbs were drawn inwards. The little patient seemed every few minutes to be on the verge of general convulsions, though no actual convulsion took place. One of the cheeks was flushed. On examining the body, erythematous patches were found over the ankles, knees, elbows, and wrists; these were very evanescent, and moved from joint to joint. The diarrhoea had increased, the motions being very watery and of a greenish colour.

November 5th. The symptoms of yesterday were all exaggerated. The pupils were dilated, and the child seemed to be unconscious. Up to this time, food by the bottle had been taken; but it was difficult now to induce the child to have it. The lips were parched and cracked.

November 6th. This was the first day any attempt had been made to take the temperature of the body, which was found in the evening to be 102.5 deg. During the day, nine motions had been passed, now of a yellow colour. The head-symptoms were better, though the child still lay very quiet.

November 7th. Dr. West saw the child, as I was unable to decide the exact nature of the case, and, from the various symptoms that had appeared, was inclined to look upon it as a case of enteric fever. Throughout the day, the child remained very quiet, and appeared weaker than on the previous day. He had passed four motions; two were yellow in colour; the other two were greenish. The temperature in the morning was 100 deg.; evening, 102 deg. The abdomen was slightly tympanitic.

November 8th. An increasing desire for food was manifested. The temperature in the morning was 99.8 deg.; evening, 102 deg. Tympanites was increased. He had four motions.

November 9th. Great prostration was seen in the patient. The abdomen was very much distended. Temperature, morning 101 deg., evening 102.4 deg. He had two motions.

November 10th. The temperature was considerably lower, being 98.6 deg. in the morning and 101 deg. in the evening. The child appeared better. He had two motions.

November 11th. The child passed a good night and took his food well. Morning temperature 98.6 deg.; evening 102.2 deg. He had two motions.

November 12th. To-day there were many signs of improvement. There was less tympanites. He had only one motion in the twenty-four hours. Morning temperature 97.4 deg.; evening 101 deg.

November 13th. The little patient was gradually getting better, though the number of the motions had increased to six. Morning temperature 99.4 deg.; evening 99.8 deg.

November 14th. Morning temperature 97.2 deg.; evening 99.6 deg. He had four motions.

November 15th. The strength was improving. Morning temperature 97.2 deg.; evening 97.8 deg. He had two motions.

November 16th. From this day, convalescence progressed favourably, and the child gradually regained his usual strength. The only sequelæ that appeared were a few boils.

REMARKS.—About the diagnosis of the case there can be no doubt, for it was suspected by Dr. West, whom all will acknowledge to be our best authority on children's complaints; and his suspicion was confirmed by the mother of the child being seized with the same fever a week afterwards, in which the eruption and other characteristic symptoms of the disease were fully developed. The temperature was never very high; but I am inclined to think that the normal temperature was a degree less than the average—namely, 97.4 deg.; for, when the child recovered, that was the uniform temperature obtained. Great care was exercised in taking the temperature, the thermometer being placed both in the groin and in the axilla.

POISONING BY PHOSPHORUS: POST MORTEM EXAMINATION.*

By ALFRED SHEEN, M.D., Cardiff.

ELIZABETH A. L., aged 27, a prostitute, was admitted into the Union Hospital, on the afternoon of June 24th (Monday), said to be suffering from the "effects of poison", as certified by the district medical officer; but as to when the poison was administered, or what it was, there was no reliable evidence. Some said she had taken it on the previous Wednesday; others on the Wednesday week; and that it was "rat-poison". She was sent to the hospital in a cab; and, when helped out, walked between two women to the ward, and was put to bed. She was continually retching, but did not vomit.

When I saw her, about 6 P.M., she was in bed, tossing about, and behaving exactly like a drunken woman, taking no notice of what was said to her, but alternately groaning and retching, and making use of such expressions as, "Lord, have mercy". Her pupils were dilated, but not fixed. Pulse and temperature were normal. I was satisfied she had been recently drinking, whatever else was the matter with her.

She took small quantities of milk from time to time. The retching continued; no vomiting. The bowels were moved two or three times; she continued groaning and tossing about; and she died next day (25th) at noon.

A *post mortem* examination was made at 6 P.M. on Thursday, June 26th. The weather was very hot. There was no cadaveric smell. The body was in very good condition. The expression of face was calm. Bloody fluid was oozing from the mouth and nostrils. The thumbs were turned to the palm, and the fingers flexed. The elbows rested on the table, so that the hands were six inches from the table. There were no marks of violence on any part of the body. The subcutaneous fat of the abdomen and chest was one and a half to two inches thick. In the *left pleural cavity* were a few old adhesions towards the liver, and about an ounce of blood-tinged fluid. In the *right pleural cavity* were recent adhesions anteriorly. The *lungs* were both deeply congested throughout; they were crepitant, and floated in water. The *heart* was pale, flabby, fatty. The left ventricle contained a pale-coloured clot (*ante mortem*). The right ventricular wall and chordæ tendinæ were much congested. The valves were healthy. The *liver* was smaller than normal, and its surface was somewhat uneven; it was cirrhotic in a marked manner throughout. The *stomach* was distended with gas, containing about an ounce of thick dark grumous-looking fluid. The internal surface was of a dirty-grey colour, apparently thickened; there was no softening. The oesophageal end was congested; near it, a surface of about four inches square was covered with bright red ecchymosis, in spots of various size. The internal surface of the *intestines* throughout was of a dirty-grey colour, on washing which, similar spots, but smaller, to those in the stomach were seen here and there. They contained semi-fluid substance, evidently milk, etc. The *spleen* was normal. The *kidneys* were enlarged and fatty. The *brain* was not examined.

The poison swallowed was "Steiner's vermin-killer". A similar bottle to the one the deceased had was shown at the inquest; it was an ounce bottle, containing a light blue-coloured paste, which smelt of phosphorus, and which probably contained it, mixed with flour or some such substance, and coloured with Prussian blue; but how much phosphorus it contained, or how much of it was taken by the deceased, there was no evidence to show. Some of the witnesses who saw her on the Thursday or Friday, stated that what they called "smoke" occasionally

* Read before the South Wales and Monmouthshire Branch.

issued from her mouth when she was sick, but they had no opportunity of ascertaining whether it was luminous in the dark.

Now, how much of the related *post mortem* appearances were due to poisoning? I think there was undoubted evidence of some irritant poison having been swallowed; and there was evidence of disease from continued drinking. To what was the congestion of the lung due? and what was the immediate cause of death? The verdict of the jury was that the woman died from the effects of swallowing irritant poison, accelerated by a diseased condition of the body, brought about by continued drinking.

From the evidence given at the coroner's inquest, it appears that the woman lived in a brothel; that she swallowed the poison on the Wednesday previous to admission; and that from this time, till a surgeon saw her on Monday, the 24th, she was frequently complaining of pain in the bowels, and asking for medicine, getting salts, castor-oil, etc.; and that she was drinking all this time. It also came out in evidence that another woman took her on the Friday morning, within thirty-six hours of her swallowing the poison, to a druggist; that they told him she had swallowed rat-poison; that he questioned her, gave her some medicine and directions as to her food, and saw her again on the Saturday morning, and gave her further directions. I think you will all agree with me that it is monstrous that such persons, ignorant, as they of necessity must be, of such matters, should coolly trifle with the life of a fellow-being, as this man did in this case. It may be said, "Oh, if people are such fools as to go to druggists to have their ailments treated, why should anyone interfere?" But that is by no means the whole question. People are ignorant on these matters: they reason that, as chemists and druggists have to do with the compounding of medicines, they must know something of their application in disease. It is the druggist who sins, in his impudent assumption of knowledge, which he knows he cannot, and does not, possess. It is lamentable to think of the frightful amount of misery, and not unfrequently of death, that is brought about by the unblushing dishonesty of these people, who thus trade upon the ignorant credulity of the public. If it were only a question of a man suffering in pocket, one might fairly say, "Serve him right"; but when it is a question of life, disease, and death, the matter is far more serious.

CLINICAL MEMORANDA.

OBSTRUCTION OF THE BOWELS.

THE remarks of Dr. Clifford Allbutt and of Mr. Teale upon this subject, in the JOURNAL of January 11th, recall a case that occurred to me some years ago at Malta.

A warder of the military prison, upon whom I had operated for strangulated hernia, had made a good recovery, the wound having healed by first intention, the only difficulty of the case having been persistent flatus. On or about the tenth day, this increased, in spite of all treatment, to such an extent as to bring about an accident that the old man's words will best describe. "I burst, sir," said he, "and went off like a railway-whistle". Upon examination, it was found that the bowel had given way, and at the centre of the line of incision was a wound like that which marks the exit of a bullet; so everted and ragged were the edges, that the force of the pent-up flatus escaping must have been very great. Marked relief and ease followed, with no bad result, save, of course, the formation of a fæcal fistula, and the old man left the hospital shortly afterwards.

CHARLES SPURWAY, M.R.C.S., Grand Hôtel, Pegli, near Genoa.

ULCERATION OF THE FRÆNUM LINGUÆ.

A FEW months ago, in the pages of the JOURNAL, occurred some correspondence on the above subject, in pertussis. I believe that by some the ign was looked upon as pathognomonic. Some years ago, when house-surgeon to the Lancaster Dispensary, and during a severe epidemic of this disease, I looked for this sign in the majority of cases, but found it often wanting, so much so that I gave up keeping notes of the cases in which it occurred. That it is not pathognomonic of whooping-cough is, I think, proved by a case which I saw in my consulting-room to-day, viz., a child aged thirteen months, which had been suffering from catarrhal pneumonia for ten days or a fortnight, with pretty severe cough. At the request of the mother, I examined under its tongue, and found a well marked ulcer, such as we see in whooping-cough. The cause of it was also evident, for the child possessed only two lower incisor teeth. I think we may, therefore conclude that ulcer of the frænum is caused by the tongue being projected over the lower incisor teeth, and therefore is not a reliable sign when taken alone, in whooping-cough.

WM. BERRY, L.R.C.P. & S. Ed.

THE DIAGNOSIS OF ABDOMINAL ANEURISM.

IN the JOURNAL of February 8th, there are given short records of three cases of "probable" aneurism of the celiac axis, under the care of Dr. Whiphram of St. George's Hospital. Very grave doubts as to the actual trunk which is the seat of aneurism in these cases exist in my mind; I, therefore, venture to draw attention to a method of examination which possibly may be of some use in coming to a proximate conclusion concerning the nature and situation of pulsating tumours of the abdomen. The method to which I refer is that of placing the patient on his hands and knees and noting carefully if the pulsation (1) persist as when he is lying on his back, (2) is diminished, or (3) ceases entirely. As far as I am aware, it is to Professor Moore of Dublin that we are indebted for this valuable hint. In a paper "On the Differential Diagnosis of Abdominal Aneurism" (*Dublin Quarterly Journal of Medical Science*, August 1869), this physician remarks: "For my own part, I consider persistency and equality, after a careful examination in all positions, the most characteristic features of abdominal pulsation; consequently, when we meet with an abdominal tumour of any kind carrying pulsation in the supine position, place the patient on his hands and knees, when the pulsation, if due to aneurism, will persist; but, if due to tumour overlying the vessel, the pulsation will disappear from the tumour falling off the vessel, unless they are firmly attached by adhesions." In every case of abdominal pulsation I meet with, I never omit to place the patient in the position recommended by Dr. Moore, and note carefully what changes (if any) occur in the force of the impulse communicated to the hand. In doing this, it is very necessary that the hand should be applied to exactly the same part of the abdominal wall in both positions, and, when possible, I keep my hand *in situ* while the patient is "turning over".

In my remarks on a case of aneurism of the celiac axis (*Irish Hospital Gazette*, January 1st, 1875), the following occurs bearing on this subject. "On placing the patient on his hands and knees, the pulsation was lessened: a fact which, I think, may be explained by regarding the pulsation as being made up of two factors—(1) the impulse of the blood passing through the sac itself, plus (2) that communicated by the aorta lying behind. It will be easily perceived that, by placing the patient in the prone position, the aortic shock would be removed to a greater or less extent, and consequently the force of pulsation lessened in proportion."

Thus, then, we may fairly conclude, generally, that—1. Persistent pulsation in all positions indicates aneurism of, or a tumour intimately connected with, the aorta; 2. Diminished pulsation in the prone position points to aneurism of the celiac axis, or of some other vessel lying in front of the aorta; 3. Entire cessation or marked enfeeblement of pulsation is characteristic of a tumour in no wise connected with the great vessel.

ROBERT S. ARCHER, A.B., M.B.Dub., Liverpool.

SURGICAL MEMORANDA.

CHRONIC BLENNORRHOËAL INFLAMMATION OF THE MIDDLE EAR, AND DESTRUCTION OF THE MEMBRANA TYMPANI, FROM THE COMMON FLY.

THIS case is of so rare occurrence, that a short account of it may be sufficiently interesting to justify its publication. Alice N., aged twenty-seven, came to me, on April 13th, 1878, complaining of deafness in the left ear, with muco-purulent discharge and tinnitus. Nine years ago, she felt a house-fly buzzing in her ear, which remained there a short time before it was dislodged. The following evening, she complained of ear-ache, the result of which was that phlegmonous inflammation was set up and was allowed to proceed without radical measures being adopted. Shortly afterwards, a discharge appeared, and on examination, the walls and inner end of the auditory passage were found spongy, red, and superficially abraded. It is presumed that the inflammation was phlegmonous, as she described its symptoms so accurately. On looking for the membrane, a quantity of yellowish discharge concealed it, which, on being washed out, disclosed, not merely a small pin-hole or chink to be discovered only by the aid of Politzer's bag, but a large ragged opening, and the handle of the malleus quite gone. Indeed, the other bones may be destroyed; but from symptoms that follow, there is reason to believe they are either ankylosed or adherent to the tympanic walls. She states that her hearing varies a good deal, and that she can often rectify it herself; an illustration of which she gave me by contorting the muscles of the face and lower jaw, very much as a horse does when he has difficulty in exercising deglutition with some article of food which he feels has been not properly masticated. By this means, I conclude, she restores the ossicles *in situ*, or nearly so, their ligaments not having been altogether destroyed by the ulceration—and her ailment resolved