the gravy made from the giblets. The children, three girls and a boy, had only a little, and chiefly off the breast, as also did Mr. M. The son wanted to eat more, but Mr. M. took it from him as he did not think it good. In the evening and next morning Mr. and Mrs. M., three of the children, the mother's help, and the cook all felt unwell, three of them vomited, and all had pain in the abdomen and diarrhoea.

I administered an emetic to Mrs. M., which I repeated in a quarter of an hour. These did not act, and I at once passed the stomach tube and well washed out the stomach with warm water, little else returning than the water and a little mucus. The husband returned from the city at 8.30 P.M., and was much alarmed when I told him of his wife's condition. He himself had felt uncomfortable pains after leaving home early in the morning, and had been to a chemist's and taken a good draught of aperient water. I told him there was little doubt that it was due to poisoning by ptomaines from eating the turkey. I remained with the patient the greater part of the night. At about 11.30 P.M. she passed a copious motion under her, which was very foul smelling. I administered hypodermics of ether, etc., but could not arouse her by any of these means; she remained quite unconscious, breathing quietly; the abdomen was not distended, the pupils were moderately dilated and did not react to light; the conjunctival reflex was absent. In the morning I got Professor Sidney Martin to see her in consultation. He entirely agreed with the diagnosis, and advised continuation of the treatment with the hypodermic injection of ether and of strychnine. Nutrient enemata of peptonised gruel were administered. Reaction had now set in; the temperature was 101.6° in the axilla, and the pulse was 136. Dr. Martin also recommended me to use warm boracic lotion for repeated washing out of the large intestine. This I did, turning the patient gradually over from the left side, and back then to the right side, and back again in order to wash out as much as possible of the large intestine. The patient, however, remained comatose, never recovered consciousness from the time I first saw her, till death occurred at 2.10 A.M. on February 17th, she having been unconscious for 31½ hours. There was a rise of temperature on the evening of February 16th to 103.6°. The following is a copy of the notes I made at the necropsy, at which Mr. H. S. Elworthy, F.R.C.S., kindly assisted.

Height 5 feet 2 inches. Fairly well nourished. Pericardium contains a normal amount of clear fluid. Heart the size of deceased's closed fist, weight as removed 8½ ozs. Pulmonary valves normal, aortic valves normal; some irregular thickening of mitral valves (old). Tricuspid valve normal; some recent clot and fluid blood in the cavities. Heart muscle normal, no induration or degeneration noticed. Aorta, coronary arteries, and large blood vessels quite healthy; no staining. Tongue slightly furred; oesophagus normal, but some slight redness near the lower end. Larynx healthy, trachea and bronchi slightly red and infected. Right pleura no fluid and no adhesions, left pleura same. Right lung dark coloured on section, somewhat oedematous, otherwise healthy; left lung same; cut portions of both float in water. Peritoneum slight dulness and stickiness generally, where covering ascending colon more marked. Stomach no ulceration, some petechial patches about the lesser curvature, contents ½ ounce fluid (kept No. 1). Intestines: Petechiae along upper part of small intestine, more in large intestine in transverse colon; no glands seen in mesentery. Liver: Surface smooth, weight 3 lbs. 7 ozs., consistence diminished, cut surface greasy; gall bladder full of green bile. Spleen not enlarged, consistence normal, dark in colour. Right kidney 3½ ozs., capsule only slightly adherent, more friable than normal; left similar; both cloudy-looking on section. Bladder healthy, urine none present. Suprarenals normal. Uterus small, cavity tending to obliteration, otherwise healthy; slight amount of mucus seen at external os; ovaries normal. Meninges healthy, some slight amount of fluid under membranes, vessels on surface fairly full; nothing abnormal noticed on surface of brain; vessels at base quite healthy. Brain weighs 50½ ozs., healthy on section; about a drachm of clear fluid in the ventricles; left posterior cornu somewhat enlarged; small oedematous swellings on the choroid plexus on each side. Crura, pons, cerebellum, and medulla normal in appearance externally and on section.

REMARKS.

The course of the case seemed clearly to indicate poisoning by food. There was the partaking of tainted food which affected all the members of the household, some more than others. In the patient who died there was at first the combination of *malaise*, weakness, and gastro-intestinal symptoms which usually accompany food poisoning. These were, however, not accompanied by fever. This appeared later, and with the more severe symptoms may be taken to indicate bacterial poisoning as distinguished from chemical poisoning.

THE German Otological Society will hold its sixth annual meeting this year at Dresden on June 4th and 5th.

A NEW METHOD FOR LOCALISING BRAIN LESIONS.

By ROBERT H. COX, F.R.C.S.I.,
Shanghai, China.

THIS method supplies a simple and infallible means of mapping out on the scalp the positions of any (or all) of the underlying convolutions of the cerebral cortex, a result accomplished, with the "cerebro-graphometer" and its chart, almost automatically.

The cerebro-graphometer consists entirely of the mechanical device known technically as "lazy-tongs," formed into a circle with two accessory loops, one bearing the numerals and the others the letters A to V.

The chart shows, on a gnomonic projection, the boundaries of the lobes and convolutions of a hemisphere of the brain, with the lines of latitude and longitude corresponding to the numbers and letters of the instrument (Fig. 1).

Fig. 1.—A diagrammatic map (on a gnomonic projection) of the external surface of a hemisphere of the brain, showing the boundaries of the lobes and convolutions, and the lines of latitude and longitude corresponding to the engraved rivets of the instrument.

Localising is performed as follows: Extend the instrument and apply the end of the lettered loop, marked V, to the occipital protuberance and the other end to the glabella, then press down the loop to the scalp in the middle line and close the circle round the head, so that the 10 on the numbered loop will lie on the lettered loop. Consult the chart for the bearings, and place the number 10 on the letter of longitude, when the number of latitude will rest over the part sought for.

Fig. 2.—The same projected on the right side of the skull; also shows the instrument in position for localising.

Fig. 2 shows the instrument in position for localising; also the evolutions mapped out.

The instrument is equally applicable to all sized heads, and forms its own unit of measurement for each, thus eliminating the errors caused by using standard measures for varying surfaces. It is compact, light, durable, and may be rendered aseptic by boiling. Messrs. Arnold and Sons, London, are the makers.

LIST OF INDICES

TO IMPORTANT REGIONS OF THE BRAIN CORTEX.

DESCRIPTION.	INDEX.
<i>Motor Centres: External Aspect:</i>	
Inferior Extremity.....	LK 8
Superior „.....	K 6
Face.....	1 4
Lips and Tongue (Broca's lobe).....	C (Left Side) 4
Head and Eyes.....	1 7
<i>Mesial Aspect:</i>	
Leg.....	KL 10
Trunk.....	JK 10
Arm.....	IJ 10
Head.....	HI 10
<i>Sensory Centres:</i>	
Hearing.....	J 12
Sight.....	R 6
<i>Special Convolution:</i>	
Frontal Ascending.....	I @ K 4
Superior.....	C @ J 8 1/2
Middle.....	C @ I 6 1/2
Inferior.....	E 4
Parietal Ascending.....	J @ L 3 1/2
Superior.....	M @ N 3 1/2
Supramarginal.....	MN 4 1/2
Angular.....	O 5 1/2
<i>Occipital:</i>	
1st.....	Q 8
2nd.....	S 8
3rd.....	U 8
<i>Temporal:</i>	
1st.....	C @ N 2 1/2
2nd.....	J @ Q 7 1/2
3rd.....	T 3
<i>Special Fissures:</i>	
Rolando's.....	H1 @ L 3 1/2
Sylvius'.....	E @ M 2 1/2
Middle Meningeal Artery.....	E 3
Cerebellum.....	V 7

NOTE.—The Letters and Numerals correspond to those on the instrument.

When two letters are placed thus—LK—it means a point half way between them

When an index is given thus— $\frac{1}{4}$ @ $\frac{K}{5}$ —it means the portions at these two points and that between them, when like this—

$\frac{M @ P}{9}$ @ $\frac{N}{7}$ —it means that portion from M to P on the line of latitude marked 9, down to N on the line marked 7

NOTES ON A SUCCESSFUL CASE OF
PYLOROPLASTY.

BY
THOMAS OLIVER, and FREDERICK PAGE,
M.D., F.R.C.P., Physician to the Royal Infirmary, Newcastle-on-Tyne. Surgeon to the Royal Infirmary, Newcastle-on-Tyne.

THE following case seems to us to be of sufficient value to be recorded on account of the severe nature of the operation performed upon a patient rapidly dying from sheer starvation, and who, shortly after the shock and the immediate consequences of the operation were recovered from, gained strength and put on flesh at such a rapid rate as to render her hardly

recognisable by her most intimate friends. To the medical officer of the convent, Dr. Ruddock of Newcastle, the writers gladly acknowledge their indebtedness, not only for his skilled assistance at the operation, but for permission to publish the notes of the case.

On November 2nd, 1896, one of us, Dr. Oliver, saw in consultation with Dr. Ruddock, a nun, aged 25, in one of the Roman Catholic convents of this city, a French Canadian by birth. She was extremely emaciated, pale, and so feeble that she could not sit up in bed. After having suffered from dyspeptic symptoms for several years, followed by marked declension of health, she was transferred from the West of England to Newcastle in the hope that our bracing atmosphere would act as the much needed restorative. Anorexia, gastralgia, and recurrent vomiting were the symptoms which caused her to seek medical relief. Of late, debility, anæmia, and emaciation had made rapid strides. At first the vomiting only occurred after meals and gave relief to pain, but latterly it had been occurring at irregular and rather lengthened intervals—three to four days—when large quantities of liquid would be ejected, frequently coffee ground in character, occasionally of an ashy-grey colour, and usually with a most offensive odour. Previous to February, 1896, menstruation had been irregular, but since that date it had been in complete abeyance. The bowels were constipated, the urine normal. When seen by Dr. Oliver, the patient was too ill to be subjected to a prolonged examination. The temperature was normal, pulse 78, small and flickering. The face was pale, and expressive of lengthened suffering; tongue moist and clean. The heart and lungs were healthy. Abdomen was slightly protuberant, especially in its lower half anteriorly. Liver dulness was normal. Stomach: the area over which a normal resonant note could be heard was increased, whilst occupying the lower half of the abdomen, and extending almost to the suprapubic line was a cystic swelling, dull on percussion, the dulness varying with change of position of the patient. Fluctuation was well marked. On auscultation, and even without it, a splashing sound could be easily heard. Nothing was felt at the pylorus. Dilated stomach was diagnosed, and as the patient was extremely ill a fresh attempt was made by means of strong beef tea enemata, containing a few drops of laudanum, administered four times a day, to get her into a better condition for the surgical treatment which seemed to us the only chance left her. As the enemata were retained she soon began to gain in strength and vitality, but the improvement was only temporary. As consent had meanwhile been obtained for the surgical procedure, it was decided, after consultation with Mr. Page, ill as the patient was, and hopeless almost as was her condition, to perform without further delay abdominal section.

NOTE BY MR. PAGE.

On November 26th abdominal section was performed. Upon opening the abdomen in the middle line above the umbilicus, the stomach was found to be enormously dilated. The pylorus was thickened and fixed. Mikulicz's operation was performed. The stricture only permitted a pair of sinus forceps to pass through from the stomach to the duodenum. For some hours it was very doubtful as to whether the patient would rally; but gradually she did so, and made a rapid and most satisfactory recovery. Pyloroplasty for the treatment of non-malignant stenosis of the pylorus does not seem yet to occupy, in the estimation of British surgeons, the position it deserves. Gastroenterostomy still appears in this country to be the operation resorted to in many cases of simple stenosis and yet few surgeons, I am sure, who in their own practice contrast the results of the two operations will be inclined to adopt gastroenterostomy.

It has been said that "recurrence of the stricture is a physical impossibility" after this operation—a somewhat rash statement, perhaps. The operation has now been practised for some years, and I have certainly not heard of a recurrence. The man upon whom I operated in the year 1892—the first case of pyloroplasty in Great Britain—remains well and is at his ordinary work, and I know of other cases in this neighbourhood where there has been no recurrence. The great danger arises from the operation being deferred too long. Two of my patients died from the direct effect of the operation within a few hours of its performance.