Dr. Paul dissuaded him, and advised him to take a sea-voyage. Dr. Paul did not see the patient again for a week, when he found him quite collapsed and rapidly sinking. For three days, Captain R. had been vomiting the same green-coloured bilious matter, almost without ceasing. This symptom resisted the most careful treatment, directed by Dr. Andrews. Neither food nor medicine was retained for an instant, until a few hours before death, when the vomiting ceased, more, as it appeared to his attendants, from exhaustion than from the remedies used.

I am indebted to Dr. Andrews for the following account of the *post mortem* appearances.

The body was emaciated. Rigor mortis was normal. The lungs were healthy. *Heart.* The muscular substance was undergoing fatty degeneration. There was a fibrinous clot in the right ventricle. The *Liver* was large, softened, and congested. The stomach was tied and cut off just above the cardiac orifice, and was carefully removed; but, when the duodenum was reached, it broke down under the pressure of the fingers, and the contents, a black fluid, escaped into the cavity of the abdomen. The oblique portion of the duodenum was of a deep chocolate colour, softened, thickened, and ulcerated. Upon examining its internal surface, pus was observed to ooze from a minute aperture on the right side. Tracing this with a probe, it was found to lead into an abscess about the size of a cricket-ball in the lobulus quadratus of the liver, full of laudable pus. The liver, gall-bladder, pancreas, stomach, and duodenum, formed one adherent mass, united by the inflamed lesser omentum. The great omentum was inflamed in patches. The serous covering of the transverse colon was ash-coloured, softened, and adherent to the liver; the mesocolon was inflamed and thickened. The gall-bladder was distended with thick tarry-looking bile. The ductus communis was apparently impervious. The stomach and bowels were full of a dark fluid, and the mucous membrane was congested throughout. The *Kidneys* were both congested; the left was enlarged, with commencing fatty degeneration.

Dr. Andrews adds: "The immediate cause of death was, I consider, exhaustion, from inability to retain food in the stomach. The above described condition is more than sufficient to explain why this was so. Had the patient lived a few hours longer, the issue might have been different, as the abscess was on the point of discharging itself into the duodenum, thus relieving stomach and duodenum from pressure, and making nutrition possible."

I have published this case because I think it of interest and importance from a diagnostic point of view. The real significance of persistent vomiting following on hepatic symptoms, however slight, did not escape the observation of Morehead, who, writing on the diagnostic value of the symptoms of hepatitis, thus expresses himself: "Nor may we overlook the relations of the concave surface of the liver to the stomach, and the explanation which this affords of the occasional occurrence of vomiting." And he adds: "But this symptom is more frequently observed in the advanced than in the early stages of hepatitis;" that is, as in the case before us, when suppuration has occurred, and the abscess presses on the stomach and duodenum. I can call to mind several cases very closely resembling that of Captain R., one with a more fortunate issue. A lady, after a chill, had slight hepatic symptoms, so slight as to cause little alarm. The liver was but little enlarged; there was hardly any pain, not much fever (it was before the days of the clinical thermometer, which in hepatitis is invaluable). From an early date, the stomach was irritable. At last, after a marked rigor, vomiting became almost incessant, the exhaustion of the patient became extreme, and her death was hourly looked for. Suddenly, nearly a pint of pus was vomited; the irritable condition of the stomach subsided; nutrition became possible; and this lady returned from the very gates of death to good health.

If fresh evidence were required as to the untrustworthiness of the absence of pain as a sign of hepatic abscess, the case of Captain R. furnishes it. It can never be sufficiently kept in mind that, unless the capsule of the gland partakes of the inflammatory action, a large abscess may exist without pain being complained of. We have now at Netley an officer who served on the expedition to the Gold Coast. He was brought to Netley raising daily, through the right lung, ten or twelve ounces of purulent matter from a liver-abscess on the convex aspect of the right lobe. In this case, the liver was much enlarged; but the utmost freedom of percussion and palpation was allowed without eliciting a complaint even of tenderness. Nevertheless, I was soon led to the opinion that there was another abscess deep in the substance of the gland, for the following reasons: 1. The enlargement of the liver; 2. The case had a dysenteric history, multiple abscesses when hepatic mischief supervenes being the rule in such cases; 3. Persisting high temperature, the thermometer ranging from 101 to 104 deg. Fahr., notwithstanding the free discharge of pus; 4. Progressive emaciation,

Acting on this evidence, I passed the longest needle of Dieulafoy's aspirator between the eighth and ninth ribs in the axillary line, four inches deep into the substance of the gland, reaching an abscess, and evacuating twenty-four ounces of pus by means of the aspirator. It was found impossible in this case to retain a drainage-tube in the cavity of the abscess, as it always will be when it is situated so far from the surface, more particularly when, as in the case of this officer, the liver is adherent to the diaphragm, and made to partake freely in the movements of this muscle.

THE GAINS DERIVED FROM THE USE OF THE LARYNGOSCOPE.

By GEORGE JOHNSON, M.D., F.R.S.,

Professor of Medicine in King's College; Physician to King's College Hospital.

ONCE more, in reply to Mr. Thornton: I am aware that the muscles of the larynx may be affected by extension of disease from the mucous membrane. I have seen such cases often; but I do not consider this an "idiopathic disease" of the muscles. Moreover, in the case which forms the subject of this discussion, there was no history of any affection of the mucous membrane, which, during life and after death, appeared perfectly healthy. The crico-arytenoid articulation was opened after death; and in the specimen, which is preserved, it may be seen to be quite normal. The muscles were not examined microscopically.

Early in the ensuing session, I purpose to make a communication to the Royal Medical and Chirurgical Society, in which I hope to be able to give a satisfactory physiological explanation of bilateral spasm and bilateral palsy of the laryngeal muscles resulting from pressure on the trunk of one pneumogastric nerve.

CLINICAL MEMORANDA.

MAMMARY ABSCESS IN AN INFANT.

DR. STEPHEN's report in the JOURNAL of July 25th of a case of mammary abscess in an infant three weeks old recalls to my mind a similar case that I saw last year. On referring to my register of obstetric cases, I see that I attended Mrs. D., a primipara, aged 40, on July 25th, 1873. She was safely delivered of a male infant. On August 9th, I was called in to see the infant, and found him suffering from two mammary abscesses, which I opened, and from which escaped a considerable quantity of greenish pus. The infant recovered, and I heard no more of the case. I had not seen the infant for some days previously to August 9th, so cannot, of course, say whether, as in Dr. Stephen's case, the abscesses originated in the retention of milky secretion. But I think there is sufficient similarity in my case to make it worth recording, especially as it is the first case of the kind I have seen, and the one reported in the JOURNAL appears to be unique in the experience of Dr. Stephen and his medical friends.

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CASE OF HYDATID OF THE BRAIN: EPILEPTIC CONVULSION: DEATH.

The following case is, I think, interesting from its rarity, and also from the *post mortem* examination explaining certain peculiar symptoms which existed during life, and likewise the sudden epileptic seizure and death.

A. G., aged 17, an inmate of a reformatory for the last two years and a half, consulted me in June last for a slight ulcer of the leg, which quickly healed; but my attention was directed to her general health and her strange conduct. She would steal things, and secrete them under her bed, without any object. She refused her food, or crumbled it up and hid it in her pockets. She would lie on the floor and sleep in the daytime, but at night was restless and noisy, disturbing the other inmates of the room. She placed books and other articles under her pillow, which, she said, was to make her head ache. She told her companions that she was shamming, that she might be sent to a hospital. On one occasion she attempted to strangle herself with a piece of ribbon tied tightly round the neck.

As I could discover no actual disease to account for this strange erratic conduct, I attributed it to hysteria, the result of amenorrhoea, she having menstruated but once. The matron informs me that, until the last few months, she was one of the best behaved and intelligent girls in the institution; and that, even so late as two days before her