that dirty-red, slimy, bad smelling, never abundant expectoration which hysterical women with phthisis often exhibit at the bottoms of their spittoons; this may be left to itself. The other exception is a serious one; it comprises those forms of hæmoptysis, usually copious and angry, occurring in advanced and very chronic cases where there is a considerable amount of fibroid induration. In such patients, notable dyspnoea on exertion has for a long time past been a prominent symptom, and respiration has been maintained by a very small extent of lung-substance. These cases are open to a special danger—that of fatal embolism in the right chambers of the heart or the pulmonary artery. Not uncommonly, the course followed is for the bleeding gradually to abate in quantity, remaining, nevertheless, of the same angry red; then urgent dyspnoea suddenly sets in, and death takes place within forty-eight hours. These are cases calling for extremely careful treatment. Can it be right, where only a small surface is available for respiratory function, to contract those few vessels with ergot? Or can it be good practice to pass styptic medicines into a patient's circulation when his cachectic state, his low vitality, and perhaps some febrile movement, render him especially liable to the formation of thrombi? It is wisest to limit ourselves to external applications, chloroform-pads, dry cupping, sinapisms at a distance or other derivative treatment, with appropriate general management.

Perhaps I may be allowed to conclude with two cautions, commonplace they may seem, but both of them the outcome of bedside experience. One is, to have some responsible person in attendance night and day, on all cases of severe bleeding, till the attack has completely passed away. Death in hæmoptysis is generally sudden, and it is very appalling to discover too late the consequences of omitting this precaution. The other is, to decline positively to examine a patient's chest while there is any hæmoptysis. Irrespectively of the danger of the process, an opinion arrived at by auscultating a chest during or immediately after a bleeding is not a reliable one.

NOTE ON A CASE OF PSEUDO-HYPERTROPHIC PARALYSIS (?): RECOVERY.

By H. DONKIN, M.B., F.R.C.P.,

Senior Assistant-Physician, Westminster Hospital; Physician to the East London Hospital for Children.

ON the 19th of November last (1881), I saw a boy six years old among my out-patients at Westminster Hospital, whose mother brought him on account of his having been unaccountably "falling about" for a week, and being quite unable to run or walk fast. She stated that he had been "slow and inactive" for about five or six weeks previously, and that she had noticed that his calves and buttocks seemed larger than before. These facts were given spontaneously, not elicited by questions.

The child's previous medical history included the occurrence of some inflammation of the eyes at birth, measles, and whooping-cough. At three years old, he was observed to be excitable and passionate, this state lasting some months; but he had no "fits" of any kind. The only other child in the family died at the age of six months with diarrhoea. There was no evidence of parental syphilis. The mother had had two miscarriages; and the history of the father, who is dead, was obscure. Subsequent inquiry failed to find the trace of any affection like pseudo-hypertrophic paralysis in the mother's family.

The boy stood with his legs wide apart, straddled and swung from side to side as he slowly walked, fell down on attempting to walk quickly, and was unable to raise himself from the sitting posture without pressing on one of his knees, and previously turning round and sitting on all-fours. There was protrusion of the abdomen, and a noteworthy degree of lordosis. On stripping him, it was obvious to me and the students who were present that his calves and buttocks were remarkably large for a boy of his size. The skin, especially over the lower part of the body, was markedly mottled; and, after repeated trials, I failed to elicit the knee-jerk, except perhaps very slightly in the left leg. Knowing, however, how erroneous it often is to attach any value to the absence of this latter phenomenon in children, and the general want of knowledge about the importance of this symptom at all, I mention it only because, on the recovery of the boy, which is the excuse for this record, the knee-jerk was elicited in both legs with as much ease as could be expected in the case of a rather excitable child. There was not any obvious enlargement of the muscles of the upper extremity. But I was able on that day to make but an imperfect examination, and unfortunately postponed both the measurement of the girth of his calves and all further methods of inquiry. Owing to an unavoidable absence, I did not see the case again till January 7th, more than six weeks after the first visit. Then, to my surprise, beyond

some waddling in walking, I noticed no symptoms of loss of power. The boy could run with ease, and raise himself from the ground in the ordinary manner, even without placing his hands on the floor. The calves still appeared to me to be somewhat large; but the mother, again spontaneously, observed that both the calves and buttocks had "got quite small again". There was no mottling of skin. On the 14th, I saw him again. He still waddled slightly in walking; and I again failed, as I had also on the 7th, to produce any knee-jerk after careful trial. The mother believed the child to be now quite well. On the 21st, I could detect nothing abnormal about the child or his movements, with the exception of the knee-jerk symptom. I saw him again on February 10th, when I did not examine him; and for the last time on March 11th, when I found the appearance of the body normal; the gait in no way altered; running performed with perfect ease; and the knee-jerk produced with tolerable readiness.

The treatment I ordered from the first was complete rest; the boy having previously been exercised by the mother, believing, as she did, that he was careless. For medicine, as he looked somewhat weakly and pale, although quite cheerful, I gave him our mixture of iron and nuxvomica. This he discontinued taking on February 10th.

I am well aware that this is but an imperfect report of the case, and that the diagnosis may be open to question. Still there is enough to show that we may have to look out at least for a set of symptoms *simulating* the disease about which so much has been written and so little is known. And there would seem to be no reason in nature why there should not be some temporary affection of the nerve-centres (even if this disease be regarded as connected with changes in the cord) giving rise to transient symptoms, just as we have the same possibility hinted to us in the occurrence of other forms of recovering paralysis.

I would disclaim any very probable connection between the drug-treatment and the result, believing that, to whatever the symptoms were due, *rest* must be far more reasonably credited with their disappearance.

STRANGULATED UMBILICAL HERNIA AFTER PARTURITION: OPERATION: RECOVERY.*

By HERBERT BRACEY, M.R.C.S.Eng., Birmingham.

MRS. L., aged 41, who had had twelve children, and one miscarriage, had suffered from bronchitis for some years. She was confined on January 30th, 1881, at nearly full time. Labour was natural. The child was alive, and fully developed. The patient was suffering from a severe attack of bronchitis at the time of parturition. Great care was taken in applying the binder securely, as the abdomen was very flabby, and when she coughed the abdominal muscles seemed to give way, as if they had no power of resistance. There was no appearance of any tendency to umbilical hernia, nor had she ever suffered from one. I left her at 9 P.M., and was called to her again at 4 A.M. the following day, when I found her suffering intense pain, and discovered an umbilical hernia, about the size of an orange, very tense, and nearly black. With difficulty this was reduced, a pad was placed over the ring, and a plate and several napkins over that, and the binder firmly applied.

The next day, February 1st, I applied a pad made on purpose, and secured it by strapping, and all seemed to be going on well; but on the next day, February 2nd, the third day from the confinement, the cough being still very violent, the hernia was again protruded. The symptoms were very urgent, intense pain and great distress; vomiting, which nothing checked; anxious expression of countenance; with small feeble pulse and cold clammy skin. Reduction was again tried, but failed; and after consultation with Mr. Bartleet, it was decided that operative measures were imperative. The patient was put under chloroform by my assistant Mr. Holdsworth; and, with Mr. Bartleet's kind assistance, I made an incision in the median line, over what appeared to be the neck of the sac, and divided the very thin layers of fascia on a director. On reaching the sac, the ring was found to be very tight. An incision was made, without opening the sac, in a direction immediately upwards, but still reduction was difficult; when suddenly the sac burst, and its contents, which appeared to be partly omentum and partly bowel, were readily returned. The rent in the sac was carefully not examined; but the whole thing was quickly pinched up, and the skin brought together by silk sutures; and a pad, plaster, and bandage were applied. The patient was at once relieved, and no vomiting recurred.

It is unnecessary to record the daily notes of temperature and pulse. It is sufficient to say that the progress of the case was one of uninter-

* Read before the Midland Medical Society.

rupted recovery. After the first two days, all pain subsided; the cough continued very troublesome; so that, in addition to the pads and bandages, a nurse had to be kept constantly by the bedside to make firm pressure over the seat of the mischief whenever an attack of coughing came on. This, however, gradually got better; and on February 21st, nineteen days after the operation, twenty-three days from the confinement, I applied a truss with a conical ivory centre of about an inch and a half diameter at the base, placed in the centre of a second flat pad six inches in diameter, and the patient was allowed to get up, and made a good recovery.

I have been unable to meet with any recorded cases of strangulated umbilical hernia occurring during, or soon after, parturition successfully operated upon; and I therefore make this case public, and should be glad to know if any other member of our Association has had a similar experience.

TOXICOLOGICAL MEMORANDA.

THREE CASES OF POISONING BY STRAMONIUM.

CASES of poisoning by stramonium are by no means common; but, apart from this fact, it is interesting to trace the accident by which these persons were poisoned with it. On March 19th I was summoned to a house where three members of a family (mother, daughter, and granddaughter), who had been quite well up to the time of having dinner, were soon afterwards seized with symptoms of poisoning, apparently by belladonna. I found on inquiry that they had had for dinner broth, with dried herbs in it, and also some beef, with turnips, carrots, and potatoes. In about ten minutes after taking the broth, and before rising from the table, they began to feel uncomfortable symptoms, these differing in each case. The mother felt her head first affected, the daughter her throat, and the child her stomach, causing nausea and vomiting. These symptoms supervened much more quickly than is usually experienced in poisoning by belladonna. As they had eaten nothing else for dinner besides what I have mentioned, it seemed hard to understand how they had been poisoned. I, however, obtained the remainder of the dried herbs, but there were only a few small pieces left. On adding boiling water, in order to make an infusion of them, the leaves expanded, and I found two unmistakable portions of the leaf of the *datura stramonium*, also two of the characteristic buds of the plant and the corolla of a flower. On filtering the solution, I applied a few drops to my eye, and it rapidly and fully dilated the pupil, causing indistinctness of vision and loss of accommodative power, which lasted for forty-eight hours. A stramonium plant most probably had been growing amongst the herbs and was unwittingly picked and dried with the rest. The following is a short record of the cases. Mrs. A., aged 70, was quite unconscious when first seen four hours after dinner; her pupils were widely dilated and insensible to light. Her lips were swollen and the lower one was of a purplish hue. She was quite unable to swallow. Her pulse was 90, soft and compressible. There was complete loss of power in her lower extremities, accompanied by subsultus tendinum, but she was busy with her hands pecking at imaginary objects. She also had several convulsions. My stomach-pump, unfortunately, being out of order, I gave her a subcutaneous injection of one-sixth of a grain of pilocarpine, followed by a similar one in a quarter of an hour. This produced free vomiting and perspiration. She then began to rally, and I left her after giving her a fourth of a grain of morphia in pill. She had a fair night, but was very giddy and weak next day and unable to get up. Susan A., a daughter of the above, was in a less serious condition, being in a state of mirthful and busy delirium and very restless. Her pupils were widely dilated, and her cheeks flushed. She was able to take an emetic, and her bowels had been very freely moved—four times since dinner. She complained much of her throat, also of headache and vertigo. Her first sensations of discomfort, she afterwards told me, were referable to her throat. She gradually improved, but her throat and the mucous membrane of her mouth were sore for several days after. The granddaughter, a child four and a half years old, appearing poorly and vomiting after dinner, was taken home, nearly a mile off, to which she walked, though wandering more or less in her mind. She then came under the care of another medical man, who found her very restless and suffering from illusions. She was able to swallow an emetic which caused renewed vomiting, and she was then treated with small doses of opium, under which she gradually became quieter, and was nearly well on the following day. Morphia, physostigma, and pilocarpine are all physiological antidotes to belladonna and its allies; but if pilocarpine can be depended upon to cause free vomiting (physiologically) as in the above case, its value would be enhanced in such cases of poisoning.

Todmorden.

H. COUPLAND TAYLOR, M.B.

REPORTS

OF

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF GREAT BRITAIN AND IRELAND.

UNIVERSITY COLLEGE HOSPITAL.

TWO CASES OF MALIGNANT DISEASE OF THE OESOPHAGUS.

[FOR the notes of these cases we are indebted to Mr. STANLEY BOYD, F.R.C.S., Surgical Registrar.]

CASE 1. *Stricture of Oesophagus: Gastrostomy: Death: Necropsy.* (Under the care of Mr. MARSHALL, F.R.S.; Notes taken by Mr. TILLEY, Ward Clerk.)—W. F., married, aged 65, a coachman, of very temperate habits, was admitted on October 22nd, 1881. Three months earlier, whilst he was eating, a piece of beef stuck in his throat; but he managed to push it down with a spoon. Before this, he had had no symptoms. Since the occurrence, he had been unable to swallow any solid food, as it always seemed to stick in the gullet opposite the cricoid cartilage. He became an out-patient soon after the difficulty in swallowing began; and during this time bougies No. 9 to 21 were passed, causing little pain—the mucus covering the larger sizes showing twice or thrice a single streak of blood. No other blood was ever expectorated. At first, relief was experienced; but after a time there was some difficulty in passing the stricture, and he was admitted an in-patient.

The patient was a thin man, not at all anæmic, and fairly strong. He gave no history of syphilis, or of injury to the gullet. The loss of flesh seemed accounted for by want of food. Neither finger nor eye detected any swelling in the neck. The stricture was about eight inches from the teeth, and could be entered only from the left side. Bougies Nos. 9 to 18 were passed, and gave marked relief, the patient becoming able to swallow bread-and-butter and eggs; he also gained three pounds. Being able to pass bougies for himself, he was sent home. About three weeks later, however, he returned, unable to introduce any instrument through the stricture, and having lost weight, liquids only having been swallowed during the two previous weeks.

Mr. Marshall now decided to perform gastrostomy, and this operation was done in two stages. The first (on November 29th) consisted in making an incision about three inches long parallel to the costal margin, and having its centre opposite the tip of the ninth cartilage. The anterior edge of the liver was felt immediately, by the finger introduced into the peritoneal cavity. Passing along the under surface of the organ and down along the anterior surface of the small omentum, the stomach was found at once, and seemed much contracted. The colon was not seen. The stomach was now fixed to the anterior abdominal wall by two circles of sutures; the first attaching the gastric peritoneum to the parietal peritoneum and the under layer of the sheath of the rectus; the second approximating the gastric peritoneum and the skin. The spray was used, and an antiseptic dressing applied.

Between the first and second parts of the operation, the patient had no symptoms. The highest temperature was 100.6°, on December 1st; but it fell afterwards to normal. He was fed by enemata every four hours, and his only complaint was that his throat felt rather dry. The second part of the operation was performed on December 3rd, no anæsthetic being used. An incision was made into the stomach large enough to admit a tracheotomy-tube; this caused only slight pain. Antiseptics were still continued. On December 4th, it was found that a free escape of dark fluid was occurring from the stomach through the tube, which gastric fluid had caused numerous superficial ulcers of the skin of the abdomen. The tube was plugged; and the abdomen was powdered with chalk, and covered with lint soaked in carbolic oil. On December 5th, the patient was comfortable. Four tablespoonfuls of pancreatised food were given by the mouth every four hours, and he swallowed more easily. On December 7th, the enemata were discontinued; two ounces of food were injected into the stomach every four hours; milk was taken by the mouth in small quantities. He continued to do well until December 9th, the temperature varying from normal to slightly above it. On the 9th, he seemed to choke whilst drinking. He made frequent attempts to expectorate for three hours afterwards, and permanent orthopnea set in. On the 10th, the temperature varied from 101° to 100°; the pulse was 28, small and weak; respiration was shallow; the tongue was covered with a brownish fur; and the patient felt very weak. On December 11th, he was still weaker; the voice was failing; there was slight delirium at night; the temperature was 99.4° to 100.2°; on December 12th, 98.4° to 100.4°. The pulse was