of the pain. She was then lying on a couch, with her legs extended, and complaining of severe pains in the abdomen. There was great tenderness, especially over the right hypochondrium and epigastrium. The whole abdomen appeared somewhat distended, and was hyperresonant, the liver dullness not extending below the ribs. Nothing could be felt on palpation. There was no hernia, and no history of injury or strain. She thought she had had attacks of gallstone colic on previous occasions, but the history was not clear. The tongue was clean, there was no dyspnoea, no collapse, and the pulse was full and beating 64 per minute. The face was flushed and perspiring. There was some slight bile-stained vomiting.

I prescribed a carminative mixture, and ordered turpentine stupes. This treatment appeared to have given her much relief, for she was able to have her midday lunch, and talk cheerfully and rationally to a neighbour who came in to see her. The urine was high-coloured, but contained no blood.

I was sent for again at 5.30 P.M., and found the patient practically moribund. She was intensely cyanosed, breathing very shallowly, and with a pulse that could hardly be felt at the wrist. She was perfectly conscious, and said she was in little pain then. There was a doubtful history of straining at stool an hour or two previously, but she was too ill to give any reliable account of what had happened since lunch. The abdomen was more distended, and much less tender. Evidently there was rupture of some internal organ. She died about 6 P.M. the same day.

At the *post-mortem* examination, made next day with the assistance of Dr. Macevoy, who had kindly seen the case with me on the previous afternoon, the peritoneal cavity was found to be filled with a large mass of pultaceous olive green faeces which had escaped from a transverse rupture in the ileum. There was no peritonitis. The colon was enormously dilated and thinned in parts, as also the lower part of the ileum. There were faeces in the bowel below the seat of rupture as well as above. A good deal of blood-stained mucus was noticed in the lower part of the colon. There were no bands, no intussusception, no volvulus, no appendicitis, and no evidence of gall stones. The gall bladder was healthy, the liver a little fatty. The rupture was about 1 inch long, and occurred in the transverse diameter of the ileum about 6 inches from the ileo-cæcal valve. Where the gut had ruptured there was an oedematous purple patch about the size of a halfpenny. There were no ulcers in any other part of the bowel, and no enlargement of the lymphoid follicles nor evidence of new growth.

The case at first suggested ruptured gall bladder from gall stones, but the *post-mortem* examination gives no support to that hypothesis. Her age was against intussusception, and the duration was extremely short for volvulus. Is it possible that the mere weight of faeces in a dilated and thinned bowel could have caused some temporary kink in the gut, nipping a small piece of it, which piece finally gave way under the effort of strain during defecation?

CASE ILLUSTRATING A NEW METHOD OF TENDON SUTURE.

By H. LITTLEWOOD, F.R.C.S.ENG.,

Senior Assistant Surgeon to the Leeds General Infirmary.

F. P., aged 36 years, a joiner, was admitted to the Leeds Infirmary on August 6th, 1895, with a traumatic aneurysm of the right radial artery at the back of the wrist. There was also evidence that the three tendons of the extensor muscles of the thumb were divided about the same position.

The following history was given: A month before admission, whilst refitting a shop window a piece of plate glass fell across the back of his wrist, causing a wound. He was taken to a hospital, when the tendons were sutured and the wounds dressed. The wound was quite healed on admission to the infirmary.

Operation.—On August 10th, under ether, an incision was made over the aneurysm; this was completely dissected out, and the radial artery above and below the sac ligatured. The incision was prolonged and the skin reflected up, so as to ex-

pose the divided ends of the tendons. The three extensor tendons were found divided and separated for at least 2 inches; some silk sutures were found attached to the ends. It was now found impossible to bring the cut ends into apposition, so the following method was adopted:

A transverse incision was made half-way across each tendon about $1\frac{1}{2}$ inch from the divided ends (*a*); from this point the

a Point of division for splitting tendon. *b* Tendon split to within a short distance of divided ends. *c* Position of suture.

tendons were split to within a short distance of their divided ends (*b*), the parts reflected down, and the free ends sutured by means of fine silk (*c*). In this way the interval was bridged over without any tension on the newly united parts. Having stopped all bleeding, the wound was sutured with silkworm gut, and the hand and forearm bandaged with a firm uniform wool dressing, the thumb being placed in the extended position.

The dressing remained on nearly a month, the patient being treated as an out-patient after the first week. On removing the dressing all the wound had healed with the exception of a granulating surface about three-quarters of an inch in length. This was rather a long time in healing, but did so in about a month.

The patient was shown at the meeting of the Leeds and West Riding Medico-Chirurgical Society on November 29th, 1895. The wound was then soundly healed; the movements of the extensor longus and extensor brevis pollicis were good, but that of the extensor ossis metacarpi was weak.

The plan adopted in this case appears to offer in certain cases some advantages over other methods of tendon suture where the divided ends are separated for such a distance, and if it is successful when the tendons are so slender as those of the extensors of the thumb, it should be so in other cases where one has stouter tendons to deal with. The tendons must be manipulated with the greatest care, and of course the asepsis must be perfect. I attach great importance to the permanent dressing of wool, applied with a fair amount of uniform pressure.

I have to thank Mr. J. R. Lambert, the dresser, for the notes of the case, and for his care in dressing the patient during the time he attended in the out-patient department.

CASE OF DISSECTING ANEURYSM OF AORTA: RUPTURE INTO PERICARDIUM.

By H. S. ELWORTHY, F.R.C.S.,

Late Assistant Medical Officer, Northumberland House Asylum.

THE case is that of R. H., aged 51, warehouseman, married, who became insane in 1889. In September, 1890, he began to complain of vague pains in the abdomen, and in November had a fit followed by temporary paraplegia, and pains and cramps in the abdomen. He was very lazy in habits, lying

down or sitting about nearly all day, and while under my care for 18 months almost constantly complained of abdominal pain, for which no cause could be found.

Dissecting aneurysm of aorta. was pale, the mitral valve slightly Photograph of aorta laid open showing clots between coats. atheromatous but not dilated; the internal and middle coats had ruptured transversely all the way round, except half an inch on the concavity of the arch, one inch above the semilunar valves. The external coat was stripped up all along the arch, except along a narrow border half an inch wide on the concavity. The external coat had ruptured into the pericardium by a vertical slit three-quarters of an inch long on the posterior aspect of the first part of the arch, the centre of it corresponding to the transverse rupture of the inner coats. The blood had passed between the middle and external coats up the innominate artery, along the whole length of the thoracic and abdominal aorta on its posterior aspect, nearly obliterating its lumen, and reaching as far as an inch into the left external iliac. The condition is shown in the engraving from a photograph of the abdominal aorta. The clots between the coats was recent. The specimen is in the museum of St. Bartholomew's Hospital.

UNIVERSITY OF CHICAGO.—The erection of the first of the four buildings of the new biological school of the University of Chicago, to which part of Miss Culver's recent gift of 1,000,000 dollars (£200,000) is to be applied, has already been commenced. It is proposed to erect special buildings for zoology, botany, anatomy, and physiology respectively.

MEMORANDA: MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

THE TREATMENT OF CARBUNCLE.

QUITE twenty years ago Sir James Paget published his now classical lecture on this subject, in which he stated that "cases uncut heal more readily than those cut;" and further, that "carbuncles, if not divided, not infrequently suppurate only about their centres and slough only in their central parts, and the borders clear up by the softening and dispersion of the inflammatory products in them. In some cases they completely abort." It is my belief that, if seen before softening has taken place, resolution can generally be effected by pressure combined with the application of iodine, and that in any case this plan of treatment gives the best results obtainable. Iodine is, of course, a very old remedy, and has, I fancy, fallen into disrepute through an error in its mode of application. The weak tincture has been used instead of the strong liniment. It has possibly been somewhat the same with regard to pressure, for we are told in Holmes's *Surgery* that "the treatment by pressure (with plaster), as Dr. O'Ferrall prescribed, has fallen into disuse." It is doubtless in very many cases difficult to apply pressure effectively; but when the carbuncle occurs on a limb I can confidently recommend the following treatment: Paint the carbuncle and the skin immediately surrounding it freely with iodine liniment, and over this place a thick pad secured firmly by means of an elastic bandage. The immediate relief this gives is very marked, and the patient is able to go about his business as usual.

Peckham, S.E.

HENRY E. MABERLY, B.A., M.R.C.S.

FATAL CASE OF POISONING BY A.B.C. LINIMENT.

ON December 12th Mr. T. T. T., aged 75, about 10.50 p.m. went from his bedroom into an adjoining room with the intention of taking a bronchial mixture, but by mistake took hold of a $\frac{3}{4}$ oz. bottle containing equal parts of lin. aconiti, lin. belladonn., and lin. chloroform., of which he swallowed $\frac{3}{4}$ oz. before he discovered his mistake.¹ A relative at once administered an emetic of mustard and water.

I saw him at 11 p.m. with Mr. Ewart, and found him sitting supported on the side of the bed, retching violently. Only slight emesis had occurred. His face, which had an expression of extreme anxiety, was covered with a clammy perspiration, and was drawn and pallid. The pulse was full and regular. He complained of a burning sensation in the epigastric region and extreme suffocation.

I injected hypodermically apomorphine gr. $\frac{1}{8}$, which in 20 seconds produced emesis (very slight), and followed it by $\frac{3}{4}$ oz. of brandy with water. As violent retching continued without further emesis, another hypodermic was given, but failed to produce vomiting. His speech now became lost, and the arms and hands were in a state of clonic spasm. They rapidly became fixed tonically in an arched position in front of the chest, with the hands midway between pronation and supination and the thumbs flexed into the palm. The legs were flexed on the thighs and the thighs on the abdomen.

A hypodermic solution of digitalin, gr. $\frac{1}{50}$, was now given and a sinapism applied to the cardiac region, but nevertheless the pulse became feeble and irregular and the heart's action weak. He now became unconscious; the pupils were dilated and did not react to light, and there was no eye reflex. The lips were blue and the face livid, with frothing at the mouth. At this time, twenty-five minutes after the swallowing of the mixture, the radial pulse became imperceptible and the heart's action very irregular. The body and extremities were cold and clammy and the urine escaped involuntarily.

A hypodermic injection of 20m of ether was administered

¹ Quantity of aconitin in 3iv of lin. aconiti = $\frac{1}{2}$ gr.

Quantity of ext. bellad. alcoh. in 3iv of lin. bellad. = gr. xviii.

Quantity of chloroform in 3iv of lin. chloroform = 3ij

Largest therapeutic dose (according to B.P.) of aconitin, gr. $\frac{1}{10}$.

Largest therapeutic dose (according to B.P.) of ext. bellad. alcoh., gr. $\frac{1}{2}$.

Largest therapeutic dose (according to B.P.) of chloroform, mx.