An Address

ON

SUDDEN AND UNEXPECTED DEATHS.

DELIVERED BEFORE THE ST. PANCRAS AND ISLINGTON
DIVISION OF THE BRITISH MEDICAL ASSOCIATION,By WM. WYNN WESTCOTT, M.B., D.P.H., J.P.,
H.M. CORONER FOR NORTH-EAST LONDON.

I HAVE found great difficulty in selecting a subject familiar to myself and likely to be of interest to the members of this Division of the British Medical Association. As, however, the majority of you are general medical practitioners, the sudden death of your patients must always be a matter of concern and regret, and the reason for its occurrence a fitting subject for investigation.

As a coroner, my professional duty lies in the endeavour to solve the problem of the causes of death in each reported case, by means of general evidence given by relatives and casual friends as well as by the facts observed by those present at or near the time of death. The investigation is much simplified if the evidence of a medical man conversant with the constitution of a deceased person is available, and this is rendered of still greater value if there has been attendance on the deceased for ailments of recent date. However sudden a death may appear to be in any case, it is probable that there has been, perhaps long pre-existent though not recognized, and quite unknown to any observer, some flaw in the structure and in the action of one or more vital organs. We all know we must die some day, but we take very different views of the best course to adopt in our conduct towards the coming change. Some persons are careless, others are living daily in nervous dread of death. Some believe, and no doubt wisely, that the less one allows the mind to think of illness and death the more healthy one's insight and outlook remain. On the other hand, there are many who have convinced themselves that it is only by constant attention to the mode of life—to diet, exercise, and regimen—that prolonged life can be anticipated. Some bear in silence and gloom a haunting dread of infection and ultimate "cold gradations of decay," while others run about seeking advice from medical science or from quackery, in the belief that by the ingestion of drugs alone can health be preserved.

Some people are haunted by fear of disease coming on through an hereditary taint; others put too great a trust in the knowledge of being descended from tough and long-lived ancestors. In the smallest community of the family circle even, we may observe almost every possible attitude of mind toward the approach of man's inevitable destiny.

In the endeavour to account for a sudden death, after the items of evidence already referred to, it is now commonly thought that the results of a *post-mortem* examination may be relied upon to explain the medical cause of death. In our cities and towns such an examination is now made in almost all cases; but in country districts it is frequently neglected. It must be admitted that the value of a *post-mortem* examination will very largely depend upon the skill and experience of the operator. In this country the local medical practitioner who has known the deceased, the doctor who has attended most recently, or the doctor who was called in after death, has almost invariably been chosen to make such examination for legal purposes. On the Continent, and to some extent in Scotland, this work is entrusted to a pathological expert appointed by the judicial authorities or the police. Such a doctor, having all the sudden deaths and tragedies of the district brought to his personal notice, must soon become more able to reason correctly upon *post-mortem* appearances than a private medical practitioner who is only called upon to investigate a sudden or violent death as an exceptional incident. Again, it is in no way desirable that a doctor in general and in midwifery practice should be occupied with *post-mortem* work.

Hence we may observe a growing tendency to employ specialists in morbid pathology to investigate the causes of death. It is hoped that the creation of a new public officer—a medical and forensic examiner—would lead to

further study of the subject, to greater accuracy in *post-mortem* work, and so to less conflict of medical evidence in criminal trials.

It is desirable, however, that the work and opinions of such examiner should not lead to any neglect in obtaining the evidence of any medical practitioner who has been in attendance upon a deceased person, or present at his death, or called in after death, because my experience makes me yearly more and more confident that the simultaneous consideration of both these evidences can alone obviate erroneous conclusions, which may lead to most serious mistakes. Some recent attempts to supplant the medical practitioner in forensic duties by a specialist have led to unfortunate results, due to the loss by medical men not in affluent circumstances of a source of income they have so long enjoyed. It is, then, desirable, that any further delegation of *post-mortem* work to special medical officers should be authorized and regulated by new legislation, and not undertaken by any individual public official, however well-intentioned.

In the very proper desire to obtain accurate results there has been for many years what I conceive to have been an exaggerated view of the importance of legal *post-mortem* examinations in cases of sudden and violent deaths. The medical profession appears to have taught the public that by a *post-mortem* examination alone could the cause of any death be ascertained, and that if an autopsy was made the cause of death was at once apparent. Unfortunately this view is not in accordance with the facts, for in very many cases the *post-mortem* appearances will only show the presence of so much disease or injury as would render death a probable event from its existence. Or it may show so much disease or injury as would certainly lead to death in the immediate future. It is in only a minority of cases that such a lesion is found as is incompatible with continued life. In considering the diseases and injuries to which man is liable, it is almost impossible to say what circumstances must be fatal. Take, for example, what loss of blood is impossible to be sustained; no one can state the amount, or even the proportion of the total blood in the body. How much brain injury must kill, it is vain to make any estimate; large areas may be rendered useless by softening or haemorrhage without causing a sudden death; whereas a puncture in the floor of the fourth ventricle, or in a small area of the medulla oblongata may cause instant death. Some persons die suddenly from an angina pectoris, which the mere valvular lesion in the heart may alone be found to explain. A man may die of a mere pinch of a healthy testicle, while another may last for years with a cancerous tumour of the testis, which may kill only by slow exhaustion. There are hundreds of deaths from syncope or exertion, which cannot be explained by any cardiac or arterial lesion of instantaneous occurrence. Epilepsy, again, causes many sudden deaths, and leaves no gross lesion in any organ by which it can be recognized, and the occurrence of a fit cannot be proved in the absence of evidence of the events of the hours before the death occurred.

By the interdependent healthy action of the brain, the heart, and the lungs, life is maintained, said the great French physiologist Bichat, and he added that death begins at either the heart, lungs, or brain; this is no doubt true, especially when we refer to the appearances seen at the hour of death, but we are now in search of a more exact answer to the question, Why did this person die?

We desire a definite answer for several reasons. First, for personal and family satisfaction, and in regard to life insurance; secondly, for legal reasons, so as to be assured that no person is to be blamed for the death; thirdly, in order to secure accuracy in death registration; and, lastly, to guide survivors and their medical advisers in their efforts to preserve the lives of other persons in the community.

There have been several definitions of a sudden death, but it is not now my purpose to attempt any definition of the term, but rather to refer in general to such deaths as occur with little or no warning, or are preceded by no such symptoms as have led to any anticipation of a fatal issue at the time when it occurred. Deaths following external wounds and injuries are not within the present view. It is a difficult matter to offer any classification of sudden deaths, either by means of the organ affected or by symptoms preceding death, so it is proposed to refer

to several groups of cases which come prominently before the coroner's notice.

Many fewer inquests upon cases of sudden death are held in country districts than in London; first, because so many coroners will not hold inquests unless there is some suspicion of foul play, and also because country doctors are much more ready than London practitioners in poor neighbourhoods to offer a certificate of the cause of death, based upon presumption and hearsay, in the absence of observation during medical attendance. This laxity of practice robs death registration of its accuracy, and may occasionally enshroud active criminality, as well as negligence amounting to misdemeanour.

From a tabulation of inquests held by me I have found that the chief factor in sudden deaths has been cardiac 60 per cent., cerebral 30 per cent., and pulmonary 10 per cent., so far as obvious symptoms and gross organic lesions can show, but such classification is not very definite, as cases occur in which it becomes uncertain in which category to place a death; for instance, if a man die of syncope, exhaustion, haemoptysis, and phthisis, the death may be put down to cardiac or to pulmonary disease.

SYNCOPE FROM HAEMORRHAGE, ETC.

Sudden deaths from syncope are marked by loss of sense and motion accompanied by pallor and sighing, fading respiration.

External bleeding is an obvious cause, and so is internal bleeding appearing externally, as is seen in the haemoptysis of phthisis, the haematemesis of ulcer and cancer of the stomach, and of alcoholic gastritis; also of acute congestion of the liver; then there is the haemoptysis of aneurysmal ruptures of the thoracic blood vessels, and of some cardiac valvular lesions, notably of mitral stenosis. The bleeding of pulmonary apoplexy may also be shown by bloody expectoration. A few persons die of syncope from epistaxis, and a few also from the rupture of varicose veins of the legs and vulva, although the pressure of a finger would save life. The bleeding of piles and of cancer of the bowel, as well as menorrhagia, *post-partum* haemorrhage, and all the forms of haemorrhage due to organic disease of the womb may give rise to syncope. More rarely bleeding from the kidneys and bladder may cause a fatal faint.

Internal and concealed haemorrhage is a somewhat frequent cause of a sudden syncope, as from placenta praevia, rupture of the womb in parturition, or of a Fallopian tube in extrauterine pregnancy. Aortic thoracic aneurysm frequently causes a fatal but only internal bleeding, and occasionally this occurs with abdominal aneurysms; of these seven out of ten are of males. Phthisical haemothorax must not be overlooked as the cause of a sudden death.

Internal bleeding from a rupture of the spleen is occasionally found, especially in the tropical countries, after the slightest of external injuries, and the same may be said of the pancreas, liver, and kidneys. Remember also the liability to sudden syncope from perforation of the bowel in about the third week of typhoid fever, and in some cases of colitis such as are now called appendicitis. Apart from internal haemorrhage of serious amount, fatal syncope may occur from the shock of rupture of the stomach, bowels, or womb, etc.

SYNCOPE FROM HEART DISEASES, ETC.

It has been estimated that 60 to 70 per cent. of all sudden deaths end in syncope and are due to diseases of the heart; most of these have originated in acute rheumatism, from scarlatina, or from alcoholic fatty degeneration of the heart muscle. The others from the heart strain of bodily labour, of army duties, or of athletic exercises. Of cardiac valvular diseases, those of the aortic valves are most often suddenly fatal, and next those of the mitral valve, while diseases of the pulmonary and tricuspid valves are seldom found as a cause of sudden and unexpected death. Angina pectoris apparently due to atheroma of the coronary arteries appears to kill by the shock of a sudden spasm of pain. Cardiac rupture is not a very rare event in London, and may occur without any definite extra effort being used. General atheroma of the great thoracic arteries is also often assigned as a prime factor of a sudden syncope.

Sudden death from syncope has also been attributed to the ingestion of a large quantity of cold water when

greatly excited by exertion or in very hot weather, and a heavy meal of solid food in old people may lead to a fatal fainting.

Syncope may also occur from sudden changes of pressure on the blood-vessels, such as occurs from the tapping of a dropsy of the abdomen, or a pleuritic effusion, or the quick emptying by a catheter of a greatly over-filled urinary bladder.

Sudden syncope is not uncommon after severe burns; in these cases we often find peritonitis from inflammation and perforation of the duodenum.

Simple fatty degeneration of the heart muscle is the only lesion found in some cases of fatal syncope in delicate persons, whether obese or emaciated. Victims of chronic alcoholism are extremely likely to die suddenly from a syncope; and this occurs during attacks of delirium tremens and also during the periods of exhaustion with nausea which follows drinking bouts, as well as in the late and well-recognized stages of debility from liver and kidney disorganization which close the lives of many drunkards. In such cases a *post-mortem* view shows only a pale and flabby state of the cardiac muscles, with some dilatation of the cavities.

A calculation made by me in 1891 of 1,000 inquests showed 210 verdicts of death from syncope; of these there was evidence of alcoholic excess in 57 cases. Of 77 cases of fatty degeneration of the cardiac muscle there were 33 chronic inebriates.

Sudden heart failure is well known to have been due to mental impressions—such as fright, terror, and emotion—acting on a heart of feeble muscular structure, one affected by fatty degeneration or disordered innervation. The occurrence of a sudden pain of great violence, as from operations, tooth extraction, or the passage of gall stones, of renal calculi, etc., and from sudden blows on the testis, epigastrium, belly, or chest, may produce a suddenly fatal issue. Certain poisons, of course, cause a sudden fatal syncope, such as aconite and the cyanides. I must not omit to notice that simple fatal syncope may be due to muscular exhaustion, especially during or after sexual intercourse; among 1,100 inquests a year, I have about four such occurrences, always of males.

ASPHYXIA AND LUNG DISEASE.

Lung diseases existing alone do not afford, so far as my experience has gone, a large proportion of unexpected sudden death, except from the arterial haemorrhage of phthisis. Pure asphyxia is rare, except from pneumothorax, apart from quite recognizable attacks of pneumonia, etc., which take the cases out of the list of sudden deaths.

A diffuse pulmonary apoplexy may occur very rapidly, and cause asphyxia, and is not denoted by any profuse external bleeding.

Deaths from the complications of pleurisy may occur somewhat rapidly, and without warning.

I have myself seen and recorded sudden deaths from asphyxia from purulent fluid, due to the rupture of unsuspected abscesses in the mediastinum into the bronchi or trachea.

Thoracic aneurysms have, I believe, led to sudden fatal asphyxia from pressure on the pneumogastric nerve.

In the course of cases of chronic Bright's disease we may anticipate the occasional occurrence of a fatal result from asphyxia due to oedema of the lungs; this is especially the case after surgical operations, and if acute bronchitis intervene. Asphyxia will also be caused by oedema of the glottis, whether from disease or injury by scalding, or wasp or bee stings.

During the puerperal state, sudden death is not uncommon from thrombosis of large vessels, and from embolism of the brain or lungs; such cases may end by coma, asphyxia or syncope.

Sudden deaths from asphyxia are observed from over-dense atmosphere, as when working in caissons and mines; or from over-rarefaction of the air, as in balloons; or from the presence of poisonous or irrespirable gases, especially of carbonic oxide. Our present-day illuminating gas is much more fatal to life than that of earlier years, being largely composed of gas from water, which contains much carbonic oxide, and less from coal, which contained more hydrogen and marsh gas.

Persons may die asphyxiated from hydrophobia, tetanus, from strychnine poisoning, from the effects of such drugs

as conia or woorara, or from a respiratory palsy caused by an embolism, or a haemorrhage about the cerebral centres which stimulate the muscular breathing apparatus.

If the respiration is suddenly stopped death occurs in about three minutes, as is well seen after immersion in water, when this occurs without a fatal syncope.

COMA AND BRAIN DISEASES.

Sudden deaths accompanied by coma are mostly due to diseases of the brain or to apoplexy—that is, haemorrhage into its structure, or upon its upper or lower surface. Tumours and abscess of its substance cause prolonged illness and arise from tubercle or syphilis. All these causes are found fairly easily by *post-mortem* examination.

The cases difficult of explanation are the deaths from coma (profound insensibility, loss of mind and motion, without any necessary association with loss of cardiac power, or asphyxia) which display to the pathologist no gross lesion of the brain, spinal cord, or other vital organ. I refer to such cases as the sudden death in coma after attacks of convulsions. In persons known to have had previous epileptic fits it is usual to allege epilepsy as the cause of the death, but this is not capable of any pathological proof. Some similar cases are attributed to uraemia, if a test of the urine found in the bladder shows the presence of albumen. In other cases the discovery of grape sugar in the urine is considered to be sufficient proof that death has been due to diabetes. Perhaps in the future the microscope may throw further light upon these obscure deaths from coma.

A somewhat sudden death from coma with or without convulsions arising from uraemic impurity of the blood is said to follow the pressure of a retroverted gravid uterus upon one or both ureters, but this must be very rare, as I have found no case among 15,000 inquests.

A sudden end by coma occurs in the course of long-standing disease of the middle ear with ruptured membrana tympani and a purulent discharge; there is danger if the discharge ceases. Such cases are generally due to tuberculosis.

Deaths from coma may be due to external violence of which there has been no witness, and for which there may be seen no external mark; in such cases *post-mortem* examination may disclose a fracture of the skull with depression of the bone, or with cerebral compression due to haemorrhage. This fracture may be of the vault or of the base, or through the important regions of the ear. Such an injury may happen after an apoplexy, which may cause the sufferer to have a sudden and violent fall.

KIDNEYS AND URAEMIA.

A healthy state of the kidneys is as necessary to life as the integrity of the heart, lungs, and brain—which Bichat called the "tripod of life"; but death from kidney diseases has no fourth type of death to supplement syncope, asphyxia, and coma, so affections of the kidneys end in one of the already recognized three ways.

Modern physicians of great repute allege that kidney diseases are among the commonest causes of sudden death. A fatal termination often rapidly follows the onset of coma and convulsions of a uraemic nature set up by failure of the kidneys to purify the blood; these symptoms are a recognized termination of cases of chronic Bright's disease and of acute scarlatinal nephritis, but these forms of illness are not likely to be overlooked, and so such deaths are hardly included in my subject as unexpected and sudden. Chronic kidney diseases, especially granular contracted kidney, associated with the weakness of a hypertrophied and often dilated heart, are a not infrequent cause of the sudden fatal syncope of middle-aged persons who have lived freely, and this occurs without any well-marked period of definite illness. In a similar manner gout has been classed as a cause of sudden death; chronic gout is often a companion of disorganized kidneys, which obstruct the circulation, lead to cardiac hypertrophy and dilatation, and to sudden syncope. The sudden retrocession of acute gouty inflammation from a joint has often been followed by an unexpected death.

Sufferers from kidney disease bear infectious diseases badly, very often get septicaemia after surgical operations, and are specially liable to death under anaesthetics.

Cases of Addison's disease are very likely to end fatally in a sudden manner.

Of recent years the unexpected deaths of children have been frequently attributed to an enlarged thymus gland, which is supposed by its pressure on the trachea or on the pneumogastric or recurrent laryngeal nerves to provoke anginal seizures. It has been said that a proportion of infants found dead in bed with mothers and nurses, have not been suffocated by clothing or by the adult's body, breast, or arms, but by sudden congestion affecting an overgrown thymus gland. *Post-mortem* examination of such cases would show the signs of asphyxia and an enlarged gland, but it would be difficult to exclude the factor of deprivation of air by light clothing, etc., insufficient to cause pressure marks.

I am inclined to think that in women the change of life is occasionally the reason for a sudden death which leaves no definite *post-mortem* signs. The stoppage of a recurrent drain on the system leads to a congestion of vital organs, as well as to a uterine plethora, and I have heard of several cases showing a short period of suffocative sensation ending in a quite unexpected death.

CONVULSIONS FROM VARIOUS CAUSES.

A sudden death in convulsions, apart from any definite coma, may occur in epilepsy, and is also often seen in infancy associated with the first dentition, and a form of still more rapid death is noticed from the localized spasm commonly called laryngismus. The final convulsive twitchings of asphyxia due to croup and diphtheria may fairly be called a mode of sudden death.

Of deaths from self-generated poisons, in addition to those from uraemia there are somewhat sudden deaths due to cholaemia during jaundice and due to disease of the liver or derangements of the bile ducts.

Acetone circulating in the blood in the course of cases of diabetes is also considered to be likely to cause a sudden death.

If a person be found dead with water in the air passages, drowned in only a few inches of water, a mere puddle, it is almost surely a case of epileptic convulsions and coma.

Sudden death with asphyxia and convulsions is not seldom found due to choking by a foreign body, food, teeth, jujube, lozenge, etc.

The sudden onset and fatal issue of convulsions arising from oedema glottidis must not be overlooked, whether from laryngitis, insect stings, or Ludwig's angina. This oedema has been noted in cases of diabetes and Bright's disease.

In deciding upon the cause of an unexpected or sudden death (as in making a diagnosis) it is necessary to consider whether it has been to the interest of the person who has died, or of any other person, to assist in obscuring your judgement as to his recent state of health; and this again needs to be revised by an opinion as to whether if, against his or her real interest, he or she may not be under control of some hysterical prepossession. Remember also that women will occasionally be found to hide diseases and symptoms from a bashfulness and modesty so great and perverse as to be hardly credible. I have known several cases of female deaths reported as sudden and of cause unknown, when the medical man called in during the latter hours of life has been quite unaware that his lady patient was dying of gangrene, of a strangulated femoral hernia, or was bleeding to death from the bowel, or from ruptured varices of the vulva.

In the holding of inquests upon cases of sudden death, one notable fact has often been remarked—that the deceased had been apparently specially well immediately preceding the death. There has always been a popular idea that in lingering life and gradual death from illness there often occurs a "lightening before death."

Roman Catholics have a special interest in the subject of sudden death, because that Church desires the opportunity of spiritual ministrations, of baptism, conditional absolution, extreme unction, or of penance and the Eucharist. The priest desires to know, if possible, how long life may last, and how long consciousness will remain, and it is highly desirable that no one should die unshriven.

When death seems imminent the members of a Roman Catholic house send for their own or any priest. If the patient be dead on the arrival of the priest, he leaves

without doing anything. So that it is very desirable in such cases to decide the moment of death. Roman Catholic physicians have noted the recovery, sometimes only for a short time, of many cases of apparent death. Dr. A. O'Malley, of the United States, narrates thirty cases of apparent death (query, *who* said "death" had occurred?) in four of which entire recovery followed suitable skillful treatment.

I remember one case where I entered the chamber and was told the patient, an aged woman, had been dead many minutes, when, on giving brandy on a sponge in the mouth, the lady recovered and lived until the next day.

Roman Catholic authorities have said that in case of a sudden and unexpected death, such cases of resuscitation should authorize a priest in giving conditional absolution or baptism within an hour or two after apparent death, especially in cases of violent death of healthy persons. They add: "We do not know when the soul enters the body, and there is the same doubt as to the moment when the soul deserts the body, so give every possible benefit of religious observance."

Roman Catholic doctrine recites that the death without the "rites of the church" of an ailing member whose death may be anticipated by a medical attendant is a matter of grave concern. The times for death may be anticipated with much certainty in many acute diseases, and warning given to the priest, while in most chronic diseases the end can be calculated very nearly. Still, we must remember the old saying, "Death always comes unexpectedly."

Hippocrates wrote that the most difficult question asked of the doctor was, Will the patient live? His chapter "On the Progress of Disease" may still be read with advantage.

The occurrence of sudden death from a legal point of view is often a happening of the gravest importance. Apart from the serious results often resulting from intestacy, the loss of a personality in almost all businesses is a matter which upsets all arrangements and terminates many contracts. It locks up banking accounts and stops payment of cheques already drawn but not cashed. A sudden death often intervenes between the service of a summons as juror or witness and the date of the duty required, and such a death may lead to the loss of suits which would surely have been gained.

The occurrence of a sudden death of which the cause is unknown involves the holding of a coroner's inquest, with all its unpleasantness to family life, and it may give rise to serious, even if unfounded, suspicions of foul play by relatives or friends; or of neglect, which may be very difficult to disprove.

Deaths from the felonious administration of poisons are no doubt a rarity to-day, but in former times the sudden death of a notable person was often attributed, and no doubt rightly, to secret poisoning. Madame Brinvilliers in France and the Borgias in Italy certainly caused many sudden unexplained deaths.

Having now passed in review in a cursory manner the causes of sudden death and noted the unfortunate results which may arise, it may be permissible to say that it may yet be to the recipient a great blessing. Members of the Church of England are accustomed to pray every week of their lives to be delivered from sudden death*; is it wise to do so if the fervent prayer of a righteous man avaleth much? Doctors and nurses see most of slow deaths from disease; how many of such long for a slow dying? Relatives and friends who have just left the deathbed of a dear one who has suffered long the terrors of pain—bleedings, vomitings, hiccoughs, purgings, and delirium—do they not always say, "May I be spared a long illness"?

The frequent suicides of those who suffered severely show that a sudden violent death is preferred to a slow natural dying.

The present discussions on an artificial euthanasia also show that death by natural illness is a disaster to be avoided.

There remains our duty as medical men; it has from the time of Hippocrates been a perfectly definite article of rightful duty to protect life as far as is possible.

The means of deferring death are identical with the

means of curing disease and preserving health. Apart from correct treatment and advice, patients can only be warned in which direction their ailments and imperfections may threaten a fatal issue. So long as a patient is actually under medical attendance he will generally conform to rules, but when urgent symptoms have passed and he is left to his own devices, the full force of the old fact—*humanum est errare*—comes into play, and Death secures his victims with considerable ease.

AN UNUSUAL CASE OF SUICIDE BY SUFFOCATION.

By J. MILL RENTON, M.B., CH.B.,

EXTRA-DISPENSARY SURGEON, WESTERN INFIRMARY, GLASGOW.

THE patient, a middle-aged man, was brought to the work-house by the police with a history of delusions. On examination, no definite signs of insanity were found, but it was thought desirable to keep him under observation.

On the evening of the same day, quite suddenly, he became violent and excited, and, in order to ensure his safety, he was placed in a padded room. After being removed there he became much quieter, and finally lay down and went to sleep. An attendant visited him regularly, and he appears to have slept soundly for several hours. When seen at 9 p.m. he was fast asleep, but at 9.20 p.m. it was noticed that his bedclothes had been thrown off, and on further examination he was found to be dead.

When seen by me a short time afterwards, the body was lying on its back with the arms outstretched. The face was placid, and no marked cyanosis was present; there was, however, lividity of the lips, ears, finger and toe nails; there was also some dried blood on the lips. The mouth was closed but the jaws were not clenched, and were easily opened by the fingers. Inside the mouth a piece of flannel about 1 ft. long by 1 in. broad was found, and behind this were two almost similar strips. The last of these was so firmly packed down over the epiglottis that it was withdrawn with some difficulty. He had obtained these strips by tearing up his blanket, and had evidently suffocated himself by packing them down his throat.

I record this case, as suicide by this method is comparatively rare, and only a few similar cases are mentioned in medico-legal literature. Casper, in speaking of the subject, says:

Experience teaches that suicide by stuffing the air passages with foreign bodies is a most unheard-of affair.

Taylor also considers it to be very rare, but gives details of 3 somewhat similar cases. One of these is specially interesting, as the patient had been examined and certified as dying from "apoplexy," and it was only accidentally that a plug of cotton was found in the throat.¹ Three other cases are recorded in the *BRITISH MEDICAL JOURNAL* of 1882, and one of these was resuscitated by prompt medical treatment being adopted in time. Glaister also mentions a case of a similar nature, where a man forced cloth down his throat by means of a wooden spoon, but he considers the occurrence to be very uncommon.

Cases of this nature emphasize the necessity of always examining the mouth and throat in cases of sudden death. I was interested at the time to note that apparently no effort had been made by the man to withdraw even the last strip of flannel, as I found it well back in the mouth. Considering the fact that death probably took place comparatively slowly, it is striking that, while yet in a semi-conscious state, he should not instinctively have withdrawn at least one piece. It, however, only goes to show the extraordinary perversion of the primitive instincts in a determined suicide.

I have to thank Dr. Edmunds, of Chesterfield, for permission to publish this case.

REFERENCE.

¹ Handyside, *Edinburgh Medical and Surgical Journal*, 1842.

BIBLIOGRAPHY.

Casper's *Medical Jurisprudence*.
Taylor's *Medical Jurisprudence*.
Glaister's *Medical Jurisprudence, Toxicology, and Public Health*.
BRITISH MEDICAL JOURNAL, vol. II, 1882.

* But theologians tell us that this word "sudden" means "unprepared for."—W.