nervous wreckage that confronts us. Where does it come from? In short, what is its heredity? I am not now speaking only of asylum cases, but one would have thought that the asylums would have produced available statistics. I find, however, that Dr. Clarke, of Banstead Asylum, when writing on this subject in the *Journal of Mental Science*, says: "We have no statistics of insanity that are of any practical use. In the tables published annually by the asylums and by the Commissioners, the defective histories swamp and entirely violate the good ones, and no table gives any information as to the normal relatives or offspring of the psychopathic." The treatment of criminals is said to be a failure, and it always will be a failure on the opposing lines adopted and suggested, for the reason that you will not alter the constitution of a man's nervous system by handing him over to the philanthropic humanist, who would treat him as a spoiled child, any more than by putting him in prison. A seizure of "grand mal" is not dealt with satisfactorily, either, by a strong man holding the victim down, or by an old lady administering soothing syrup with kind words. But do we lock up criminals to reform them? Surely we lock them up to protect society, as we excise a cancer to save the individual. Doubtless it is true that, in our administration, cases have been classed as criminals that should have been otherwise dealt with.

It appears to me that some form of segregation, however attained, is inevitable in the not very distant future, if we are to avoid a continuous increase in nervous degeneration. In making a diagnosis in our routine work we get the available facts and marshal them as best we can in order to draw what seems to us the soundest conclusion. But here we have criminals, lunatics, feeble-minded, epileptics, alcoholics, and a host of other neurotic degenerates, and yet we have hardly any facts to guide us as to their origin. It is really remarkable that we know so little not only of the heredity of these unfortunates, but also of our soundest and best stock. Surely it is the duty of a Government responsible for the destinies of a people to obtain information on this the most important factor determining the advance or degeneracy of their population. Powerful and thoughtful indictments have recently been made based on such statistics and facts as are available. Are we allowing to slide what, in his *Social Evolution*, Benjamin Kidd speaks of as "projected efficiency," and, as writers like the Whethams maintain, the sound stock to dwindle while the unsound are rapidly increasing?

Before we cry out in panic for a remedy we ought to demand the facts on which alone a diagnosis can be made. The influence of the medical profession in matters of this kind is great, and that is my reason for venturing to address you on what is only, on its broader aspects, a medical question.

A CASE OF PERFORATED COMMON BILE DUCT FOLLOWED BY SUBPHRENIC ABSCESS, OPERATION, AND RECOVERY.

By C. CAMPBELL-HORSFALL, M.B., CH.B.VICT.,
NEWQUAY.

THE patient in the following case, a married woman aged 45, had suffered for years from dyspepsia and spasmodic pains which were at times intense and radiated over the upper abdomen and chest. I saw her during two attacks, which were unmistakably due to gall stones, and it was during the last of these that occurred the catastrophe which is the basis of this note.

The patient had been seized with intense pain in the chest and upper abdomen and signs of common duct obstruction, jaundice, bile-stained urine, pale stools, and a moderate degree of fever. She had consented to operation, and this was to take place as soon as the acute symptoms had subsided. On March 14th I had left her comparatively comfortable, but on reaching home I had an urgent summons to return at once. I found her lying in bed quite immobile, pale and cold, pulse 120, and temperature 100°. It seemed that shortly after I had left she had been seized with an agonizing pain causing her to jump out of bed, and then collapsing. There was no rigidity of the abdominal muscles, nor was there any marked tenderness.

Deep pressure in the region of the gall bladder produced a well marked diaphragmatic grunt.

The following day there was moderate distension of the abdomen; pulse 120, but temperature falling. From the anamnesis I concluded the common duct had ruptured, and so, with the assistance of Dr. Tonking of Camborne, I proceeded to explore her abdomen.

Operation.

Under ether anaesthesia I opened the abdomen through the upper right rectus. On opening the peritoneum bile-stained fluid and pus welled up into the opening. After shutting off the peritoneal cavity an exploration was made of the biliary region, and although one could trace the stream of bile and pus down to the region of the common duct, the actual tear could not be located; the gall bladder was shrunk. A rubber drain was carried down to the common duct and a cigarette drain placed in the right kidney pouch. An incision was next made over the pubes, and Douglas's pouch was found filled with bile-stained fluid; this was gently mopped away and a tube inserted. The visceral peritoneum did not show any marked inflammatory action.

Progress.

The pulse was much better after the operation, and the patient was put back to bed in the Fowler position and proctoclysis commenced. She quickly rallied from the operation. Next day she was fairly comfortable, but looked blue and the skin leaky. As there had been no vomiting and she was very thirsty cold water was allowed freely. The tubes were removed on the fifth day. The day following she complained of pain in her left side; the temperature went up to 103°, and pulse 112. A definite fluctuating mass could be made out on the left side.

The same evening under ether I evacuated a large collection of bile-stained material from this side and inserted a drain. There was a good deal of shock after this, but under salines and pituitary extract the pulse recovered and the patient seemed much easier. The temperature fell, but the pulse still remained rapid. In spite of this her condition was not satisfactory, respirations became more frequent, the upper part of the abdomen ceased to move, and on March 25th there was distinct evidence of another collection of matter in the upper abdomen.

Second Operation.

Under ether an incision was made through the left upper rectus, and at once one came upon a large accumulation of biliary matter, together with a quantity of mucus similar to the contents of the small intestine. The cavity could be traced up under the diaphragm towards the right side. A large drainage tube was put in and a counter-opening made in the left flank, with through-and-through drainage.

Result.

Almost at once there was a marked improvement in the patient's condition, and this continued. During this time she had an attack of pain and evidence of renewed blocking of the common duct, but whatever the cause it quickly subsided, and with the exception of some fluid in the left chest (which has now disappeared) her convalescence has been uneventful, and she is now in better health than she has been for many years past, and instead of denying herself foods is able to eat and digest anything.

This case is interesting, not only on account of the satisfactory result, but because the usual triad of symptoms—pain, vomiting, and muscular rigidity—accompanying an intra-abdominal catastrophe were conspicuous by their absence. There was no vomiting at any time, and previous to the first operation, beyond the distension there was nothing to indicate the focus of infection except the history of the case which was undoubtedly gall stone disease.

Rupture of the common bile duct is extremely rare. Perforations of the biliary system, though by no means frequent, form an important class in the production of abdominal catastrophes. McWilliams has collected 108 cases from the literature.

In a series of 3,180 operations on the biliary system, there were only 29 cases of perforation, or less than 1 per cent. In the series of 108 cases there were only 4 cases of perforation of the common duct.

1. *Kehr*.—Female, 51; symptoms four days; perforation of common duct; cholecystectomy. Died.
2. *Riedel*.—Male, 56; symptoms three days; perforation of common duct and gall bladder; cholecystotomy. Died.
3. *Routier*.—Female, 56; symptoms one day; perforation of common duct, free bile; cholecystotomy. Recovered.
4. *Neupert*.—Female, 42; Symptoms fourteen hours; perforation of common duct at juncture with cystic duct, free bile; cholecystectomy. Recovered.

To this number must be added my own case. The five cases show in a very graphic way the importance of early operation in these cases. In the first two the symptoms had been in progress for four and three days respectively, and both died. The other three were operated on within thirty-six hours after perforation, and all recovered.

In regard to the treatment of these cases, incision and drainage offer the only chance. The procedure in any one case must necessarily depend on the conditions found, remembering always that the patient should be conducted to a cure with the least possible sum total of hazard to his life.

PELLAGRA IN GREAT BRITAIN: THREE NEW INDIGENOUS CASES.

BY

LOUIS W. SAMBON, M.D., F.Z.S.,

LECTURER TO THE LONDON SCHOOL OF TROPICAL MEDICINE AND
PARASITOLOGIST TO THE WELLCOME RESEARCH
LABORATORIES.

To the number of indigenous cases of pellagra so far recognized within the United Kingdom, and published in the *JOURNAL* of July 5th, I must now add three others, one from Shropshire, a second one from Cardiganshire, and a third one from Napsbury Lunatic Asylum.

The first case was kindly notified to me on July 7th by Dr. L. E. Dickson, M.O.H. Bridgnorth. Dr. Dickson wrote as follows:

The interest attaching to any case resembling pellagra induces me to send you notes of a patient now under my care who presents many of the symptoms described as being present in the cases published in last week's *BRITISH MEDICAL JOURNAL*. My patient (see figure) is a girl of 7 years, who has always lived in Bridgnorth, and who, I am told by her parents, has never eaten any maize. Up till her fourth year she had no illness beyond childish ailments. She then commenced to have nocturnal enuresis, which has gradually become more troublesome. In her fourth year she also developed so-called "eczema" on the hands and face, which recurred each spring and lasted through the summer, disappearing in the winter. This year the rash appeared in April and has persisted till now, being worse during the sunny weather. About a month ago I was asked to see her, as she had been having some curious seizures which had become very frequent and alarmed her parents. These seizures, I was told, had first been noticed when she was 4 or 5 years old. Her mother says that she always calls out that she is giddy and then has a slight convulsive attack during which her left arm and leg twitch and she falls to the ground, but does not lose consciousness and has never bitten her tongue. They commenced to be more severe about a month ago, at the end of May. I have never seen her in one of these attacks.

The rash on the face and arms is symmetrical, covering the forehead, the malar prominences, the bridge of the nose, and the lips down to the chin. The upper eyelids are clear, and there is a clear space in front of each ear. A separate patch crosses the front of the throat. Both hands and forearms are covered up to the elbows. The skin is red and inflamed; there is considerable branny desquamation. Here and there, there are fissures in the skin, and one or two pustules. The eruption is accompanied by a sensation of burning or "scorching."

The tongue is clear with a little sore-looking red edge,

but no actual ulceration. There is hyperaemia round the anus and over the buttocks, but no desquamation. The bowels are generally relaxed, and for a week there has been diarrhoea with offensive musty-smelling pale stools. The urine has been so far normal.

The girl's speech is affected, and she cannot articulate clearly; she is decidedly dull and below the mental standard for her age.

There is constant tremor of the hands, particularly the left, and twitching while asleep. The knee-jerks are slightly exaggerated. She is giddy and cannot stand with her eyes shut and feet close together. There has been no Babinski's sign until to-day.

Last night (July 6th) she had a more severe attack than usual when at tea, and I saw her about 6.30 p.m., when she was lying down, having then recovered from the seizure, which I was told affected only the left side.

This morning I saw her again and found her almost unconscious, breathing rapidly, with a rapid pulse and temperature 101.2° F. The diarrhoea had ceased, and she

had taken no food since tea the night before. Her right arm and leg are now rigid, and there is right-sided facial paresis. She can move the arm and leg, but not freely, and sensation is diminished on the right side of the body. There is Babinski's reflex on the right side. No blood count has been made, and no examination of cerebrospinal fluid.

As I have never seen any case of pellagra, I am unable personally to say whether this present case of mine resembles pellagra or not, and therefore hope I am not unnecessarily taking up your time by writing this short account to you. I need hardly say that if it in any way interests you it will give me pleasure to send you any further details.

Dr. Dickson's letter did not reach me until July 10th, when, on wiring, I found that the patient had died on July 8th. Nevertheless, I went to Bridgnorth and saw the body on the morning of July 11th. As I had expected from Dr. Dickson's description, the case was one of typical pellagra. The characteristic symmetrical dermatitis was well marked; it covered the face almost entirely,

formed a broad band over the anterior aspect of the neck, covered the backs of the hands, encircled the wrists, and extended over the external surface of the forearms up to the elbows. Both Dr. Dickson and his partner, Mr. S. C. Padwick, who had seen the little girl the day before her death, stated that the skin lesions were of a brownish-red colour. The mother told me that the eruption had appeared each spring in the three previous years, disappearing completely in the winter, when the patient improved so greatly in health that she looked quite a different girl. Both parents assured me most emphatically that the child had never eaten maize in any form whatsoever.

I examined the remaining three children, but found no manifest evidences of pellagra, although, according to the mother, one of the girls seemed to have presented this last spring a slight rash on the backs of the hands. With Dr. Dickson and Mr. Amoruso I drove to the Cantreyn Brook north of the town, where I was told the children

Dr. L. E. Dickson's case of pellagra in a girl, aged 7 years, at Bridgnorth.
Eruption on face, hands, and forearms.