ploratory puncture was made, with every antiseptic precaution, the result being that perfectly clear, pale yellow fluid was obtained. For the next day or two there was a slight increase in the effusion, then for about three days it was stationary, the condition of the patient being satisfactory until August 5th, the seventeenth day of illness and the sixth from the diagnosis of the effusion; he then sweated a great deal during the night, and the appetite, which was improving, again fell off. The temperature was found to be 103°. As this state of things continued without any appreciable alteration in the physical signs, the exploring syringe was used again on August 7th, and this time pus was drawn off; aspiration was at once performed, and 8 ounces of pus obtained. From this time the recovery was good, and when the boy was examined eight months afterwards there was no difference between the two sides of the chest.

CASE II.—F. C., aged 7, a tall, thin girl, was taken ill suddenly September 26th, 1891, the initial symptoms being severe, the temperature going up to 105°. Physical examination did not reveal anything beyond rather harsh breath sounds, but on the third day some patches of consolidation were made out in the left lung, and for the next week the case ran the ordinary course of a broncho-pneumonia, the temperature gradually coming down to below 100°. On October 4th, the eighth day of the illness, the dulness at the left base was more general. As this increased an exploratory puncture was made the next day, perfectly clear fluid being drawn off. Two days after this the temperature fell to normal, and remained down for a week, but on October 11th it suddenly rose to 102°, and as it remained high for the next few days the exploring syringe was inserted again, and this time pus was found. The chest was aspirated on October 16th, the twentieth day of illness and the twelfth from the recognition of the effusion; 8 ounces of pus were obtained. After the aspiration the temperature fell to subnormal, and the child made a satisfactory recovery; three exploratory punctures made on October 28th, ten days after aspiration, all failed in finding any fluid whatever.

An interesting point in this case was that although aspiration was performed within a fortnight of the effusion becoming manifest, there had yet been time for some adhesions to form as evidenced by the flattening of the chest and a slight lateral curvature. As these adhesions in children frequently give way in the course of time, it was thought that this result might be hastened by a course of exercise; so as soon as the child was able to bear them she practised the extension motions of drilling, suspension, dumb bell exercises, and Busch's exercise for lateral curvature with the most satisfactory result, a cyrtometer tracing taken six months after showing almost perfect symmetry between the two sides.

MYELOID SARCOMATA OF UPPER AND LOWER JAWS: PARTIAL EXCISION OF LOWER, AND COMPLETE EXCISION OF RIGHT UPPER JAW.

By ALFRED PARKIN, M.S., M.D.LOND., F.R.C.S.,
Senior Assistant-Surgeon to the Victoria Hospital, Hull.

F.M., aged 3½, was admitted into the Children's Hospital on October 21st, 1891, for a large swelling in the floor of the mouth. No family history of importance. Had always been a strong healthy child, except for a few infantile complaints, until nine months before admission, when a swelling appeared above the front upper teeth, on the right side of the face. The swelling came without obvious cause, grew gradually to its present size, and was painless; it gave rise to no inconvenience except a slight deformity. Six months ago a second swelling appeared in the front of the lower jaw, and grew rapidly, displacing the teeth in its growth. Lately this swelling has begun to bleed, and from time to time a good deal of blood has been lost from it.

Upon admission there was a firm elastic swelling in front of the lower jaw, causing the lip to protrude, projecting backwards into the mouth, being only slightly prominent when the mouth was closed. It was oval in shape, and did not involve the floor of the mouth, but on account of its extending backwards for about 1½ inch, it so pressed up the tongue to the roof of the mouth that swallowing was difficult, and asphyxia probable in the course of a few days. The surface was smooth, with slight superficial ulceration in places. The swelling was clearly attached to the symphysis, causing some apparent thickening of the bone, which, however, felt slight. The incisor teeth on each side had been thrust out by the growth the width of which was about 1½ inch, and length 1½ inch. No glandular enlargement, no pain on manipulation.

Arising from the right upper jaw, above the lateral incisor and canine teeth, was a soft, globular, elastic swelling, firmly fixed to the superior maxilla, but not adherent to the super-

jacent structures. Surface quite smooth and bluish; no pain on manipulation; no blockage of nose; slight depression of front of palate. Superiorly the swelling gradually faded off with an indistinct margin about half an inch below the edge of the orbit. No displacement of the eye.

The swelling arising from the lower jaw, from its duration (six months), rapid growth, hæmorrhagic tendency, and soft elastic feel, seemed undoubtedly of a sarcomatous nature; it looked like a gigantic epulis, and did not appear to be a central sarcoma, judging from the slight apparent thickening of the bone and a tendency of the bone to pedunculation. On account of rapid growth and imminent danger to the child, who did not seem capable of existing another week if nothing was done, I determined, in spite of the existence of a second tumour, to operate immediately. The second swelling was the only evidence of dissemination.

Consequently, on October 25th, under chloroform, I proceeded to excise the portion of the lower jaw from which the growth sprang, that is that portion between the two first molars. A vertical incision was first made through the lower lip to the chin in the middle line, the soft parts dissected off the bone and the attachments of the muscles divided. The bone was then partially sawn through on each side, and the section completed by bone forceps. Hæmorrhage was profuse, but was soon stopped after removal of the growth. A silk suture was passed through the base of the tongue and through the neck to prevent the tongue from falling back. The lip was sutured and dressed with collodion and blue wool. A trochar and cannula inserted into the upper swelling gave no indication of its being cystic. The operation lasted thirty-five minutes.

The child did uninterruptedly well. The floor of the mouth was brushed over daily with a 10 per cent. solution of iodoform in ether. Highest temperature, 101.4°. Stitches removed about the tenth day.

On October 30th, five days after the first operation, the condition of the child being excellent, I proceeded to remove the right upper jaw, my intention being if possible to leave the orbital plate of the superior maxilla. An incision was first made through the upper lip and along the right side of the nose; the flap was reflected, all bleeding stopped, and the extent of the growth ascertained. After dividing the hard palate the superior maxilla was divided horizontally half an inch below the orbital plate. The lower three-quarters of the bone along with the growth was easily removed, and it was then seen that a portion of the growth extended up to the orbital plate. It was therefore necessary to continue the incision beneath the orbit, saw through the malar bone and nasal process of the superior maxilla, and thus remove the orbital plate with the remnant of the growth. The operation lasted thirty-five minutes; hæmorrhage was severe, and the child much collapsed, but recovered considerably in the course of a few hours.

The wounds both healed by primary intention; some opacity of the right cornea resulted, which at the time of writing had quite disappeared.

Six weeks after the operation the child developed a sharp attack of broncho-pneumonia, but soon recovered.

The discharge from both wounds remained perfectly sweet throughout, and practically ceased before the broncho-pneumonia came on.

Examination of the portions removed showed in each case a soft reddish gelatinous growth in the centre of the bone, arising apparently in the cancellous tissue, and "expanding" the compact bone on each side. In the lower jaw the growth had spread backwards into the mouth, and here was not confined by bone. The teeth had been pushed away on each side, and could be easily removed. In the upper jaw the growth had originated and spread between the two plates of bone forming the anterior surface of the superior maxilla, and the posterior plate had been so pushed back as almost to obliterate the rudimentary antrum, which could be recognised as a very small cavity posteriorly; the palate bone had been left behind, probably all the better for the patient. Both growths had been completely removed.

Microscopically each growth showed a stroma of firm fibrous tissue, with abundant small spindle and round cells, among which were many myeloid cells with a varying number of nuclei—in other words, a typical myeloid sarcoma.

REMARKS.—The points which seem to be of special importance are—1. The existence of a double swelling of very rapid growth, with threatened asphyxia from pushing back of the tongue; 2, the rapid recovery on each instance from so serious an operation performed on so young a child; 3, absence of any complication; this I attribute to the careful application of the ethereal solution of iodoform; 4, the rarity of the case; Mr. C. Heath, in his essay on the jaws, stating that myeloid sarcomata of the jaws occur after 25 years of age. The amount of repair which has taken place in so short a time (three months) seems to me surprising. There is scarcely a trace of a scar visible on the lower lip. The two portions of the lower jaw are united by dense fibrous tissue, with what feels like some new bone on the left side, and in the centre the new tissue causes the chin to retain its prominent shape. The repair is greatest in the situation of the right upper jaw, where a firm hard mass of tissue has developed in the situation of the gum, and resembling very much the alveolus on the opposite side. Behind this is a small gap scarcely more than $\frac{1}{4}$ inch from before backwards, and $\frac{1}{4}$ inch from side to side. There is no trace whatever of any recurrence, and the child, though pale and still weak, can talk quite well, and takes her food without the slightest difficulty. The amount of disfigurement is extremely slight; the only thing visible is a slight sinking in of the lower lip, and a little prominence of the left upper central incisor. There is no displacement of the right eye.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

POISONING BY HENBANE SEEDS.

DURING the evening of May 6th I was called to see four people who said they had taken something for dinner and supper which had poisoned them. I found the master and mistress complaining of vomiting, giddiness, faintness, dryness of tongue and throat, and incoherency of speech—two female servants complained of the same symptoms, though not to the same extent—there was also dilatation of both pupils, and a rapid pulse, 140 per minute, in the mistress; there was partial loss of muscular power generally.

On inquiry I found all had partaken of some clear soup flavoured with "celery seeds," a bottle of which had been bought that day from a greengrocer in the neighbourhood. I took the bottle away and handed it over to Messrs. Hogg, the chemists, for examination, and they found the bottle contained nothing but henbane seeds (*Hyoscyamus niger*). The cook told me she had used half a teaspoonful to flavour about three pints of the soup, and as far as I could make out the symptoms of poisoning began within ten minutes of the food being taken. On inquiry next day at the greengrocer's I found another bottle of henbane seeds ready to be sold as celery seeds, and a bottle of celery and henbane seeds mixed. A strong magnifying lens served to detect the mistake. My treatment consisted in assisting the vomiting, and then giving black coffee and brandy.

Somers Place, W.

HENRY C. MARTIN, M.D.

SUICIDE BY CHARCOAL FUMES.

As suicide by charcoal fumes is rare in England, I herewith forward notes of a case.

H. G., aged 26, living alone, and of lazy and drunken habits, was found dead lying on his side on a bed in a small room. He was uncovered from the waist downward. All apertures which could admit air into the room had been carefully blocked, and a large tea tray of burnt charcoal by the bedside told its own tale. The first to enter the room described the smell as offensive and close.

A *post-mortem* examination was made forty-two hours after he was last seen alive. The surface of the body from the head to the soles of the feet was of a deep red colour with the exception of those places on which the body rested, and these places were white. There was a white ring round the neck corresponding with the upper border of the collar,

which was rather tight fitting. The face was livid, a frothy fluid issued from the mouth, and there had been hæmorrhage from the nostrils; the eyes were half open; the pupils dilated, the sphincters ani and vesicæ had relaxed, and urine and fecal matter escaped on the bed. Upon incision the abdominal and pectoral muscles were of a very bright florid colour. The right side of the heart was distended with fluid blood. The stomach was almost empty, with patches of congestion here and there, whilst many of the vessels in the submucous coat were plainly seen injected with florid blood. The kidneys weighed $5\frac{1}{2}$ and $5\frac{1}{2}$ ounces, capsules adherent; the liver 67 ounces, capsule adherent and substance very friable. Upon opening the skull the vessels in the coverings of the brain were found distended with blood, so also were the sinuses. Upon section bright florid blood issued from the cut vessels in the interior of the brain.

GEORGE VINCENT, M.D., M.R.C.S., D.P.H. CANTAB.
Ipswich.

HÆMORRHAGE FOLLOWING TONSILLOTOMY.

A CASE of severe hæmorrhage following tonsillotomy, for which the common carotid was tied by Mr. Arbuthnot Lane, as reported in the BRITISH MEDICAL JOURNAL of April 30th, induces me to mention the following case which occurred about fourteen years ago:

A girl, aged about 20, had her left tonsil excised at the Throat Hospital, and severe hæmorrhage ensued. The application of cold and astringents having failed to check the bleeding, pressure was resorted to, which controlled it for the time, but it recurred as soon as the pressure was removed.

As the case was beginning to assume a serious aspect, it was evident that something must be done to speedily stop the hæmorrhage. It occurred to me that the failure with astringents was due to their being improperly applied, and I therefore mixed one part of gallic acid with three parts of tannic acid, and, after adding a few drops of water, kneaded the powder into a very stiff paste. Having rolled some of it into a ball about the size of a marble, I introduced it into the mouth on my left forefinger, and rubbed it firmly into the bleeding surface, at the same time making counterpressure from the outside with my right hand. As the result of this treatment, the bleeding quickly ceased and did not recur.

I have since met with a few cases of severe hæmorrhage following tonsillotomy, and in each of them the bleeding has been quickly and easily stopped by the treatment I have above mentioned.

Harley Street, W.

T. MARK HOVELL.

I THINK the case related by Mr. Arbuthnot Lane (and the remarks made thereon by others) before the Clinical Society of London to be most interesting and instructive. In the last patient on whom I operated there followed severe hæmorrhage and inflammation, but the patient ultimately recovered in a satisfactory manner.

In another case, a young gentleman was operated on by an eminent London surgeon, but in the train home he was seized with severe hæmorrhage from the cut tonsil. I was hastily summoned, and found the patient bleeding profusely and quite faint, and blanched from loss of blood. With some difficulty, owing to the constant flow of blood, I applied the liq. ferri perchlor. fort., and with a couple of applications the hæmorrhage was arrested, and no ill effect followed.

In both these cases the patient had to journey home several miles, and I determined never again to operate unless the patient could remain quiet and under observation for at least several hours; and I think Mr. Lane's case and these two which I relate ought to cause teachers and authors to give better instruction and information about the matter than they do at present.

Orpington, Kent.

R. ALEX. SHANNON.

EFFECT OF ICE IN AMPUTATION.

THE two following cases, which were exhibited at the Edinburgh Medico-Chirurgical Society recently, illustrate the advantages of ice in amputation cases.

CASE 1 was operated on nearly thirty years ago. Left forearm and hand were crushed under the wheel of a loaded waggon some two miles from his home. I lost no time, and