draughts repeated, and Pil. Sap. cum Opio, gr. v., given at night.

22nd. Slept two hours at a time twice last night, and is decidedly better; pulse 60; countenance natural; no tremor; less talking; no allusion to the poisoned cake to-day. Mixture continued, and the pill again at bed-time.

23rd. More sleep, and is better in all respects. Contin. Mist. Pil. et Haust. purgans.

24th. Slept nearly all night; found him dressed and walking about his house; looking pale, and feeling weak, but otherwise very much better; quite rational and free from pain; bowels open; took some meat yesterday for dinner and enjoyed it; has had no beer or other stimulus at present.

R. Sol. Morph. Acet. dr. ij.; Sp. Lavand. Co., m. xx.; Inf. Gent. Co., oz. vj. M. Capt. oz. j., ter die. Pill at night, *if restless*. To continue meat for dinner *if he have appetite for it*.

26th. When I called to-day, to my surprise he was gone about his farm with his gun, and I did not see him.

28th. Again found him out. He has slept well each night, and he has taken his medicine less frequently: His wife thinks him as well as usual, except that his temper is more irritable. He has continued well up to the present time.

Remarks.—There is still so much obscurity in the physiology and pathology of the nervous system, that there is scarcely any safe guide to the treatment of nervous diseases, save that which is derivable from experience; and it is therefore desirable that cases which are calculated to throw light upon this intricate subject should be carefully and faithfully recorded. Delirium tremens is one of the diseases about which great uncertainty prevails, and practitioners are at variance with regard to its proper treatment. Opium is generally considered the sheet anchor; but a celebrated American physician has recently denounced it as improper. It is not my intention to enter generally upon the subject of *delirium tremens*, which is without doubt very frequently a fatal disease; but only to shew that, however well understood when unmixed and genuine, it may make its appearance under circumstances of complication, which materially interfere with facility of diagnosis and certainty of treatment.

Mr. — had been accustomed, for years before I knew him, to be bled and cupped; sometimes on account of severe cerebral disorder, sometimes because he thought he required it. By my advice he has broken through the habit, and for several years has lost no blood except on the occasions referred to in the case. His last illness was very slight before he was bled; it very much increased afterwards, and assumed a character of inflammation which seemed to indicate the necessity for further loss of blood. The delirium, pain in the head, flushed face and suffused eyes, rapid pulse, and costive bowels, seemed to point out that his cerebral symptoms arose from inflammation, and the probability was increased by the super-vention of convulsions. The relief produced by copious blood-letting in his former attacks appeared to

afford a clue to the nature of the disease, and an indication of treatment in the present instance. But I noticed that in constitution he was retrograding; that his bulk was diminished within the last twelve months; that his attack came on gradually, after drinking, and that his symptoms were worse rather than better after the bleeding; that although there was delirium, and that severe and constant, it was not the violent raving of phrenitis; that although his head and upper parts were hot and flushed, his feet were generally cold; that although his pulse was rapid, it was not hard and wiry; that his constipation seemed to depend upon general derangement of the chylipoietic viscera; and although convulsions under such circumstances are generally supposed to indicate meningeal inflammation, I thought it possible they might arise here from deficient controlling power in the brain. There were undoubtedly *symptoms* of inflammation present; but they were not unequivocal; there were also probable appearances of delirium tremens, and I felt sure that if the latter predominated, and I treated the former with activity, I should be likely not only to render the signs of delirium tremens more determinate, but also to render further treatment unavailing. It was possible too, that much of the cerebral disturbance arose from disorder of the digestive organs, and it was at any rate safe and proper to put them in order.

This course was therefore taken; the bowels were emptied, a flow of bile produced, warmth excited in the extremities, cold applied to the head. The consequence was the disappearance of the symptoms which led to the apprehension of inflammation of the brain, leaving those of delirium tremens, though without tremor, so obvious, that further difficulty as to diagnosis was at an end. The rapid cure of these latter by opium is strikingly in favour of its employment; and the testimony of many practitioners in this country amount almost to a certainty as to its value, when used with judgment and discrimination. My impression of the case above narrated is, that the bleeding in the first instance was either unnecessary or injurious, and that if I had acceded to the wishes of the patient and his friends by repeating it, he might like many others, have fallen a victim to delirium tremens, or have drawn on a prolonged existence with some paralytic defect.

Coltishall, June 23rd, 1847.

ON SACCULATED OESOPHAGUS CO-EXISTING WITH STRICTURE.

By W. C. WORTHINGTON, F.R.C.S., Senior Surgeon to the Lowestoft Infirmary.

(Read at the Annual Meeting of the Suffolk Branch of the Provincial Medical and Surgical Association, held at Beccles, June 17, 1847.)

Judging from the few cases furnished by English medical authorities, sacculated oesophagus, co-existing with stricture, may be looked upon as a pathological deformity of uncommon occurrence. Among Continental writers, Isenham and Sandifort have alone

noticed it. Two cases are described by British practitioners; one by Mr. Ludlow, surgeon, of Bristol, the other by Sir Charles Bell.

An account of Mr. Ludlow's case is to be found in the third volume of "Medical Observations and Enquiries," headed, "Obstructed Deglutition from a Preternatural Dilatation of, and Bag found in, the Pharynx," detailed in a letter from Mr. Ludlow to Dr. William Hunter, illustrated by engravings, read August 27th, 1764. The subject of this case was a man nearly sixty years of age. The disease was supposed to be caused by a cherry stone having lodged in his throat, but was coughed up at the end of a few days. Death did not take place till five years after this occurrence. Upon a *post-mortem* examination, a muscular bag was discovered, passing down between the œsophagus and vertebræ. It was described as being formed by a dilatation of the entire substance of the pharynx, the uniformity and thickness being so exact that it was impossible to ascertain at what particular part the dilatation began. Mr. Ludlow accounts for the formation of this pouch in the following manner:—"It is highly probable," he says, "that the cherry stone must have been forced between some of those irregular loose folds which abound in the lower part of the pharynx; and as the patient during that time ate his meals as usual, the stone being forced on by the aliment, in the act of deglutition, might create a cavity at least equal to its own size, and, perhaps, even larger, from the addition of some of the aliment. The stone, when returned, of course left a cavity which became a recipient for particles of food, and thus by degrees it increased in size."

At page 64, in the second volume of Sir C. Bell's "Surgical Observations," is described a case of a preternatural bag, formed by the membrane of the pharynx. The subject was a gentleman, who applied for relief owing to a disease of the throat, which gave him great uneasiness, and occasioned difficulty of swallowing. Many ineffectual attempts were made to pass the bougie. Death, however, was not ascribed to the complaint in his throat, but from what cause, is not stated. After death there was found a bag projecting from the lower and back part of the pharynx, pushed into a space between the œsophagus and spine. The bag was not covered with muscular fibres, but is described as a hernia or protrusion of the inner coat of the pharynx, between the strong fibres of the muscular coat.

With these few observations I shall now proceed to a brief statement of the case which has recently come under my notice.

Colonel D., aged 69, of a robust constitution, had the greater part of his life indulged an enormous appetite. Three years previous he experienced slight dysphagia, which continued for eighteen months without any apparent aggravation; his general health continued unimpaired. In the months of January and February, 1846, deglutition became more difficult, accompanied with a degree of emaciation. In July following he came under my care; there then existed considerable difficulty in swallowing solids, which required to be finely comminuted before they could be made to pass

the œsophagus. Just about this time Mr. Crosse saw the patient in consultation with me. A probang was introduced into the œsophagus, which became obstructed at or near the cricoid cartilage.

This operation was afterwards repeated at intervals, but I could never succeed in passing the instrument beyond what was considered the seat of stricture. It was remarked during the progress of the symptoms, that at each meal a portion of food appeared to be swallowed, but was shortly returned unassimilated, the process very much resembling that observed in the ruminating class of animals. Eventually the patient became totally incapable of swallowing food even in the most attenuated form.

For three weeks previous to death, which took place the following month of October, he was solely sustained by a pint of strong beef-tea, containing a glass of sherry, injected up the rectum every eight hours.

The pharynx, œsophagus, together with the larynx and trachea, were carefully removed for the purpose of inspection. A pouch or bag was discovered proceeding from behind the œsophagus opposite the cricoid cartilage, which must have hung down between the trachea and cervical vertebræ. Nearly two-thirds of it was covered with muscular fibres derived from each of the constrictors, which were much stronger and more developed than in health. The pharynx was laid open by an incision, commencing from its posterior border in the direction of the median line, and continued into the pouch two-thirds of its length.

This exposed the entire pharyngeal cavity which was found dilated far beyond what is natural. Immediately behind the cricoid cartilage, and opposite the commencement of the pouch, there existed in the œsophagus a stricture, formed by a transverse fold of the mucous membrane, and which would only admit a large-sized urethral bougie. The œsophagus below the stricture was contracted, but its mucous membrane throughout healthy.

There can be little doubt that in this case the stricture was the primary affection, and that the pouch became developed in consequence. Had the nature of the disease been detected in its earliest stage, and carefully treated with bougies, in all probability the serious consequences which followed might have been averted, for in the preparation, (which was handed round,) there exists no degeneration of structure at the seat of stricture, the stricture being caused simply by a contraction of the mucous membrane, which no doubt might have been easily made to dilate.

Lowestoft, June 21, 1847.

ON TURNING IN LABOURS RENDERED DIFFICULT BY DISTORTION OF THE PELVIS.

By THOMAS RADFORD, M.D., Consulting Physician to the Manchester Lying-in Hospital, &c.

Whatever practice can safely supersede the *murderous* operation—*craniotomy*, should be adopted. The records of operative midwifery ought not to be stained with so