during the day, still helping himself with two chairs. Ordinary sticks did not afford sufficiently firm basis to support him, so I had two straight sticks constructed, with a basis to each like a small plate.

On May 5th, 1899, he was walking about the ward by the help of one of his sticks and a chair.

CONDITION OF PATIENT MAY 20TH, 1899.

Left Side.

Hip-joint.—There is fair power of flexion of hip-joint and possibly a very slight power of extension, but the latter doubtful.

Knee-joint.—There is fair power of extension of left knee-joint, so that the leg can be held straight out in the air. There is no power whatever to flex the left knee-joint. An appearance of this movement is produced by flexing the hip-joint when the leg at the knee-joint naturally bends owing to gravity, but if the femur be fixed no flexion at knee-joint can be produced.

Ankle.—No movement whatever at ankle-joint, foot in position of moderate "varus."

Right Side.

Hip-joint.—There is slight power of flexion of hip-joint present, but less than on left side. There seems to be very slight power of extension, but this is doubtful.

Knee-joint.—No movement.

Ankle.—No movement.

Anæsthesia.—Total anæsthesia on right side up to groin, on left side up to level of about 3 inches above knee-joint.

Reflexes.—Knee-jerks and plantar reflexes absent.

Nutrition.—Wasting of both limbs below knee-joint.

By comparing the report of this patient's condition before the operation with that taken on May 20th last, it will be seen that as far as the muscular system is concerned the improvement depends chiefly or entirely upon greater power of muscles which were not at first absolutely paralysed. The only movement that the patient performed voluntarily before the operation was lifting the left leg slightly, so that the increase of power in the muscles as above described has been very great. The chief improvement in nerve power has been the partial restoration of the functions of the bladder and the better nutrition, shown by the healing up of the bedsores. The improvement in general health is also very considerable, for whereas the patient appeared to be rapidly sinking at the time of his admission to the City Orthopædic Hospital, he is now in fairly good health, is cheerful, and enjoys life.

Subsequent History.—In August, 1899, this patient went to the seaside for a change. The rules of the institution where he was received did not permit him to take as much rest as he had been accustomed to. The bath chair which he was permitted to use was furnished with a hard seat, and bedsores, which had healed long previously, returned in the old places. He begged to be allowed to remain in bed so that these sores might heal, but this request was not acceded to. He returned to London in an emaciated condition, the bedsores suppurating freely. His temperature varied from 100° to 103°. There was constant irritation in the bladder, although it was washed out frequently. With perfect rest and careful attention he began to recover again, but uræmic poisoning supervened, and while semiconscious he wounded himself seriously with his razor, cutting deeply in the hypogastric region, but without wounding the bladder, bowels, or large vessels. He succumbed the next day to uræmic poisoning and exhaustion.

Early operation, before his kidneys had become affected, would probably have led to a much more satisfactory result.

CASE OF SYPHILITIC DISEASE OF THE HEART AND LIVER: SUDDEN DEATH.

By SURGEON PERCIVAL M. MAY, R.N.

The following case is of some interest, as cases in which the heart is implicated in acquired syphilis are comparatively rare:

J. A., aged 30, A.B., was admitted into the sick bay at the Royal Naval Barracks at 8 A.M. on June 22nd. He complained of intense pain in the front of the chest and constant vomiting. He stated that he felt quite well the previous evening, but that the symptoms came on in the night. His extremities were cold, his complexion pallid, and his expression anxious. The pulse was very slow and full, the respirations were shallow. He was constantly coughing and expectorating frothy sputum, and he vomited three or four times. On auscultation moist râles were to be heard on both sides of his chest in front, but the heart sounds could not be distinguished at all. He was ordered turpentine stupe to the chest, with hot bottles to the extremities, and was given ether and strychnine, but without any improvement in his condition. He sank rapidly, and died a little over an hour after his admission.

A *post-mortem* examination was made some twenty-four hours after death. The body was that of a well-nourished man, and there were no marks of any scars anywhere. Rigor mortis was well developed. The thoracic cavity was first examined, and the pleura was found to contain a considerable quantity of blood-stained serous fluid. There were no pleuritic adhesions. The lungs were bulky, heavy, deeply congested, and when cut into a large quantity of blood-stained serous fluid exuded. The pericardium contained a slight excess of pericardial fluid, and near the apex of the heart were some patches of recent lymph. The heart was

found to be dilated and hypertrophied; it weighed 21 ounces. The right ventricle was much dilated, and the right auriculo-ventricular valve was incompetent. In the left wall of the right ventricle, at its upper part, and between the two ventricles was a hard, yellowish-white, irregular, nodular mass, about the size of a pigeon's egg, situated in the muscular fibre of the heart, and infiltrating its substance. The growth was firm; when cut into the surfaces gaped, and could not be scraped away with a knife. There was also a small nodule about the size of a pea occupying one of the pulmonary semilunar valves. This growth, together with the small nodule, must have caused considerable obstruction to the flow of blood through the pulmonary artery. The right auricle was also hypertrophied and dilated, but the hypertrophy was not very marked. The left ventricle was dilated and somewhat hypertrophied, and the left auricle slightly dilated.

The arch of the aorta was the subject of an acute aortitis, the inner coat being much inflamed. At the cardiac origin and extending upwards for 2 inches the aorta was much dilated and its coats much thickened. The inner surface was covered with numerous broad greyish white patches, which were slightly raised, hard and somewhat gelatinous looking. Here it seemed that the endarteritis was of a more chronic nature.

The liver was hard and large, weighing 65 ozs. There were many scar-like depressions and puckered cicatrices to be seen on the surfaces, and these on being cut into showed yellow, tough circular masses, some of these being of large size.

The spleen weighed 8 ozs. and was healthy, and the remaining organs were found to be perfectly healthy.

Examination of a microscopical section of the tumour in the heart proved it to be a typical gumma, showing small round cells with an intercellular substance infiltrating the muscular tissue of the heart. There was also some slight caseous degeneration.

There was a well-marked previous history of syphilis in this case, the patient having become infected in June, 1889, with secondary manifestations in July and October in the same year, so that it was exactly ten years from the initial infection to the period of occurrence in the heart. This corresponds with the mean time of occurrence in 18 cases, recorded by Grenouiller. As regards the situation in the septum ventriculorum, only 2 cases have been previously recorded, 1 by Julien and 1 by Wilks; these were from a collection of 19 cases; of the remainder, 8 were in the right ventricle, 3 in the right auricle, and the rest in the left ventricle. No symptoms were noted in this case before the sudden death revealed the condition of the heart, and this appears to be the usual thing in syphilitic diseases of the heart.

A CASE OF POISONING WITH LIQUOR MORPHINÆ HYDROCHLORIDI: RECOVERY.

By HORACE C. COLMAN, M.B., C.M. EDIN.

Broughtly Ferry, N.B.

THE following case is an instance of poisoning with morphine hydrochloride, due to the taking medicinally of a little over a grain in rather less than twenty-four hours:

A phthisical patient, on account of hæmoptysis, was directed, on the morning of August 4th, 1899, to take 20 minims of the liquor morphinæ hydrochloridi every four hours. At 4 A.M. on August 5th I was sent for, and found him in the following condition: He was quite unconscious, the pupils were moderately contracted, but not pin point. His skin was warm, and of an earthy colour, and he was sweating profusely: his lips were extremely pale. The conjunctival reflex was lost. Respiration had almost ceased; at intervals there were one or two gasping respirations, and then a long period of quiescence. The pulse was 90 to 100, and full but not very soft. I found from his wife that he had taken four doses of the medicine I ordered, and had insisted on taking a dose of a mixture containing morphine that had been previously prescribed, the last dose being taken at 11 P.M. At that time his wife said he seemed to be drowsy, but was quite sensible. The noise of his breathing woke her up and alarmed her about 3.45 A.M. There seemed to be no doubt that he was suffering from opium poisoning, and, seeing that five hours had passed since the last dose had been taken, it seemed useless to wash the stomach out. At 4.10 A.M. I started artificial respiration, and gave him gr. $\frac{1}{10}$ each of strychnine and atropine hypodermically. There was slight improvement in the pulse after this, the sweating ceased, and the pupils dilated a little. Artificial respiration had to be continued, as if stopped the cyanosis, which was not present at first, became worse, and the pulse-rate quickened. From 5.30 A.M., with the assistance of Dr. Bruce, artificial respiration was continued until 7.45 A.M. In spite of whisky, m xxx hypodermically twice, and continued artificial respiration, there was no improvement, but rather the reverse. The failure of respiration seemed to be the most urgent, and I determined to try the inhalation of strong ammonia. A bottle of 0.80 ammonia was held to his nose for two artificial respirations. The patient became almost black in the face, and his body gave a convulsive heave. The cyanosis passed off in a few minutes after gr. $\frac{1}{10}$ of digitalin followed shortly by gr. $\frac{1}{10}$ of strychnine and gr. $\frac{1}{10}$ of atropine. From this time on there was some improvement—namely, when artificial respiration was stopped; he took a few good breaths, though they soon ceased. I repeated the administration of ammonia, holding the bottle further from his nose, with much the same effect as before, though milder. At 7.45 A.M. he began to breathe naturally, and there was an occasional flicker about his eyelids. We were now able to obtain some coffee, and I poured 10 ozs. of very black coffee with $\frac{1}{2}$ oz.

whisky down the stomach tube, which was followed by very rapid improvement. At 8.30 he was a natural colour and breathing steadily; although very dazed, swallowed some beef-tea from a spoon about 9 A.M. At 10.30 A.M. he was practically recovered, except that his accommodation seemed paralysed, and his tongue and throat very dry, doubtless from the atropine.

I was able practically to exclude the possibility of an attempt at suicide or error in dispensing, and I estimated the total amount of the morphine salt he could have had in the day was just over 1 gr. (m 110 = 1 gr.). In the three days before he had been given 3 drachms of liq. morphinæ for a previous hæmoptysis. It seems hardly likely that a slight increased dose would be sufficient to poison him, but it is difficult to explain the occurrence. Possibly the employment of an active aperient the night before may have suddenly increased the absorbing power of the alimentary canal, and that thus some of the previously-administered morphine may have been rapidly absorbed in addition to the larger doses he was taking during the succeeding twelve hours.

The points of interest in the treatment were, first, the marked beneficial effect of inhalations of strong ammonia, a means I have not seen recommended before, but which I shall certainly try again if occasion offer. Secondly, the well known stimulant and antidotal effect of strong coffee, which in this case was not used till very late owing to our inability to obtain it. Thirdly, that $\frac{3}{8}$ gr. of atropine in two doses gave very marked symptoms of belladonna poisoning.

The patient had no return of the hæmoptysis, and was very soon at work again.

MEMORANDA:

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

ANOTHER UNUSUAL CASE OF BLOOD-POISONING.

I BEG to forward you, for publication, the following short report of a case which may be of some interest to the readers of *Some Unusual Cases of Blood Poisoning*, as contributed to the *JOURNAL* of July 8th by Dr. T. Harris.

The patient, aged 30, was confined of her third child on the morning of July 28th. The baby was born half an hour after I entered the house, the nurse not having arrived. Two vaginal examinations were made, as by the time I reached her the head was pressing on the perineum. The placenta was expressed twenty minutes later, and came away, with the membranes, apparently intact. There was the merest tear in the perineum.

Everything went on well for a week, save for some little trouble with one breast in which there had been an abscess. The bowels moved naturally on the third day, and daily thereafter. Once an enema was given. The lochial discharge was quite moderate, as it always was after her confinements, I was informed. No douches were used. Once the thermometer registered 99°.

On the eighth day I was surprised to find the patient enveloped in all the blankets in the house and a pillow on her feet. The nurse told me that she had "caught a chill" by not covering herself up at night. There was some nausea, her face was flushed, and urination "scalded" her. Temperature 104, pulse 130. No abdominal tenderness, even on deepest pressure, and no tympanites.

Quinine in an alkaline mixture was given. The lochial discharge was, as usual, quite inoffensive and light in colour.

The same evening the temperature had fallen, 100.4. pulse 100. Next day, August 5th, the thermometer registered 104.6, pulse 140. A vaginal examination was made, the uterus was freely movable, no tenderness on bimanual pressure, os patulous, perineal tear completely healed. A good douche was given, vaginal and uterine. At 5 P.M. the temperature was 105.6, pulse 140. Breasts had been opened two or three times. Breasts somewhat tender. She was stripped, and I gave her a tepid sponge, which lowered the temperature 1° and the pulse 20 beats, and she fell asleep.

At 9 o'clock the same evening, in conjunction with my colleague, Dr. Weld, she was anaesthetised, placed in the dorsal position, the vagina properly cleansed, and the os uteri dilated. On passing the finger into the uterus, which was some $\frac{3}{4}$ inches long, the anterior wall and fundus were felt smooth and hard. On the posterior wall was the placental site elevated and boggy. This was carefully everted with the flushing spoon, and some small shreds of placental tissue removed, which to all appearances were perfectly sweet and

sound. The uterus was washed out with plain sterilised water, and the patient put back to bed. Three or four hours after the operation the temperature ran up to 106°.

At 9 o'clock next morning it was 100, pulse 100.2. She was resting easily, and taking nourishment well. The same evening the temperature was 100.2, the next day normal, and in a week the patient was out of bed.

The points to which I wish to draw attention are:

(1) The entire absence of any symptoms indicative of a uterine source of trouble, in which particular it resembles Case III reported by Dr. Harris.

(2) The advisability of regarding all serious or prolonged rises in temperature in the puerperal state, which cannot be accounted for by some definite evidence, as uterine in origin, and of acting swiftly on that decision. Try the douche first, and if that fails of speedy betterment use the curette.

And if we fail to do good we cannot do harm if careful and aseptic, but I maintain that in 99 per cent. of such cases nothing but good will result.

Vancouver, B.C.

J. M. PEARSON, M.D.

A CASE OF SNAKE BITE TREATED BY DR. CALMETTE'S ANTIVENENE.

THE patient, a strong Canarese coolie, aged 26 years, was bitten by a cobra on the right ankle, behind and just above the internal malleolus.

He rapidly became unconscious, and was brought to the surgery about one hour after being bitten. When seen he was in a state of collapse, but could be roused, when he complained of pain at the seat of injury, the marks of which were quite distinct. The pulse was thready and rapid, and surface of the body cold.

The wound was rapidly incised, until blood flowed freely, and pure nitric acid applied. He was then given an injection of 10 c. cm. of Calmette's antivenene deeply into the right flank.

Stimulants were given, and he was kept under observation for some hours, during which gradual improvement set in, though the man still remained very drowsy, and the pulse was weak and fast. When he attempted to walk the paresis was very marked, and he was removed to his lines. On visiting him some hours afterwards I found he could walk without assistance, but staggered, and complained of weakness and pains in both legs and slight diarrhoea.

He was then ordered a mixture of ammonia and nuxvomica every four hours, with strong soup and brandy every two hours.

As his surface temperature remained very low he was wrapped in blankets, and hot stones placed round him during the night.

Next morning he was much improved, and this was maintained; the paresis gradually wore off, the pulse steadily gained strength, and he returned to work four days after quite recovered.

The cobra was full grown, measuring 51 inches. The time which elapsed before the patient was seen is, perhaps, against his having received a very large dose of venom, but being a strong healthy coolie his resistance was probably great.

A few days ago a coolie was reported to me as having died a few minutes after being bitten by a snake which was not identified, and occurrences like these point to the necessity that every government or private dispensary should be supplied with antivenene, which is certainly the best remedy for snake bite available.

ARTHUR BEVERIDGE, M.B., C.M.

Surgeon S. Coorg Medical Fund.

AN ADULT INFESTED BY OXYURIDES FOR OVER TWELVE YEARS.

THE medical man who is consulted by an adult patient suffering from the presence of the parasite, oxyuris vermicularis (thread, or seat worm) often finds himself confronted with one of those problems which, whilst seemingly most easy of solution, are really most trying and worrying.

The patient, who has been under careful observation during the entire period, first complained of intense irritation at the anus in 1884, when he was over 20 years of age. Knowing little or nothing of intestinal parasites he consulted a physi-