paratively small space which existed at first between the fragments showed that the aponeurotic expansion from the muscles over the bone must have been either not lacerated, or only to a slight extent.

RUPTURE OF THE BLADDER, MISTAKEN FOR OBSTRUCTION OF THE BOWEL AND OPIUM-POISONING.

By HORACE DOBELL, M.D., etc., Physician to the Royal Hospital for Diseases of the Chest.

THE case reported by Dr. Andrews in the BRITISH MEDICAL JOURNAL of October 24th, under the heading "Rupture of the Bladder and Enteritis," recalled to my mind one which occurred to me some years ago. As the case may be of interest in conjunction with that of Dr. Andrews, I have extracted the following nearly *verbatim* from my case-book.

On Thursday, June 7th, 1860, I was requested by a surgeon in great haste to see Mr. R., as he thought him dying from opium administered in treatment. I learnt that, during the last thirty-six hours, the following had been given: twenty minims of tincture of opium, followed by sickness; a grain of solid opium, followed by sickness, but possibly retained; a drachm of tincture of opium in an enema, only partly retained. After a careful examination, I gave the opinion that the patient was suffering from uræmic poisoning, and would shortly die. He died half an hour afterwards. The account I obtained from the surgeon was as follows.

On Saturday night last, Mr. R. was in his usual health, sat late at home drinking gin and water with some friends, took more than usual, and was slightly intoxicated. He got up to go to bed, stumbled, and fell with his stomach on the arm of his chair. He groaned at the moment, but quickly said, "It is all right, I am not hurt;" walked into the adjoining room, and went to bed. He was asked how he was after going to bed; and he said again, "All right," and went to sleep. The bowels had acted before the fall. Next morning (Sunday), he felt ill; he had sharp pain in the umbilical region, and said that he felt he could not strain to get the bowels open; and they did not act. Some castor-oil was given, but did not act; and, after some time, he brought it up. The vomiting continued after this; and towards night, the patient, finding that he had passed no urine all day, sent again for his doctor, who passed a catheter, and drew off a very little. This was slightly tinged with blood, but so slightly that it was thought to be only due to the passage of the catheter; and the absence of urine in the bladder was supposed to be accounted for by the repeated vomiting. Another dose of castor-oil and a calomel and colocynth pill were given; but the bowels did not act. There was very little pain in the abdomen, the principal symptoms continuing to be a feeling that the patient could not strain to get a motion, and that he wanted some assistance to make the bowels act. An enema of soap and water was given, which brought away a little pale fecal matter. A larger one was given, with similar result; neither was attended with any unusual discomfort. The patient continued constantly sick, not retching with any force, but eructating everything, even water, a few minutes after swallowing it. The sense of inability to strain disappeared after the second enema, and a very small quantity of urine was passed naturally while at stool. The catheter was used night and morning, and two or three ounces of urine removed each time, without any blood after the first time. On Wednesday, the day before death, no natural action of the bowels had occurred since the fall; the eructation of everything taken into the stomach continued. There was very little pain, and that was about the umbilicus, and rather to the right of it, and extending up towards the hypochondrium. The region of pain was slightly dull on percussion. The whole abdomen was slightly distended, but soft, and not tender, except in the region of pain; and no part of the alimentary canal was morbidly distended by either solid or gas. The breathing was very quick and thoracic; pulse feeble, 120, not sharp or hard. The patient was rather faint, but clear in intellect. He had had no sleep since the accident. He thought he could sleep but for the sickness and "fidgety sort of pain" in the bowels; but the pain was not paroxysmal, and not enough of itself to prevent sleep. It was now considered by the surgeon that some serious obstruction in the bowels had been caused by the fall; that the suppression of urine was due to the constant ejection of fluid from the stomach; and it was decided to do nothing but keep the patient quiet, give opiates, use the catheter if required by distension of the bladder, and continue enemata. It was early next morning that I was called in, half an hour before death, as stated in the commencement; when I obtained the foregoing history of the case.

Post Mortem Examination, the following morning.—The abdominal

viscera were healthy. There were no signs of inflammation; and, on careful examination from the stomach to the rectum, no obstruction was found in the intestines, which were nearly empty. The cæcum was adherent to the iliac fossa by some bands of old lymph. There were no signs of recent action. The abdomen was full of very high coloured fluid, which had a very strong smell, but more peritonæal than uræmic. On passing the hand into the pelvis, in search of the bladder, none could be felt; but the finger went into a fossa at the entrance to the urethra. On careful examination, the bladder was found completely shrivelled up round the entrance to the urethra, with a rent two inches long in the anterior free portion of the fundus. The rent was quite patent. There were no signs of inflammation either in or about it, but considerable purple ecchymosis in the coats of the bladder leading from the rent.

Although suppression of urine is a constant occurrence in obstruction of the intestines high up, and to a certain extent of all other diseases attended by continued sickness; and although the concurrence of inaction of the bowels, obstinate sickness, and pain, following a twist or blow to the abdomen, might fairly lead to the suspicion of intestinal obstruction; and the detection of some amount of dulness about the right upper portion of the abdomen, and the absence of any pelvic pain, certainly complicated the diagnosis in this case; still I think that the unusual freedom from *tormina*, and the absence of any fecal odour in the vomited matters from first to last, together with the character of the accident—viz., a blow from a prominent object on the abdomen, after sitting for some hours drinking—might have suggested a different diagnosis. And the practical hint may be taken from the case, that, in cases of suspected obstruction of the intestines, it is wise to wait for distinct *painful peristaltic action* before beginning to administer opium; and it is a good illustration of the importance, in all cases of obscurity, of *reconsidering* the whole of the circumstances, signs, and symptoms, at each visit.

CLINICAL MEMORANDA.

[Under this head, we shall publish from time to time, as materials accumulate, short records of remarkable cases in practice which are sufficiently rare, interesting, or instructive, to deserve record, but do not call for lengthened statement or comment. Brevity and point should be the valuable characteristics of cases forwarded for this column.]

FRACTURE OF THE SKULL, WITH ABSENCE OF SYMPTOMS.

By J. T. HESTER, F.R.C.S., Hastings; late Senior Surgeon to the Radcliffe Infirmary, Oxford.

THE "remarkable case of fracture of the skull, under the care of Mr. Charles Moore," at the Middlesex Hospital, reported in the JOURNAL of October 24th, recalls one to my mind still more remarkable. I did not see the patient till after death.

A young lady, eighteen years of age, was thrown out of a carriage, which, in consequence of the horse running away, was dragged over a heap of stones. She immediately rose, and ran two miles after the carriage, being anxious to ascertain the safety of her father, who was in it. She returned home, and appeared so little the worse for the accident, that she objected to any treatment. She at last, however, submitted to be bled, that being the practice of the time (thirty years ago). On the following day, as she had a headache, a few leeches were applied. Feeling a little faint, she asked to be lifted up in the bed; and, on being so, instantly fell back dead. On the next day, I was requested to assist at the *post mortem* examination.

The skull, which was the thinnest I have ever seen (light could be seen through it), was literally split into two halves by a fracture which passed through the occipital in front and behind the foramen magnum, dividing the parietal, passing through the frontal, ethmoid, and sphenoid bones, without the slightest depression or starring in any part. I need hardly say there was no diploë. Between the dura and pia mater, there was a very considerable extravasation of blood on the upper surface of the brain, but none at its base. I was led to account for the entire want of symptoms of pressure, from the peculiar nature and extent of the fracture allowing the cranium to expand. The most extraordinary parts of the case are, that such a fracture could take place under the circumstances, and that the patient was not stunned by a fall which could occasion it.

I have no notes of the case, but write from memory; but the facts of it are indelibly impressed on my mind.