ejected from the lungs. Pulse regular; appetite bad. His bowels had not been relieved; therefore a mixture of the sulphate and carbonate of magnesia was administered, with a beneficial result.

Sixth day. The hæmoptysis ceased.

Seventh day. He was allowed to dress and to move about the ward.

Eighth day. He left the Hospital, convalescent.

He came to the Hospital on the thirteenth day after the receipt of the injury, and appeared to be quite well.

REMARKS. This case offers a good illustration of a mode of practice introduced by Mr. Hilton, and which, as far as it has been used, seems very successful in relieving the pain produced by the movement of the broken ribs. It does not produce that sense of tightness and oppression to which an encircling flannel bandage so frequently gives rise, and it affords a firm support and protection to the injured parts. The case is also remarkable, as showing how severe may be the injury inflicted on the thorax and its contents without the occurrence of constitutional disturbance.

ST. BARTHOLOMEW'S HOSPITAL.

I. TWO CASES OF EXCISION OF THE SHOULDER-JOINT.

Under the care of W. LAWRENCE, Esq., and H. COOTE, Esq.

[From Notes by W. CHIFFENDALE, Esq., House-Surgeon.]

GEORGE S., aged 44, was admitted in July 1857, on account of disease of the shoulder-joint. He was a man of spare figure, who had generally had good health, with the exception of being subject to rheumatism. Four years ago, he had acute inflammation of the shoulder, for which he was cupped and leeches, and regained the full use of his limb, but has ever since been subject to pain in the joint. On admission, there was some loss of the natural rotundity of the shoulder from atrophy of the deltoid. There were two sinuses, which led in the direction of the joint; but no bone was felt exposed. He complained of severe pain, especially at night; and any attempt at motion caused pain. His health was beginning to give way, and he was desirous of having something done for it.

A few days afterwards, Mr. Lawrence proceeded to excise the head of the humerus. A large oval flap was reflected, commencing behind and a little below the acromion, and the joint was exposed by turning the deltoid upwards. On the elbow being drawn inwards and elevated, the head of the bone started out of the socket. It was sawn through about two inches below its head. Scarcely any blood was lost, the posterior circumflex being the only artery which required ligature. The flap was secured by sutures and strapping, and the limb was brought to the side, and kept well supported.

On examining the head of the bone, the cartilages were found to be gone, and the surface was carious. When it was sawn through, a cavity was found containing dead bone, and communicating with the joint by a narrow channel. The glenoid cavity was observed to be partly denuded of cartilage, and its surface slightly vascular. The bone, where it was sawn through, was quite healthy.

The treatment after the operation included generous diet and stimulants. He progressed favourably, and was able within a month to walk about. He had, however, a fall, which retarded his convalescence; and erysipelas subsequently attacked the wound. This, however, subsided; and he went into the country in December, with the wound nearly healed. He could put his hand to his face, and had altogether a useful limb.

CASE II. R. R., aged 50, a weakly looking man, much emaciated, was admitted under the care of Mr. Holmes Coote on June 2nd, 1857, on account of a large collection of matter beneath the deltoid muscle, together with a deep sinus above the clavicle, which was discharging profusely. On rotating the limb, distinct grating was to be felt. The disease had commenced about two months before admission, after an attack of rheumatism, to which disease he was subject. As the man's health was suffering, Mr. Coote decided to remove the diseased bone. This was done on August 16th, by means of one long incision, commencing from the anterior part of the acromion, and carried downwards for about six inches. The joint having been opened, and the tendons inserted into the tuberosities divided, the head of the bone was with some difficulty made to project: it was then sawn off below the tuberosities. The cartilages were found to be absorbed in every part; and the surface of the bone was found rough, but ulceration had not proceeded deeply. The bone was quite healthy where it was

sawn through. The glenoid cavity was denuded of cartilage, and its surface was roughened. No vessels required ligature.

The man progressed favourably for a few days, when the wound began to slough, and a most copious and offensive discharge took place. Diarrhœa also set in, and the bone could be felt bare at the bottom of the wound, the granulations having receded. The wound was then attacked with erysipelas, and the patient sank exhausted fourteen days after the operation.

II. A CASE OF CUT-THROAT.

Under the care of E. STANLEY, Esq.

[From Notes by E. BARKER, Esq., House-Surgeon.]

George S., aged 32, was admitted at 1½ A.M. December 20th, under the care of Mr. Stanley, having cut his throat, half an hour previously, with his pocket-knife. He was stated to have lost two pints of blood previously to his admission. The wound was situated on the right side of the trachea, by the side of the sterno-mastoid, and was an inch and a half in length. On the introduction of the finger, it was found to be very deep. There was a smaller wound into the muscle on the opposite side.

As there was no hæmorrhage on admission, nothing was done. He was soon well enough to get up, which he was allowed to do, as lying in bed made him restless. On December 24th, as he was talking to another man, considerable hæmorrhage suddenly occurred. On account of the great depth of the wound, it seemed advisable to try the effect of pressure before searching for the bleeding vessel. The wound was accordingly plugged, and the bleeding ceased for an hour, when it again recurred. The man's condition forbade so severe an operation as would have been necessary to reach the bleeding vessel. The wound was accordingly plugged with lint steeped in water; and the bleeding again stopped, but recurred on the night of the 26th and morning of the 27th, in small quantities; and he died at 1 P.M. on the latter day. The bleeding was always checked by firm pressure, which did not interfere with the beating of the carotid artery, or with the pulse at the wrist. It was therefore correctly inferred to be from some branch of the sub-clavian; and, at the *post mortem* examination, the ascending thyroid artery was found wounded. It should be noticed, that the œsophagus was wounded: evidence of this was afforded during life by the nourishment coming through the wound.

REMARKS. This case is quoted to show that, in rare cases, arteries are laid open, both in cut-throat and other wounds of vascular parts, without any evidence of the nature of the lesion; and that we should, therefore, be always cautious in pronouncing a decided opinion when the wound is deep, and sufficient time has elapsed since its receipt to allow of the formation of a clot obstructing the issue of blood from a wound in the vessel. The case also shows the difficulties that arise in the treatment of a wound in this situation. If the vessel is not tied, the bleeding may prove fatal; yet who would willingly risk such an operation as is necessary in order to search for a vessel under the sterno-mastoid, at the root of the neck, in a wound some days old, while pressure still controlled the bleeding?

ST. GEORGE'S HOSPITAL.

CASES OF ANEURISM IN THE MEDICAL WARDS.

By G. GODDARD ROGERS, M.D., Medical Registrar.

CASE I. *Aneurism of the Ascending and Transverse Aorta.*

J. C., aged 53 years, a man of intemperate habits and very bloated in the face, was admitted under Dr. Wilson, on January 24th, 1855. His family was healthy, and he had never before suffered from illness. In December 1852, he strained himself whilst at work lifting stones, and came into the Hospital for a little time on account of pain in the right arm and right side of the chest. Of this he soon got the better; and it was not until ten weeks before his second admission that he felt any more inconvenience. He then suffered from shortness of breath, which at length became so bad, that he was unable to lie down. This dyspnoea was the most prominent symptom when he again came to St. George's. There was also great pain in the chest following a deep inspiration. After meals, the pain and difficulty of breathing were much aggravated. His tongue was coated; bowels open; urine loaded with lithates, otherwise healthy; pulse tolerably quiet and regular. At the back of the right lung, near the upper part, the breathing was exaggerated, as were likewise the voice-sounds; below the middle of the lung the respiration was deficient. A somewhat

violent impulse was perceptible at the top of the sternum, which rather projected; but no bruit was made out. The cough and voice were both those of obstruction in the trachea. He was ordered a saline mixture, with squill and digitalis; and a blister was put over the epigastrium. During the next week his cough grew worse, and he expectorated very freely. Then he was so much distressed, that he could not speak or even swallow; and by February 3rd, the orthopnoea was extreme. His face became haggard; he sat in bed bent almost double, his head being nearly on his knees. From this state of extreme suffering he was released on February 6th.

The body was examined twenty-five hours after death. There was some fulness at the lower part of the neck on the right side; and much swelling and redness of the integument at the upper and front part of the chest. Much purulent fluid was found beneath the right pectoral muscle in the neighbourhood of the second and third ribs; and this was connected with a large sloughing opening through the intercostal tissues, between the cartilages of the first and second ribs, close to the right margin of the sternum. The edges of these cartilages were slightly destroyed, and the edge of the sternum was also ulcerated. The opening was connected with the interior of a large aneurismal pouch filled with weakly clotted fibrin and blood, which was adherent to the inner surface of the sternum, the right clavicle, and the cartilages of the first and second ribs, and projected slightly above the head of the clavicle. This aneurism was formed by the dilatation of the upper part of the ascending and transverse portions of the aorta, involving it as far as the point whence the left subclavian is given off. The walls of the aneurism, as well as those of the various arteries in the neighbourhood, contained some atheromatous deposit. The left ventricle of the heart was hypertrophied, but all the valves and orifices were natural. The mediastinal glands were excessively enlarged, and there was great adhesion of the pleural surfaces on the right side of the chest. The lower part of the right lung was extensively hepatized.

CASE II. *Aneurism of Aorta bursting into Pericardium.* L. G., a somewhat emaciated individual, of temperate habits and usually enjoying good health, was admitted under the care of Dr. Nairne, on January 31st, 1855. He complained of pain in the left side, from which he had suffered since the 23rd of the preceding November, when he fancied he got a chill whilst at work. The pain extended over the whole of the left side, and was felt between the scapulæ. There was no dulness in any part of the chest, but a few bronchitic râles here and there. He was ordered a simple demulcent mixture, and a morphia draught at night. He was better for a few days, but then began to complain of great languor and sleeplessness, owing to the increase of pain in the chest. He was up every day until February 15th, when a sudden attack of vomiting, followed by syncope, compelled him to go to bed. Here he was unable to lie down, but slept with his head resting on his knees. The next morning a swelling appeared at the root of the neck. It was soft and fluctuating. He seemed very low, and the pulse was almost imperceptible. Gradually he sank into a state of collapse, and expired in the evening.

In this case a very hurried and imperfect *post mortem* examination was all that could be made. A large aneurism of the aorta had burst into the pericardium.

CASE III. *Aneurismal Pouch in Ventricular Septum: Aneurism of Right Ventricle implicating Pulmonary Artery.* I. I., aged 42, had been in the Hospital during a great part of the winter (1854-55) with bronchitis and renal dropsy. He then went out for a few weeks somewhat relieved, but returned in March with increased anasarca. His habits of life were irregular, and he had never felt strong since he went under a course of mercury some few years ago for syphilis. A distinct systolic murmur was heard at the apex of the heart, and a loud double murmur at the base, but this could not be traced along the course of the great vessels. Towards the middle of April he complained of a very painful feeling of constriction across the chest; and at this time the chest, neck, and upper extremities were enormously infiltrated with fluid. From May 7th to 11th he passed very little urine, and was constantly begging to be tapped that the oppression of breathing might be relieved. He soon sank exhausted.

An examination was made thirty-four hours after death. In addition to disease of the kidneys, and general effusion into the serous cavities, there was great enlargement of the heart. The pericardium was everywhere adherent, and in the septum between the ventricles was an aneurismal pouch. This communicated with the left ventricle by a large rounded orifice. The endocardium in the neighbourhood was much thickened, very

opaque, and apparently entire throughout the sac. A little loose coagulated fibrine existed in the pouch. The right auriculo-ventricular orifice was very large; the other openings and the valves were healthy. Immediately above one of the aortic valve flaps, and between the orifices of the two coronary arteries, was a rounded aperture of the size of a sixpenny piece, which led into an aneurismal sac at the upper part of the right ventricle. The pit corresponding to the opening was very shallow, owing to the presence of the firm coagulum occupying the sac. The aneurism was as large as a hen's egg, and projected so as to occupy the orifice of the pulmonary artery, destroying by its adhesion one of the valve-flaps and parts of the two others. It so far occupied the arterial tube that only an oval chink, admitting the tip of the finger, remained for the passage of venous blood. The walls of the sac were destroyed to a great extent, the contained coagulum being quite exposed to the blood.

[To be continued.]

ST. MARY'S HOSPITAL.

INJURY TO THE SPINE: DEATH.

Under the care of W. COULSON, Esq.

HENRY HANDSLEY, aged 41, a carpenter, was brought in a senseless state to the Hospital on October 23rd, 1857, at 5 o'clock P.M. The patient had just fallen from some scaffolding at a height of about twelve feet.

October 24th. The patient was unable to say on what part of the body he fell. He was now drowsy, but when roused he answered clearly. He felt great pain in the small of the back. He could move his legs slightly, but he experienced some pain while drawing them up; he likewise felt pain in the back whenever an attempt was made to turn him on the side. Pulse 100. He had passed one motion (with consciousness) since the accident; but had not passed urine. A catheter was introduced at once, and more than a pint of urine was drawn off: this relieved him very much. As he was unable to void urine, the catheter was ordered to be used three times a day. Eight leeches were applied to the painful part of the back.

October 25th. There was no change in the state of the patient, except that his stools now passed off involuntarily. Great pain was still felt in the back over the fourth lumbar vertebra, and to its left side; and the pain was much aggravated by any motion. On turning the man upon his side to examine the back, a little blood escaped from the urethra.

October 27th. The urine had been drawn off regularly, though there was some difficulty in introducing the catheter. The patient said he felt better. He had more power over the lower extremities; the paralysis of the bladder, however, continued. He coughed a good deal at night, with copious expectoration; he said that he had laboured under a cold for some time.

October 31st. The patient did not complain of pain in the back, unless he was moved about. The catheter was passed regularly.

November 3rd. For the last three days the patient did not present any change worthy of notice; he remained free from pain, but weak, until three o'clock this morning, when suddenly he felt worse, and sank rapidly.

The body was examined on November 4th. On the right side of the spinal column, at the level of the fourth lumbar vertebra, there was discovered a small wound which led to a large cavity; this latter was filled with extravasated blood, and extended up to the right kidney, which presented a very small point of laceration. A similar extravasation of blood existed between the lumbar muscles on the left side; and the left kidney was completely softened. The right transverse process of the second and the left process of the fourth lumbar vertebra were fractured; the sacro-iliac symphysis was also fractured. Pneumonia existed at several points, and the air-cells contained a quantity of sanguinolent serum.

REMARKS. The symptoms which attend injuries of the spine are various, and it is not always easy to connect them with organic lesions. In many cases, the symptoms are mild, though the organic lesion be severe; while in others, the change from a favourable to a dangerous condition takes place with most unexpected rapidity. Fracture of the vertebral column, considered *per se*, is neither a formidable nor a dangerous accident; it derives its danger from the violence which may be inflicted on the spinal marrow or neighbouring organs; while