CASE OF PERITYPHLITIC ABSCESS: WITH REMARKS.

By JOHN A. CAMPBELL, M.D.,

Assistant Medical Superintendent, Cumberland and Westmorland Asylum, Carlisle.

H. F., aged 36, was admitted March 10th, 1869. He is stated to have been insane for seven days; but no satisfactory history of his case could be got. When admitted, he was so weak and exhausted that he had to be carried in a horizontal position to the ward. He seemed unconscious of the presence of any one unless loudly spoken to. He kept moving his head about, gesticulating with his arms, and muttering in a low voice, but occasionally speaking loudly. The pulse at the carotid artery was 140 per minute (the radial pulse could not be counted, it was so weak). The temperature in the axilla was 101 deg.; the tongue furred; the pupils were equally dilated. The lungs and heart appeared normal; the abdomen seemed rather swollen; on percussion it was very tympanitic. Owing to his weak state and muttering, an accurate examination could not be made. He was put to bed, fed with some beef-tea, with an egg beat into it; half an hour afterwards he was found dead, lying on his back, his arms clasped over his abdomen, and his left leg flexed, the knee being bent outwards.

AUTOPSY Twenty-eight Hours after Death.—*External Appearances:* The head was shaved; the body in good condition, without any marks of injury. *Head:* The skull-cap was normal; the dura mater was strongly adherent to it. Under and over the arachnoid there was a clot of blood of recent formation over the whole of the anterior lobe of the left hemisphere, a quarter of an inch in thickness, and on the remainder of the hemisphere in a thin layer. The right hemisphere had also a very thin clot on it. Under the arachnoid there was a bloody fluid all over the brain. The dura mater in the fossa at the base of the brain was covered with a thin clot. The pia mater was much congested. On section, the grey matter was found exceedingly congested, and divided into two distinct layers. The white substance was quite pink, and full of large puncta throughout. The cerebellum was also much congested; its white substance had a very doughy feel. The pons Varolii and medulla were normal; the membranes of the spinal cord were much congested, and so was its substance. *Chest:* The pericardium contained two ounces of clear straw-coloured fluid. The left side of the heart was contracted; it contained no clot; the right side contained both red and white clot; the heart's valves were normal; the aorta was normal; the muscular substance of the heart was red outside and pale inside; the pale part was beginning to become fatty, as was seen on microscopical examination. The lungs were free in the cavity of the chest; both were oedematous and much congested at their bases, in small spots, almost amounting to pneumonia. *Abdomen:* The liver appeared very white in patches near the anterior margin of the right lobe. On section, the whole organ was found somewhat fatty and friable. Under the white patches there was purulent infiltration in spaces about the size of eggs; there were four or five such: the section looked as if studded with small abscesses close together, with some liver-tissue between them; there was no great surrounding inflammation. The spleen was very light-coloured, except in patches at the lower and posterior edge; these, on section, looked quite black and changed in structure. The kidneys were somewhat fatty and soft in texture. The stomach contained some yellowish half-digested matter; the mucous membrane of the pyloric end was very thick, and in parts very soft and half digested. The mucous membrane of the cardiac end was pale. The intestine, except at the lower end, where there were a few nodules of fæculent matter, contained nothing but flatus. The solitary glands were enlarged. Surrounding the posterior part of the caput cæcum, there was a large abscess with dark semigangrenous walls, easily opened by pulling forward the intestine. The vermiform appendix was inflamed, ulcerated into at the base, and its point gangrenous; there was no foreign body in it. The abscess communicated with the gut by means of the vermiform appendix; but, the communication not being very direct, the abscess filling had closed the orifice (it seemed valvular). The abscess contained about four ounces of pus; and its anterior wall was formed by the posterior part of the caput cæcum coli. The mesenteric glands opposite the abscess were greatly enlarged; and, when cut into, were found completely infiltrated with pus; half of their entire number were in this condition. The lymphatic duct contained no pus. There was some urine in the bladder.

REMARKS.—In this case, the history of the excitement and its duration hardly accounted for the weakness. The temperature and pulse were higher than they are found in any cases of mental aberration without inflammatory disease, except epilepsy shortly after a fit, or general paralysis in its last stage. The extremely tympanitic state of the abdo-

men pointed to something wrong there. The position of the body when found dead seemed as if the patient had been sensible to the pain in the abdomen; though at the time when he was examined he was too delirious to communicate it.

At the *post mortem* examination, the state of the vermiform appendix—its point gangrenous, its base ulcerated—and the otherwise healthy state of the cæcum and large intestine, would support the hypothesis that in this part the mischief had begun; and from the gangrenous walls and contents of the abscess, the infiltrated state of the glands, the abscesses in the liver, their number and size, the congested state of the brain, spinal cord, and their membranes, we may fairly come to the conclusion that obstruction at the vermiform appendix was the cause, the perityphlitic abscess was the result, and that it caused septicæmia, which accounts for the state of the mesenteric glands, the abscesses in the liver, and the congestion of the brain, spinal cord, and membranes, with the delirium which existed during life.

ON THE TREATMENT OF CERTAIN FORMS OF UTERINE CANCER.*

By C. H. F. ROUTH, M.D.,

Senior Physician to the Samaritan Free Hospital for Diseases of Women and Children; Consulting Physician for Diseases of Women to the West London Hospital for Diseases of the Chest; etc.

CASE VII. *Cancer in an advanced Stage; Bromine used frequently; Complete Apparent Recovery, and Covering by Mucous Membrane; Recurrence in small Points, and Removal; Refusal to continue Treatment; Irritative Fever; Death.*—Mrs. H., aged 65, was under Mr. Robinson's care, who asked me to see her. She had been married thirty-five years, and had had five children. She had had two or three miscarriages since the birth of the last child, twenty-six years ago. The catamenia stopped when she was about fifty-eight. At that time she had piles, followed by external bleeding; these recurred even now occasionally. She was a moderate liver; took scarcely any wine, occasionally a half-pint of beer. For the last two years she had had frequent discharge of offensive fluid from the vagina, of a dirty brownish colour. It was unaccompanied with pain until lately, when she had suffered occasionally from pain, or rather a sensation of drawing, in the lower part of the abdomen and across the loins. She consulted nobody, being apprehensive that it was due to her husband's indiscretions, and not being willing to expose him. More lately, the discharge had become more bloody, and seemed to lodge in the vagina, so that she could remove it with a spoon. On examination, on February 22nd, the uterus was found large, moveable, ulcerated specially at the external os, which was irregular and enlarged, and bled freely on touch. There was some extension of the ulceration upwards into the cavity. On March 29th, bromine was freely applied, and the whole of the os destroyed by it. Tincture of sesquichloride of iron was ordered in full doses, with free living. On April 16th, I proceeded to apply sea-tangle, covered with cotton dipped in bromine, within the uterine cavity. Contrary to advice, she chose to get up, and moved about in her usual way, when she was seized with severe pain and rigors. I removed the tent the next day. No bad result followed. On May 1st, I reapplied the bromine. Perfect rest was enjoined and observed. The discharge and odour soon ceased. The parts were healing well. Pain had disappeared. She left town on June 6th, comparatively well, all unpleasant symptoms having disappeared. On July 17th, she returned to town. The parts were all healed, looking very well, and covered with mucous membrane. One little spot, about as large as a pea, appeared, however, at one side, looking rather suspicious. This was destroyed; and she left London on the 31st, apparently well, complaining only of weakness.

This patient continued to improve for about three months, the discharge having ceased, and her state being one of great comparative comfort. She then began to complain of some increased leucorrhœa; but, as she was unwilling to come to town, I saw her once at her own residence, several miles distant. I found very little wrong with the uterus. One suspicious point only, of about the size of a pea, presented itself. She, however, declined further treatment, on account of the expense; and I also learnt that, for the same reason, the nourishing diet prescribed had been relinquished. It was of no use to remonstrate: she could not afford it. From this time I never saw her; but I learnt that she gradually became weaker, and died of exhaustion in March 1868.

CASE VIII. *Dubious Epitheliomatous Growth on the Posterior Surface of the Urethra; Removal by Scissors, and subsequent Destruction by Iodine; Cure.*—M. H., single, aged about 60, was several times under

* Concluded from page 231 of last number.