neuritis. It is interesting to note that optic neuritis is not mentioned as occurring in enteric fever by either Fagge, Osler, or Strümpell, while Sir William Broadbent, in *Quain's Dictionary*, mentions it only as an almost pathognomonic sign of meningitis. On the other hand, Gowers speaks of it as being not uncommon in both enteric and scarlet fevers; and Taylor records a similar case that has come under his notice.

REFERENCE.
1 *Diseases of the Heart.*

A CASE ILLUSTRATING THE DIFFICULTY OF DIAGNOSIS IN GASTRIC ULCER.

By W. CLARK ALEXANDER, L.R.C.P. and S. EDIN.,
Bowdon.

X. Y., aged 35, had suffered from dyspepsia since boyhood. The pain, seldom acute, occurred two or three hours after meals. He suffered also from flatulence and constipation, seldom vomited, and had had no hæmatemesis. For a fortnight before the present attack he had been very constipated, and the feeling of nausea and discomfort after food had increased. The pain was slight.

On February 23rd I found the patient, who had just returned from a long railway journey, in acute pain over the epigastrium. At night he vomited about a pint of bile and mucus, and felt relieved. Next day the acute pain was better, but there was tenderness over a small area, 2 to 3 inches above the umbilicus. Milk diet was ordered and a purgative prescribed. As it did not act, enemata were ordered, but with no result. On the fourth day small doses of castor oil were given, and the bowels moved twice; the motions soft, with some hard pieces. The feeling of soreness was not relieved, and at times the pain was fairly acute. There was now some distension of the abdomen and epigastrium, and a feeling of resistance on palpation over the latter.

On March 3rd, as the pain was constant, the patient was seen by Dr. Dreschfeld, who diagnosed some slight intestinal obstruction, probably due to adhesions. He advised opium and belladonna pills, and a continuance of fluid diet and enemata. As the latter wholly failed to relieve, I returned to small doses of castor oil. The bowels acted on several occasions, and some quite large hard pieces were passed. After a motion the patient felt that something had moved from the tender area, and the pain got somewhat better, but it gradually came back. I then resorted to large enemata of olive oil (with the foot of the bed raised) which relieved wonderfully for a time, but after some hours the pain returned.

On March 17th, Dr. Dreschfeld again saw the patient, and advised a surgical opinion.

On March 20th, Mr. T. Jones saw the patient, and coincided with the theory of adhesions causing obstruction, and advised laparotomy. After the day I first saw the patient the symptoms, subjective and objective, pointed to some intestinal lesion. There had been no vomiting, no pain referred to the ingestion of food, and the pulse and temperature had been practically normal.

OPERATION.

An incision was made in the middle line 4 inches long, extending upwards from 1 inch above the umbilicus. Colon presented at the lower angle of the wound; it seemed quite healthy and free from adhesions. The liver was much adherent to the abdominal wall, and on careful separation a small escape of gas was noted, having the odour of sulphuretted hydrogen. On further exploration by the probe and sinus forceps about 3j of pus escaped. The peritoneum at the lower angle of the wound was sutured, a large drainage tube inserted into the abscess cavity, the wound in the abdominal wall packed with iodoform gauze, and then left to granulate. The patient had a good night but the wound discharged very freely, and in the morning the dressings, sheets, and nightclothes were saturated. On removal of the dressings a great rush of discharge came through the drainage tube which seemed like stomach contents; this was verified by further examination.

The diagnosis now was gastric ulcer, localised peritonitis, perigastric abscess. This diagnosis Mr. Jones supported on

seeing the patient next day. Nutrient enemata were now given every three hours (3ij peptonised milk with half an egg and a little brandy, alternating with a suppository of peptonised beef). After the first twelve hours the flow of stomach contents ceased, and a viscid bile-stained fluid was freely discharged.

Despite the greatest attention to nursing and feeding, the patient gradually sank, and died five days after the operation, apparently from rapid emaciation through pure lack of nourishment. The temperature rose a little from the time of the operation till death, its greatest height being 100.6° C.

At the necropsy (at which I was assisted by Dr. Gardner, of Manchester) an ulcer, evidently, from the condition of its edges, of long standing and of about the size of a crown piece, was found on the anterior stomach wall in the lesser curvature and close to the pylorus. The site of the ulcer corresponded on the outer side of the stomach with an abscess cavity which would hold about 3iv of fluid, and was in the midst of dense and strong adhesions binding liver and stomach together. The floor of the ulcer had practically been formed by cicatricial tissue and adhesions, and an abscess having formed at the expense of these, the stomach wall had given way at the point of least resistance.

As to the cause of the rapidly fatal issue, even after the establishment of the gastric fistula, there was no evidence of shock; there was no peritonitis or further pus formation; but the fact of the very free exit for the digestive juices externally would lead one to believe that the nutrient enemata could not be prepared for assimilation.

The points of interest in the case are: The occurrence of a gastric ulcer of this size with only the ordinary symptoms of dyspepsia. (The pain had no reference to the ingestion of food, and at no time had there been any hæmatemesis.) The pain being relieved so much by the olive oil injections—a fact which made the diagnosis of ulcer still more difficult. The absence of vomiting during the month he was in bed prior to the operation. The absence of any connection between the ingestion of food and the occurrence of pain in this acute attack, although one would think the ulcer during this period would be easily irritated; and the extreme and rapid emaciation which obtained after commencing the nutritive enemata.

Reasoning from analogy it may be assumed that the correspondence of the pain to the ingestion of food in gastric ulcer must vary greatly according to the position of the ulcer, as in this case the site of the ulcer on the anterior wall and close to lesser curvature would lend itself to escape irritation, either by food passing over it or being deposited in its floor.

A CASE OF ABSCESS OF ABDOMINAL WALL FOLLOWING TYPHOID FEVER: INCISION: RECOVERY.

By GEORGE WESTBY, L.R.C.S.I., M.R.C.P.I.,
Liverpool.

MR. R., aged 21, was under the care of Surgeon-Lieutenant Steel, A.M.D., from February, 1896, to the end of May, 1896, as reported by him in the *BRITISH MEDICAL JOURNAL* of January 2nd, 1897. The particulars of the case prior to coming under my charge, are briefly these: Mr. R., in February, 1896, was found to have developed typhoid fever, complicated with peritonitis, passing on to abscess of the abdominal wall, which was incised; it was not considered advisable to do more at that time, owing to the excessively weak state he was in. This abscess apparently healed, and he returned home to Liverpool at the end of May; he was still weak, but improving, while the aperture in the abdominal wall to the right of and below the level of the umbilicus had apparently closed.

I was summoned to see him at 4.30 A.M. on June 18th, and found that he had had a sharp rigor, followed by pain in the back, and afterwards by pains all over the body, comparable with those from which he had suffered during an attack of influenza. Around the situation of the former wound there was no special pain or tenderness on pressure, but the cicatrix

trix had a raised and glassy look. In a few days it thinned down to a mere blister, which gave way, allowing the escape of about 3i of foetid pus. There was nothing faecal about it, however, and I never heard that such was the case at any period of the patient's illness. Mr. Mitchell Banks now took up the case with me, and on passing a probe he found it passed $4\frac{1}{2}$ inches into a tortuous channel running downwards and towards the middle line in the direction of the bladder; it was clear the original wound had never healed soundly but had left behind it this long sinus, the orifice of which had closed over imperfectly, and then had given rise to the belief that everything was sound. Some pus having accumulated in the sinus had caused the patient to feel very ill, a condition from which he at once recovered as soon as the cicatrix gave way and the pus escaped.

To lay this extensive sinus open in its entire length was a distinctly serious proceeding, not devoid of danger, and with the possibility of leaving behind it a weakened abdominal wall, which would be a serious thing for an officer. It was resolved, therefore, to try to get the sinus to heal if possible by various stimulating and other liquid applications, nitrate of silver, etc., all to no effect. At last Mr. R.'s patience became exhausted, and he resolved to have the sinus completely laid open, which was done by Mr. Banks on August 19th. The steps of the operation are as described by himself. As the process of laying open went on the incision necessarily became deeper and deeper. The rectus, and with it the epigastric artery, were completely divided, the incision finally ending in the suprapubic fat and cellular tissue. It was impossible, moreover, to help opening the peritoneum. Through the rent the finger introduced into the abdomen found no evidence of adherent intestine; all seemed perfectly right.

The point of interest, however, is that in the course of laying open the sinus something was cut across which exactly resembled a very small intestine; it was recognised to be the appendix vermiformis, and was stitched up. The sinus was thoroughly scraped in its whole extent, and having been put into the condition of a fresh raw wound was stitched up in its entire length, except for a small portion at its lower end, in which a tube was inserted. By this means primary union was obtained of the peritoneum, and through a portion of the long gash, thereby greatly diminishing the liability of rupture which would otherwise have resulted. The wound finally closed in December, and, having gone away for a change, the patient returned to duty in the beginning of March, the part being protected by an aluminium plate. He has remained well up to the present date.

The points of interest are:

- (1) The occurrence after typhoid fever of an abscess probably perityphlitic in character.
- (2) The occurrence of a long and deep sinus after this abscess, which had closed over unsoundly, only to give rise to a collection of retained pus.
- (3) The discovery and division of the vermiform appendix imbedded in the hard tissue of the sinus.
- (4) The satisfactory result of the operation, and the complete recovery, after so prolonged and serious illness.

POISONING BY THE "PRIMULA OBCONICA."

By J. HEADLEY NEALE, M.B., M.R.C.P.LOND.,

Physician to the Leicester Infirmary.

ON April 9th, 1896, Mrs. W., a young married lady, consulted me for a rash which had suddenly appeared the day before on her face and hands, "which itched and burned intensely." On the face the eruption was urticarial, but the blotches were too confluent; while on the hands, especially between the fingers, it was suggestive of scabies. I suspected some local irritant, and finding that the soap used was not irritating I described as carefully as I could the flowers of the *P. obconica*, but she denied having handled any. Under a topical soothing application the face was soon better, and desquamating, but the hands became intensely painful. On the dorsal aspect the spots had turned to purple blotches, while the whole palmar surface of hands and fingers had become stiff and unusable. Two days later the face was comparatively well, the blotches on the dorsal aspect of hands

and fingers fading, but there was evidence of deep-seated blisters forming at the tip of each finger and above and below each phalangeal flexure. To make sure I smartly pricked the tip of one finger and a bead of clear fluid escaped. I ordered the patient to macerate her hands thrice daily for ten minutes at a time in rectified spirit (to which was added a fair proportion of tincture of belladonna), and then to swathe them in lint soaked in glycerine and covered with oil silk, relying upon the hygroscopic properties of the spirit and glycerine and the possible action of the belladonna as an anodyne. The result fully justified the experiment. A few days later she told me that "her hands were nearly well," and she "could bend her fingers." The first thing that attracted my attention as I entered her room was the presence of three fine blooms of the *P. obconica* among other flowers on the table. On pointing out that these were the very flowers I had been looking for and asking about, she told me she had gathered them the day before in the conservatory, and on going there I found eight fine plants, some in full bloom, which she had been in the habit of watering, etc. That they had not bloomed on April 9th, when the rash appeared, opens out a fair field for research as to the properties of the several parts of this pretty but obnoxious plant.

This case recalls to my mind the result of the enthusiasm of a young assistant at the Botanical Gardens in Edinburgh. Having in his menial capacity been present at a lecture when the late Professor Dickson was decanting upon the poisonous properties of the "*Rhus toxicodendron*," this inquiring youth straightway broke a twig and smeared some of the exuding juice on his left arm, appearing at the infirmary a few days later. Never shall I forget that arm with its gangrenous-like line of demarcation, midway between the shoulder and elbow-joint, while below it was intensely red and swollen; one huge pemphigoid eruption, some of the "bullæ" being as large as pigeon's eggs. Nor shall I easily forget the enthusiasm displayed upon the faces of Professor Fraser and Dr. Murrell as, between the "clinics" which were then in progress, they watched me making a water-colour sketch of the arm. The drawing is no doubt still in Dr. Fraser's possession, and is possibly the only one extant of the result of poisoning by "*Rhus toxicodendron*."

MEMORANDA:

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

AN ANENCEPHALOUS MONSTER.

ON the afternoon of April 10th I was called to attend a lady, aged 28, a primipara, eight months pregnant. She had suffered greatly from pain in the abdomen for some days previously, and had not slept the preceding night owing to it. She was a rather thin woman of average height. The abdomen was of large size, the abdominal walls very tense, rendering palpation difficult. The fetal heart was audible at the left side, above the level of the umbilicus; the movements of the fetus could be felt low down on the right side, and were, indeed, a source of discomfort to the patient. I could not feel the head at the fundus. The os was dilated to the size of a shilling.

I ordered a simple enema, and then, having administered a dose of chloral and opium, left the house. On the following day the patient felt much better, and was able to be out of bed and came downstairs.

About 7 A.M. on April 13th I was again sent for. Throughout the night the patient had severe and frequent labour pains; the membranes ruptured before my arrival, and a foot presented. The child was delivered in about twenty minutes; when placed on the bed it did not cry, but moved its arms and legs freely for about a minute, during which time the chord pulsated distinctly; it soon, however, ceased to move.

The child, a female, was 15 inches long, the arms and legs were very thin, but of average length, the abdomen normal. It had no neck whatever, the chin being continuous with the thorax. The face was very small and the eyes prominent. The head at the level of the supraorbital ridges was perfectly flat, covered in by pretty hard bone and skin, through