dermal layers, causing desquamation of unhealthy epidermis and reproduction of a new covering, as observed in ichthyosis, psoriasis, dry chronic eczema, and also in some cases of myxœdema and cretinism.

Among its general effects I have found that in doses of 15 gr. daily it causes a pulse-rate of 120 to 140 per minute, which in different subjects may be either of high or low tension. But thyroid extract seems also to rapidly exhaust latent cardiac energy, for if the dose be unduly increased, or if the patient is not fully accustomed to it, then the heart soon tires, and the pulse, although still quick, is weakened so as to induce irritability, depression, and tendency to syncope. It is difficult to say whether increased excretory action be due to direct irritation of the secreting glands or from general increased blood pressure; possibly it arises from both.

In neither of the above cases did the temperature rise high; there was indeed a slight rise at the commencement of the treatment, but none in its later stages, although the remedy was given in larger doses, a result probably due to increased metabolism of the tissues, plus insufficient surface cooling, from the skin not acting in a normal manner, for when the skin became healthier there was no appreciable thermometric rise.

The action of thyroid extract on the nervous system in most of my cases has been depressing, patients complaining of feeling debilitated and low; but in a case of myxœdema in which I used it its action was the very opposite.

In the above cases the results are, I think, sufficiently encouraging to warrant a more extensive trial in ichthyosis, which has hitherto proved so intractable to treatment.

SKIN ERUPTIONS AND INFECTED WOUNDS.

By DAVID WALSH, M.D. EDIN.,

Physician, Western Skin Hospital, London.

THE short article by Dr. Stopford Taylor in the *BRITISH MEDICAL JOURNAL* for September 25th, 1897, calls attention to a point of importance not only in dermatology but also in general medicine. Briefly put, he presents a number of cases of dermatitis of varying type associated with septic inflammatory conditions of the skin, either of traumatic or non-traumatic origin. Such rashes, in his opinion, arise from the absorption of some morbid matter into the circulation. As that view tallies exactly with conclusions published some years since by the present writer, a few comments may perhaps have a suggestive or epexegetical value.

First of all there is of course the possible fallacy that the dermatitis may result from direct extension and surface inoculation of virus from the primary skin lesion. However, we find a large number of severe symptomatic rashes, such as those resulting from drugs and exanthems, where no such external inoculation could take place, and which therefore offer a strong analogy to Dr. Taylor's assumed absorption of septic matter. How the irritant is to affect the skin after its entry into the blood is not discussed by the observer in question. The present writer's theory is that the dermatitis results from direct inflammation of the skin by the excretion of a bloodborne irritant. A similar explanation would account for the skin phenomena met with in connection with certain drugs, exanthems, and various septic invasions. Moreover it would have a bearing upon the constantly accompanying injury to other organs of elimination as the bronchi, intestines, and kidneys.

Dr. Taylor mentions a case previously described by him¹ "of dermatitis of the eczema type beginning in a septic axillary wound, which ran an acute course, and was attended by universal exfoliation." His attention has doubtless been drawn to the curious skin eruption in a steer, described by Dr. Eddowes² at the Dermatological Society of Great Britain and Ireland. The beast had a septic operation wound, and was attacked by a severe desquamative dermatitis of the white parts of his body, while, curiously enough, the red were not affected. A white star on the forehead was not involved, a fact that Dr. Eddowes thought due to its not being licked by the animal. At the same time he compared the case with Savill's epidemic dermatitis. Of the latter disease, which presents a most important series of problems to the derma-

tologist, the present writer has spoken as "an epidemic dermatitis where the desquamative lesion has all the appearance of resulting from the cutaneous excretion of an intensely irritant product of obscure origin."³

At the end of his article Dr. Taylor asks⁴: "Do not the foregoing cases suggest to us that many skin affections which have been attributed to vasomotor disturbance and reflex irritation are due to the absorption of micro-organisms or their products either by the skin or alimentary tract?" The same question was asked by the present writer in 1890 at the Birmingham meeting of the British Medical Association in a paper entitled, *Dermatitis as an Excretory Symptom*.⁵ A comparison was then made between various rashes where the common feature was an inflamed skin and the presence of some bloodborne irritant, whether drug or specific virus. Whether or not the true etiology of symptomatic dermatitis may be ultimately found in excretory irritation, it is not a little curious that none of the existing theories are capable of explaining such every-day phenomena. So far as the present writer has been able to test his general conclusion by particular applications, it seems to afford a simple explanation to such varied rashes as those associated with scarlet fever and the rest of the exanthems, antitoxin and tuberculin injection, arsenic, iodine and a host of other drugs, gout, rheumatism, and with septic conditions of the body, local and general. In all these instances there is a marked tendency to vicarious inflammation of eliminating organs other than the skin, a disturbance which it is suggested may have been caused by the passage of an internal irritant through the essential cells of the excretory organs.

REFERENCES.

- ¹ *BRITISH MEDICAL JOURNAL*, 1892, vol. 1, p. 861. ² *British Journal of Dermatology*, p. 54, February, 1895. ³ *Excretory Irritation*, Walsh, 1897, p. 49. ⁴ *BRITISH MEDICAL JOURNAL*, September 25th, 1897, p. 805. ⁵ *Med. Press and Circular*, October 22nd, 1890.

NOTES ON FIFTEEN CASES OF INTUSSUSCEPTION.

By CHARLES P. B. CLUBBE, L.R.C.P. LOND.,
M.R.C.S. ENG.,

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In the 15 cases of intussusception that I now put on record, 8 recovered and 7 died. In 3 cases the intussusception was reduced by injection of oil without operation. In this series, then, there were 12 laparotomies, with 5 recoveries. In one of the cases that recovered, 4 inches of the small intestine was resected, and this in a child under 12 months. I have previously reported 7 laparotomies with 4 recoveries. Taking the operations in the two series of cases together, then, the figures are 19 cases, 9 recoveries, 10 deaths. The cases are given in the order in which they occurred.

CASE I.—E. G., aged 6 months, admitted to the Children's Hospital July 10th, 1895. History: Thirty hours ago screamed and turned pale. Passed blood eight hours later. Vomited several times. Under chloroform a tumour felt on the right side of the abdomen. Warm olive oil was injected, and the mass disappeared. In a few hours the child passed three motions; no vomiting. Child was discharged the next day, as it was not weaned, but it was kept under observation for several days, and remained quite well.

CASE II.—K. R., aged 5 months, admitted to the Children's Hospital October 6th, 1895. Child ill seventy-two hours. Attack began with screaming. Then vomiting, and soon after passage of blood. The child has been constantly vomiting and straining since, and passing blood and slime. On admission mass could be felt in rectum. The abdomen was opened in the middle line, and as it was impossible without undue violence to reduce the intussusception (which was caecum into colon) completely, the mass was resected and the ileum was sutured to ascending colon. The child died soon after the operation (which only lasted thirty minutes) was completed.

CASE III.—O. W., aged 1½ year, admitted to the Children's Hospital October 17th, 1895. Ill five days; constant vomiting; no motion for five days. On the second day of illness some slime and blood were passed once, but not again till to-day. On opening the abdomen intussusception was found to be a double one, ileum into ileum, and then this into the caecum. In reducing these intussusceptions the ileum was torn. The damaged part, about 6 inches of ileum, was therefore resected, and the cut ends of the bowel united with a double row of catgut sutures. The child only lived one hour after the operation was completed.

CASE IV.—E. C., aged 5 months, admitted to the Children's Hospital on July 30th, 1896. Began to scream two days ago, and soon vomited and passed a motion consisting chiefly of blood and slime. Under chloroform cylindrical tumour, extending boomerang-like, in region of hepatic

Texture of colon. Warm olive oil was injected, and the tumour was reduced partly by the oil, partly by manipulation. October 31st: The child seems quite well; has had several motions, no vomiting; discharged cured.

CASE V.—H. H., aged 13 months, admitted to the Children's Hospital September 6th, 1896, at 4 P.M. Child still at the breast. While sitting on the chair just before breakfast eight hours ago the child began to scream, which lasted for a long time. He vomited, and five hours afterwards he passed blood and slime. On admission pulse 160, temperature 100.2°, vomiting constantly. Under chloroform a mass can be felt in region of ascending and transverse colon. After an injection of olive oil the mass had left transverse, but could still be felt in ascending colon. Abdomen opened in middle line. The intussusception was found to be ileum into cæcum, and was easily reduced. The abdomen was closed and not drained. The child was very ill for three days after the operation, with high temperature and quick pulse, but ultimately made a good recovery, and was discharged cured.

CASE VI.—L. T., aged 5 months, admitted to the Children's Hospital September 25th, 1896. Ill three days. The child seemed dull, and then vomited. Was given castor oil, and then in six hours it passed some blood. It has been vomiting ever since, and passing blood and slime. After two days it was taken to a doctor, who prescribed medicine, which the child vomited. Child seems in pain, and draws its legs up. The child was pale on admission, looks very ill; pulse 144. Per rectum a cylindrical body can be felt with tip of finger. A sausage-shaped tumour was felt in left iliac and lumbar regions. Abdomen open in middle line. Intussusception, which was cæcum into colon, was reduced with great difficulty, and the serous coat was torn in several places. The child died twelve hours after the operation, in spite of injections of strychnine and digitalin.

CASE VII.—P. McD., aged 11 months, was seen for the first time by Dr. Wood, of Ashfield, September 19th, 1896, at 9.30 P.M. I am indebted to Dr. Wood for the following history and notes: "September 19th. The child was being played with by its parents in bed this morning when it suddenly screamed and then seemed to be faint. In about ten minutes it rallied. Soon afterwards it had a motion and vomited, and has vomited a good deal during the day, and has had three small motions all tinged with blood. No swelling could be felt, abdomen not tender. An enema was administered, which was shortly afterwards returned, faecal stained. Warned parents that there might be obstruction and probably intussusception. Sunday, September 20th: Seen twice; both times enemata given; bowels open twice; motion slightly bloodstained; vomiting nearly all day; temperature 100°, pulse 90. Monday, September 21st: Abdomen rather tympanitic; vomiting, bowels acted three times, slightly bloodstained; pulse 92, temperature 100°. Tuesday, September 22nd: Vomiting ceased; abdomen somewhat distended. Wednesday, September 23rd: Vomiting slight; two bloody discharges from bowels; abdomen more distended; temperature 99.6°, pulse 94. Thursday, September 24th: Two enemata; after second one a small quantity of faecal material came with flatus; this seemed to give relief to child; abdomen less distended; temperature 99.5°, pulse 96. Friday, September 25th: Child not so well; abdomen more distended; nothing to be felt; two discharges of brightish blood from bowels; temperature 99.8°, pulse 100. Saturday, September 26th: More tympanites; more general distress; bowels not moved; no flatus passed for last twenty-four hours. Sunday, September 27th: Abdomen very distended. Parents agreed to a consultation with a view to an operation."

I saw the child for the first time on the evening of this the eighth day of the trouble. Was a good colour and did not look very ill. It had not vomited much during the day. Its abdomen was a good deal distended, therefore I did not expect to be able to make out anything by palpation without an anæsthetic. Its pulse and temperature were under 100. Under the circumstances I did not think we should be risking much to postpone the operation for twelve hours, when we could get everything properly prepared for a laparotomy. Monday, September 28th, 8 A.M.: The child slept well, has not vomited much.

Dr. Coultie gave the anæsthetic, and I was assisted by Dr. Wood. Under the anæsthetic I could feel a tumour on the right side of the abdomen. I opened the abdomen in the middle line, and found that the tumour was an intussusception of the ileum into the cæcum. The small intestines were much distended, and could not be kept in the abdomen. The intussusception was not easily reduced, and as it was unfolding I could hear and feel that the bowel was tearing. After the reduction was completed I found that a portion of the ileum near the cæcum was torn in several places. So much so, and so irregularly, that I felt it would be useless to attempt to mend it by sutures. I therefore decided to resect the damaged portion of the ileum. I used drainage tubing held by pressure forceps as clamps, and removed about four inches of the ileum. The cut ends were brought together by means of a double row of fine catgut continuous sutures, starting each time from the mesentery. The ends of the one suturing the mucous membrane were turned in. No button or bobbin was used because I did not have one with me. When the joining together was completed the gut was much narrowed at that spot. Before the intestines were returned they were washed with 1 in 2,000 perchloride of mercury. As the intestines were so much distended with gas there was some trouble in returning them to the abdomen, and a good deal of strain was necessarily put upon the sutured ileum. The abdomen was closed in the usual way, a drain of iodoform gauze being left just inside the abdomen. The child was very collapsed at the completion of the operation. It was given strychnine hypodermically, and brandy into the bowel. Strychnine was continued at intervals during the day, and it was fed by nutrient enemata; brandy by mouth. Dr. Wood's notes now say: "September 30th. Some black offensive material was passed by the bowel at 1.30 to-day. After this there was a slow but steady improvement, and the child was well in fourteen days. As regards drugs, no opium was used in this case throughout, either before or after the operation. This child since that time has had a desperate attack of gastro-enteritis, and was reduced to a skeleton, but has now quite recovered."

CASE VIII.—A. B., aged 8 months, admitted to the Prince Alfred Hospital, October 31st, 1896. Ill ten days. Began to vomit two days ago. Has passed no motion but blood and slime. This evening vomit has been of faecal character. Abdomen distended. No definite tumour to be made out. Under chloroform, abdomen opened and an intussusception of

ileum into ileum was found. Intussusception was very dark, and had lost its lustre. It was reduced after some trouble, and there was some difficulty in returning the intestines to the abdominal cavity. The child never rallied and died in six hours.

CASE IX.—V. R., aged 15 months, admitted to the Children's Hospital, November 5th, 1896. Was taken ill suddenly seven hours ago, and seemed to be in a great deal of pain. In two hours it started vomiting, and two hours after that it passed blood. Under chloroform a tumour could be felt in right hypochondrium. Warm olive oil enema was given and the mass disappeared. November 6th: Has not vomited since the injection. Passed a good night, and seems very well. Has had five motions. First four contained a little blood. Discharged cured.

CASE X.—G. C., aged 5 months, admitted to the Children's Hospital, November 9th, 1896. History.—Always constipated, had a motion fifty-two hours ago, and then was suddenly seized with pain and screamed. No motion since, but has passed blood and vomited several times. On admission condition fair, pulse somewhat rapid, temperature 100°. Has had a large loose motion consisting of fine curds, faecal matter, mucus, and some specks of blood. Under chloroform sausage-shaped mass felt in right lumbar and hypochondriac regions. Olive oil injected; as tumour did not disappear abdomen was opened in the middle line. The intussusception was cæcum into colon, it was reduced with great difficulty and the bowel was torn. The tear was closed with Lembert's sutures. The child never got over the shock of the operation, and died in three hours.

CASE XI.—R. W., aged 10 years, admitted to the Prince Alfred Hospital, January 17th, 1897. He was put in one of the medical wards. Ill three days. Patient states that he was pulling a cart when he suddenly felt an acute pain in his abdomen. Since then there has been spasmodic attacks of pain coming on at intervals of thirty minutes. Has vomited. On examination a small elastic tumour can be seen and felt on the right side on the level of the umbilicus. January 19th: Pains gone, no tenderness, bowels opened by enema. January 20th: Vomited several times last night and to-day; bowels not open. An elongated tumour can be felt extending transversely across the abdomen immediately below umbilicus. Suffers from attacks of pain. The abdomen was opened at 4 P.M. A small and easily-reducible intussusception was found, consisting of cæcum into colon. The wall was thickened and hard, and tended to reinvagination after reduction of the intussusception. The portion at which the invagination had commenced looked dark and unhealthy, and there was a dimpled patch over which some omentum was drawn and fixed with a few catgut sutures. The abdomen was closed in the usual way, a Morrison's drain being used. The boy's condition gave rise to considerable anxiety for the first three days after the operation. He had a considerable amount of pain; vomited a good deal. His pulse was very rapid, without much rise of temperature. He was fed on Mellin's food and water, and white of egg and water; was given some digitalin hypodermically. His bowels were moved on the second day by enema. After this, these unpleasant symptoms gradually subsided, and the boy made a good recovery and was discharged cured, February 17th.

CASE XII.—S. M., aged 15 years, admitted to Prince Alfred Hospital February 3rd, 1897. Two days ago was seized with a sudden pain on the right side of the abdomen. The abdomen shows a distinct fullness over the right iliac fossa, extending across to the left below umbilicus. Here, also, a sausage-shaped swelling can be felt. Under anæsthetic the abdomen opened in the middle line. The cæcum was found to be intussuscepted into the colon about 3 inches. Was easily reduced. The cæcum was thickened, hard, and congested. The vermiform appendix was inflamed, and was therefore removed in the usual way. The boy made an uninterrupted recovery, and was discharged cured on March 3rd.

CASE XIII.—R. H., aged 7 months, admitted to the Children's Hospital March 22nd, 1897. Ill thirty-six hours. Passed a motion with a great deal of straining, and then only blood and slime. Began to vomit fourteen hours ago. Abdominal wall tense. Tumour of ill-defined outline can be felt in the lower part of the abdomen. Mass can be felt in rectum. Abdomen opened, and then intussusception, which was cæcum into colon, was reduced with difficulty. The appendix appeared gangrenous, and was removed. The serous coat of colon, which was torn in several places, was brought together with fine catgut sutures. The child died five hours after the operation.

CASE XIV.—H. P., aged 8 months, admitted to the Children's Hospital, April 23rd, 1897. Six hours before admission began to scream, then got faint; soon afterwards passed blood and mucus. An elongated tumour can be felt in the abdomen in region of transverse colon. Under chloroform olive oil was injected, this made the tumour disappear. As I was not certain that the intussusception was completely reduced I opened the abdomen. About 6 inches of the ileum next the cæcum was found congested but there was no intussusception. The abdomen was closed, a small gauze drain being used. 26th. Takes food well; has passed a fairly normal motion; temperature 100°, pulse from 130 to 170; temperature rose gradually during the day to 105°, pulse 180; erythema appeared on body; wound looks healthy; abdominal wall moves with respiration. 28th. Had a convulsion and died at 4 P.M., sixty hours after the operation.

CASE XV.—S. H., aged 5 months, admitted to the Children's Hospital, July 23rd, 1897, 1.30 P.M. Child perfectly well going to bed last night; awakened 3 A.M. screaming; between this time and 4.30 A.M. he continued sleepless and in pain. At this time was given castor oil. At 5 A.M. passed about two teaspoonfuls of blood. Had a fairly natural motion after this; since then he has continued to pass mucus and blood; child looks ill; eyes sunken. 3 P.M. Under chloroform a definite tumour can be felt on left side of abdomen about the level of umbilicus. About half a pint of warm olive oil was injected, buttocks being raised. No tumour could now be felt, so the child was now sent back to bed. 10 A.M. As no motion had been passed the child was again put under chloroform but no tumour could be felt. 24th. Passed a good night; has had a definite motion of the bowels this morning at 10 A.M. Did not scream or appear to be in pain; the motion was dark yellow, and contained traces of blood and mucus. 12 noon. Tumour again felt in left lumbar region. 3 P.M. Under ether and chloroform abdomen opened after an injection of oil had been given to partially reduce invagination. Intussusception found to be cæcum into colon; reduced without difficulty; gauze drain used just inside abdomen; given morphine, gr. $\frac{1}{16}$; slept fairly; morphine repeated at 10 P.M. 25th. Temperature 103°, pulse 172; taking Mellin's food, one

teaspoonful in 2 ounces of water every two hours. 10 P.M. Pulse and temperature gradually fell during the day. Drain, which had acted well, removed. 26th. Bowels opened twice naturally. From this time the child made an uninterrupted recovery. It was fed from the mother's breast during the day until it was discharged, cured, August 13th.

REMARKS.

These cases show that we must not give up rectal injections. In a certain number of cases the intussusception can be reduced by this means even when used a considerable time after the onset of the attack. In Case I the child had been ill 30 hours, Case IV 48 hours, and Case IX only 7 hours. I wish to emphasise this because Mr. Owen, in the current *Yearbook of Treatment*, in his very kindly notice of my previous paper, remarks "that we shall probably obtain better results if we altogether discard the treatment by rectal injections." In Case XIV I opened the abdomen after using an oil injection because I fancied I could still feel a small hard mass. As it turned out I was wrong, and should have done well to have waited, for I found that the intussusception had been completely reduced; and the child unfortunately died in 48 hours of sepsæmia as the result of the abdominal section. The injections, if they are to be of any use, must be given intelligently. An anæsthetic must be given, the buttocks must be raised, and warm olive oil injected by means of an ordinary enema syringe. If the anus is held around the nozzle of the syringe, very considerable pressure can be exercised on the column of oil. Common sense must tell us how much pressure to put on and when to desist. The amount of pressure could be accurately measured by allowing the oil to run in of its own weight from a special apparatus, but this is not always at hand. After apparently reducing the intussusception by injection, be careful not to lose sight of the child for a few days even though the symptoms disappear, and it passes a natural motion. The intussusception is very liable to recur. Case XV is an example of this. I think injections of warm oil should be given in all cases after the child is under the anæsthetic, even in cases of long standing when we know that it is impossible to complete the reduction by this means. My reasons are these: It always reduces the intussusception to a certain extent, and in the best and gentlest possible way; and in this way lessens the shock of the coming operation, because it lessens the manipulation of the intestines. It is especially useful in those cases in which we find the intussusception in the rectum; because if we do not use it we may find some difficulty in getting our fingers below the tumour to begin the squeezing process. After opening the abdomen in cases of long standing, where we find that the intussusception stops moving to gentle pressure, I think it would probably be better to resect at once. One can nearly always reduce these intussusceptions if we take time and use considerable pressure; but after this prolonged manipulation, which must add enormously to the shock, we probably find when the reduction is completed that the bowel is torn so much that we have no alternative but resection, which we now have to do under the worst possible conditions. I feel sure that in these bad cases we shall get better results by resecting directly we find that force must be used. I am strongly in favour of draining in all these cases by means of a small gauze drain surrounded by a piece of gutta-percha tissue placed just within the abdominal cavity; this can generally be removed in twenty-four hours.

MEMORANDA:

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

A CASE OF PULMONARY CARCINOMA.

I was called to see on January 26th, 1897, a married woman, aged 49. Her illness commenced on November 5th, 1896, and she attributed it to catching cold. Her earliest symptoms consisted of shivering, shortness of breath, and a troublesome cough; about a fortnight afterwards her face and neck swelled up and became very tender; she gradually got worse, the cough becoming more troublesome and the expectoration more purulent and blood-stained.

When I first saw her she was downstairs suffering from severe dyspnoea, with cough and muco-purulent expectoration, which contained a good deal of blood mixed with it. Examination of the chest revealed dullness from the supra-sternal notch for about 3 inches and a-half below and to the right, and an inch to the left; very little air entered the right apex, and there was also tubular breathing at the left base; there were also rhonchi over both lungs. The cardiac sounds were normal, as also was the temperature, and she complained of no pain.

She improved a little with rest in bed, but on February 12th phlebitis of the left subclavian vein came on; this gradually subsided under treatment, and for about six weeks she showed signs of improvement. Her appetite returned, and she got up, and even ventured downstairs, expressing herself as feeling better and stronger. The dullness at the apex remained the same, but the tubular breathing at the left base disappeared early in April.

After this she got steadily worse, the dyspnoea and cough became very spasmodic, and she suffered from pains darting up and down the spine. She died on May 20th, and shortly before her death the breathing at the right base became tubular, and both feet and legs oedematous.

The *post-mortem* examination revealed a cancerous mass as large as a cocoanut, occupying the middle and posterior mediastinum, extending along the root and into the substance of the right lung; there was also evidence of recent bronchopneumonia of the left base, but the other organs were healthy, though congested.

Enfield, N.

G. GREENWOOD, M.R.C.S., L.R.C.P.

A CASE OF SEPTIC PNEUMONIA.

The following case of undoubted septic pneumonia seems worth recording:

C. H. H., aged 71 years, had been suffering from spinal paralysis for three years, and was in very feeble health. On September 25th he had a rigor, his temperature was 103° F., and the respirations 60. The following morning the right lung was almost entirely consolidated; he was scarcely conscious, and was breathing stertorously. I removed a dental plate from the upper jaw, and a gangrenous condition of the mucous membrane of the hard palate revealed itself; the stench was horrible beyond description. There is no doubt that the poison he had been inhaling and swallowing was the cause of the pneumonia. His manservant, who had been in his service for several weeks, said he was certain that the plate had never been removed during that time. Death took place in less than three days from the beginning of the attack, the temperature reaching 108° before the end.

South Kensington.

ARTHUR TROWER.

REPORTS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF LONDON.

J. F. PAYNE, M.D., President, in the Chair.

Tuesday, November 2nd, 1897.

EMPHYEMA OF THE ANTRUM IN A CHILD.

MR. D'ARCY POWER recorded a case of the above, which was a condition rarely met with. The child was 8 weeks old, and came under observation with an abscess discharging below the right eye. Delivery had been effected with forceps, much bruising having resulted. When a month old the right cheek swelled, suppuration ensued, and then extensive necrosis of the upper jaw. Death took place ten days afterwards. One case of a similar nature had been recorded by Dr. Owen Rees in the *London Medical Gazette*; in this instance birth took place with the face to the pubes, and to this Rees ascribed the injury which led to the suppuration.

MR. W. G. SPENCER had seen one example of antral emphyema associated with noma; death was due to septic pneumonia.

A CASE OF ACROMEGALY WITH AN ANALYSIS OF THIRTY-FOUR RECORDED EXAMPLES.

MR. PERCY FURNIVALL reported the case of a man, aged 58, who had complained of numbness, weakness, and trembling,