I believe it to have been utterly impossible for anyone at this period to make a positive and definite diagnosis; but it was clear that a short period of time must elucidate the difficulties of the case, for, if the pains were due to syphilis and the swelling were periostitis from the same cause, all the symptoms would show a decided and rapid amelioration under the influence of iodide of potassium. Therefore, with these assurances I comforted my patient, who, in his own mind, had a rooted conviction that he was suffering from aneurism.

I placed his arm in a sling, and covered the swelling with the ammoniacum and mercury plaster; ordered him, internally, fifteen-grain doses of the iodide of potassium in decoction of bark three times a day; and arranged for him to return in a week's time. When next I saw him, he informed me that the pains left him immediately on taking the medicine, and had never recurred since; but, on examining the swelling, there was a decided increase in size, the pulsation was more forcible, and the *bruit* louder. My patient was in great anxiety; but I persuaded him to continue his treatment for another week. At the end of this period, there were marked signs of improvement, which have continued up to the present time, when I think I may fairly say there is very little, if any, trace of his original disease.

This case was certainly one of unusual interest, and for many reasons worthy of record. The usual text-books on surgery make no mention of cases of this kind, and treat of the diagnosis of axillary aneurism as being a matter of great facility. Thus Erichsen says: "The diagnosis of axillary aneurism is generally readily made, there being but two diseases with which it can well be confounded—viz., chronic enlargement and suppuration of the glands of the axilla, and pulsating tumours of the bones in this region." These remarks are doubtless true as far as the more distal parts of the axillary artery are concerned; but, in point of fact, any tumour or swelling thus connected with the bone or other tissues, is liable to be mistaken for an aneurism, when developing below the axillary artery, immediately beneath the clavicle, as in the case I have above described. The depth of the parts and the thick covering of the pectoral muscle so obscure the contour of the tumour and the character of the pulsation, as to materially increase the difficulties of diagnosis; and this is aided by the facility with which the slightest pressure on the artery produces a *bruit* in this situation. Most of the symptoms which are detailed as those of aneurism are merely referable to the secondary effects of pressure on veins and nerves, and may be produced as well by any other growth as by an aneurism. In this case there was myosis of the left pupil, which, I think, could scarcely be attributed to the pressure of any portion of the swelling which was observable; but doubtless the periostitis extended beyond that, and pressed upon some of the spino-sympathetic nerves at the root of the neck.

I think we learn from the above history how cautious we should be in believing in cases of spontaneous cure of aneurism. Doubtless, if this case had been left to itself, in course of time it would have got well, and might, but for fortuitous circumstances, have been recorded as a case of spontaneously cured aneurism. It shows, too, how the history of a patient's antecedent maladies can throw light upon present disease, and clear up difficulties which at first sight seem insuperable; for in this case, had there not been a clear history of syphilis, diagnosis would have been much more uncertain, and the treatment, which was so successful, would never have been indicated.

SUDDEN AND FATAL ILLNESS WITH ALBUMINURIA.

By JOHN RUSSELL, M.D., Neath.

A. B., aged 29, who one Sunday evening was apparently in unusually good health and spirits, was seized at about three o'clock on the following morning with violent headache and vomiting, attended by relaxation of the bowels. I visited him shortly before eight, when he was much as described above, with a hot burning skin, and his pulse from 140 to 150. Viewing the case as a violent bilious attack, which in some measure had relieved itself, I prescribed accordingly. At 11 A.M., he was thought to be something easier. At 1.30 P.M., he was seized with violent convulsions. I arrived at the house at about 8.30 P.M., when I was told that the patient had had one or more additional convulsions, and had just died. The trunk and extremities were dotted all over with spots of ecchymosis. I am not aware that the patient was supposed to have been labouring under any organic disease. The character of the illness led to the idea of blood-poisoning; and as convulsions and vomiting are acknowledged symptoms of uræmic poisoning, it was thought that the urine might throw some light upon the disease. Anything in the shape of a *post mortem* examination of the body was

positively objected to; but I succeeded in obtaining about three drachms of urine by the catheter. This, upon being boiled, became almost one gelatinous mass, and was unaffected by nitric acid. This appeared to myself satisfactory evidence as to the cause of death: but a medical friend demurred to my conclusion, inasmuch as he thought that, upon the cessation of vital action, endosmosis and exosmosis might become more active, and the urine thereby become albuminous. With the view of clearing up this point, I have since examined upwards of twenty specimens of *post mortem* urine, and in no instance in which it had been ascertained to be non-albuminous recently before death had it become so afterwards; thus proving that urine will not become albuminous as a consequence of death. I beg now to propound the question, "How far might such a condition of *post mortem* urine (as was discovered), coupled with such a train of symptoms, be considered conclusive as to the cause of death?"

REPORTS

OF

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS OF GREAT BRITAIN.

ST. BARTHOLOMEW'S HOSPITAL.

CASES OF HERNIA.

(Under the care of Mr. SAVORY.)

Strangulated Femoral Hernia in a Woman of 70, complicated with Hypertrophy of Glands concealing the Sac: Operation: Dysenteric Diarrhea: Recovery.—On Tuesday, the 12th of April, Mr. Savory operated on two very remarkable cases of hernia in St. Bartholomew's Hospital. In the morning, a spare old woman, above 70 years of age, was admitted with a tumour, of the size of an orange, over the right femoral ring, into which it could be traced by a distinct pedicle. The tumour moved freely under the skin, which was loose and natural over it. It was not at all tender, and was resonant on percussion; and immediately below it were two enlarged, but not much hardened, glands, about the size of filberts, close together. No action of the bowels had occurred for a week; for six days she had been very sick, and what she had vomited during the last two days, she said, smelt very badly. Since she had been in the Hospital she had retched repeatedly, but had brought up nothing. Her countenance was natural, the pulse about 90, the abdomen tolerant of pressure. She was rather dull and confused in her answers, but did not complain of feeling ill. She said that she had had a lump there for many years, which would go back when she went to bed, and never gave her any particular trouble. She had never worn a truss.

She was placed under chloroform; and, no impression being made on the tumour by taxis, the skin over its inner surface was divided by a longitudinal incision. After the reflection of the superficial fascia, the whole surface of the tumour was exposed, which now presented itself as a smooth spheroidal mass, with a stalk from its under surface which passed to the femoral ring. The fascia investing this was carefully divided down to what appeared to be sac; and the inner border of the ring itself was notched, but still taxis failed to return any portion of the mass. Then it was determined to open the sac; and a thin layer was accordingly raised from the front aspect of the tumour and divided. This was repeated again and again until a depth of three or four lines had been reached. It was then obvious that the substance which the tumour here presented was something more than thickened sac; but all present were doubtful of its nature. The divided surface was whitish, soft, and uniform; and the rest of the mass was so soft and fluctuating that it gave to those who felt it the impression of a cavity within. Upon now carefully examining the under surface of the tumour, the appearance of the sac, with intestine beneath, was so marked that the first layer was raised and divided, when a knuckle of tolerably healthy intestine came at once into view. Then the incision was carried upwards through the inner portion of the neck of the sac, and the loop of intestine was easily returned. There remained now the empty sac, with this extraordinary mass forming its front wall, and still as large as half an orange; but by carefully dissecting between it and the ring, it was gradually so far isolated that there was at length no hesitation in removing the whole of it, with the enlarged glands attached to it below. Upon section and further examination, it proved to be a lymphatic gland greatly enlarged, but not at all hardened—in fact, with a texture softer than natural; so soft, indeed, as still to give a sense of fluctuation when felt between the fingers. There was not the least evidence of suppuration, or of any morbid fluid or of previous inflammation, but it presented all the characters of simple genuine hypertrophy; and this