cepting chemical analysis as a test of digestibility, and thoroughly trusting in the permanency of the artificially-peptonised state of foods and the nutritive quality of desiccated and pulverised albumen and fibrin?

It is evident that there is much in the ethical aspects of the pharmacy of to-day that concerns medical men and has important bearings on the practice of medicine. Pharmacy is undergoing considerable change, but in the midst of the healthy development there is a growth which, in excessive production and the tendency to invade all surrounding interests, is verily of the nature of a cancer. It is destroying the professional spirit in pharmacy. By means savouring of chicanery and advertisements emulating in a refined manner the example of quacks, it is deceiving the public, and it has the effrontery to solicit the aid of medical men by asking them to be the touting agents for its goods.

A CASE OF LYMPHATIC FISTULA FOLLOWING EXCISION OF TUBERCULOUS LYMPHATIC GLANDS: CURE.

By H. MARTYN JORDAN, F.R.C.S. ENG.,
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W. G., aged 32, an officer in the P. and O. Company, a strongly-built, ruddy-faced, healthy man, had a slight family history of phthisis. He had no cough nor sweating at night, but was of a very nervous temperament. He had contracted syphilis six years earlier, but had had no venereal disease for many months before he came under treatment. There were numerous varicose veins on both legs, chiefly the left, and some oedema of the ankles, which had been present, on and off, for the last six years. Heart, lungs, and kidneys sound. The cause of varicose veins and oedema I believed to be obstinate constipation, from which he had been suffering for years, aided on the left side by the pressure of enlarged glands on the long saphena.

He first noticed a swelling in the left groin on November 3rd, 1893, about four weeks previously to coming to me; he attributed this to a strain he received while on duty in his ship during a heavy gale. About a fortnight after the commencement of the swelling he was seen by three doctors in consultation; they administered chloroform and incised the tumour but found no pus; the capsules of three enlarged glands were opened, but no pus being found the patient was sent back to bed.

From November 3rd till his admission his temperature had varied from normal to 100° in the morning, and from 100° to 102.4° in the evening. After the incision on November 17th his temperature was higher than at any other period of his illness.

He came under my care on December 1st, 1893. There was an oval tumour occupying the left groin—5 inches long, 3½ inches broad; its greatest diameter was parallel with Poupart's ligament. The skin over it was of normal colour and freely movable, except at the margins of the incision, which was open and discharging a little thin watery pus. The tumour itself was only slightly movable over the deeper structures. The surface of the tumour was nodulated. No true fluctuation was obtainable. There was no sore on the buttocks, anus, perineum, scrotum, penis, thighs, or hypogastric region. The tumour had increased in size since the incision.

Dr. McLeod, of Shanghai, administered chloroform and assisted me during the operation on December 2nd. An incision about 4 inches long was made, parallel with Poupart's ligament and including in its centre the former incision (the edges of which were pared). The tumour, when exposed, was found to consist chiefly of a mass of granulation tissue, which was scraped away with a Volkmann's spoon. A number of enlarged glands then came into view, and were dissected out, many small vessels supplying these glands were ligatured and divided. There was a chain of enlarged lymphatics leading down to and through the saphenous opening. All the diseased tissue was dissected away until the fascia lata was laid bare. In dissecting away the last of the disease a small anterior saphenous vein was, unfortunately, divided

close to its entry into the long saphena. Very free hæmorrhage resulted, and after several attempts to ligature the proximal end—which was almost flush with the wall of the long saphena—had failed, the ligature slipping every time the wall of the saphena was picked up and tied, I ligatured the long saphena above and below. On removing the forceps profuse bleeding again ensued. The long saphena was dissected out and a large posterior saphena was found entering exactly opposite the divided anterior branch, and therefore between the two ligatures on the long saphena. This branch was ligatured, and the hæmorrhage at once ceased. The long saphenous vein was then divided between the two ligatures. The cavity was washed out with 1 in 20 carbolic lotion, then filled with iodoform and glycerine. Nine sutures brought the edges nicely together. A small drainage tube was inserted in the outer angle. The wound was dressed with a plentiful supply of iodoform gauze. The diseased tissue removed would have filled two ordinary-sized tumblers. On section the glands showed numerous yellow tubercles, and in several places points of caseation and suppuration.

The patient passed a very bad night owing to severe chloroform sickness. In the evening of December 3rd the dressings were changed as the discharge had come through.

On December 4th, 5th, 6th, and 7th, the dressings, which consisted of several layers of iodoform gauze covered by nearly a pound of absorbent salicylate wool, had to be changed daily owing to the discharge of a thin, clear, albuminous fluid, two to three pints of which were in the dressings daily.

On December 8th all the stitches were removed, the wound had healed by primary union except ½ inch at the outer angle, where the drainage tube had been; but there was a large cavity under the skin from which could be pressed a quantity of the clear albuminous fluid which coagulated on standing.

The patient then passed out of my hands for a week, during which the dressings were very loosely applied and had to be changed two or three times a day; roughly, four to five pints of lymph flowed into the dressings during the twenty-four hours.

On December 15th I was able to resume charge of the case. The wound was firmly united, but the cavity still existed and the discharge "poured" out of the opening at the outer angle of the incision. At no time during the course of the case was even a drop of pus seen. Two doctors saw him in consultation with me, and advised opening up the whole wound. I feared, however, that it would be impossible to pick up the weeping lymphatics. As by this time the wound was firmly enough united to stand pressure, tight bandaging over a large pad of lint was employed in the hope of getting union by apposition. The pad was the size of an ordinary man's fist, it was placed over the incision, and over this about half a pound of absorbent cotton wool: the bandage was applied as tightly as the patient could bear.

Next evening, December 16th, the discharge had come through, and the case was dressed; there was about one pint and a half of discharge in the dressings. A pad of lint was reapplied, and bandaged as tightly as possible. The dressings were renewed on December 18th (when they contained about two pints of discharge); and on December 21st and 25th, when there was much less discharge (about one pint and a half in the four days). At the next dressing, December 28th, there was approximately half a pint of lymph in the dressings. On January 2nd about 2 ounces; on January 5th about 1 ounce; and on January 8th the wound was perfectly healed, and there was no discharge in the dressings.

The patient was kept under observation until January 27th. On first attempting to walk, on January 14th, there was some pain in the groin, and much oedema of the left leg in the evening. This excessive oedema persisted for some time, but was benefited by an elastic bandage applied from the toes to the thigh when walking. A year after the operation he was walking about quite freely, feeling no pain. Oedema of the ankles, equal on both sides, was present after a long day's standing. The varicose veins on the left side were smaller.

REMARKS.—An instance of "lymphatic fistula" following the excision of lymphatic glands¹ not having hitherto come

¹ Fistula following a wound of the thoracic duct is, of course, quite different.

within my experience or reading, I detail it hoping that it may be of use in the event of such an alarming complication being again met with. In this case the whole, or at any rate the greater, part of the lymph from a large surface of the body was discharged through the sinus. As day after day passed without improvement I became extremely anxious regarding this huge drain on the strength of my patient, also as to the effect on the tissues from whence it came, and, consequently, as to the termination of the case. During the first week after the operation the dressings were applied with but moderate tension, as the wound was not firm enough to stand much pressure. The next week they were, in my absence, very loosely applied, and a great increase in the quantity of the discharge resulted. The effect of the subsequent tight bandaging was almost immediate and very marked. A deduction from this case appears to be that where the whole of the lymphatic glands have to be excised, it would be better to tie all the vessels going to them before removal.

MEMORANDA:

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

HYPERPYREXIA FOLLOWING THE USE OF ATROPINE.

THIS is an example of idiosyncrasy in a baby, 1 month old, suffering from opacity of the cornea, and into whose left eye I had been dropping twice daily for a week a sulphate of atropine 4 grains to the ounce solution. On May 24th I used the atropine at 9 P.M. At 11 P.M. the nurse noticed the child to be very restless, dry in the mouth, and feverish. On being sent for at 1 A.M. next morning I found the temperature to be 107.2° F. I reduced this temperature to normal by means of the cold bath. At 9 A.M. on May 25th the temperature was 101°, and in the evening it was normal. On May 26th, at 12.30 P.M., the temperature was quite normal, and I again used the atropine drops. At 1.30 P.M. the temperature was 104.5°, but was reduced by means of an antipyretic. The temperature was normal on May 27th, and has continued so ever since, the use of the atropine drops being discontinued. The child is a very healthy one, and, beyond the corneal opacity due to injury during labour, has nothing whatever the matter with it.

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ACUTE BRONCHOCELE FOLLOWING INFLUENZA.

THE account in the BRITISH MEDICAL JOURNAL of May 4th of a case of acute thyroiditis occurring as a complication of influenza reminds me of a very similar case which I had under my care in December, 1894. Mrs. C., married, aged 42, had been suffering from influenza from December 2nd to the 13th. On December 21st she had pains all over her, and a temperature of 103°, and complained of pain in the region of the thyroid, which was not enlarged then but very tender. Six hours after having first seen her I was again sent for, and found her in great pain, and with considerable enlargement of the thyroid, and intense pricking pain in the gland and up the sides of the neck. I applied hot fomentations, which relieved the pain, and gave a mixture containing iodide of potassium every four hours, and 3 grains of sulphate of quinine in a tea cup full of milk every two hours. The next morning the gland was further enlarged, and the skin very tense and shiny over it. The temperature was 102°. There was great difficulty in swallowing, and the breathing was laboured. I painted the surface of the gland and the sides of the neck with belladonna and glycerine, and put a good thick covering of cotton wool over it. On the evening of December 23rd, about fifty-two hours after she first felt any pain in the neck, the pain suddenly left her, and she slept for the first time since its onset. The gland rapidly decreased in size for four days, but did not regain its original proportions, and is still somewhat enlarged. The patient had another attack of influenza in March last, and although she was very ill for nearly three weeks there was no pain in or enlargement of the thyroid at all.

Beyond the fact of its being a comparatively rare complication of influenza, it was interesting to note the very rapid subsidence of the inflammation, sudden cessation of pain, and the fact that in another attack this spring there was no return of thyroiditis.

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DRAINAGE IN SUPPURATIVE CONDITIONS OF THE ABDOMINAL CAVITY.

THE remarks of Mr. Arthur E. Barker in the BRITISH MEDICAL JOURNAL of May 25th are borne out very strikingly by a case that I have recently had under my charge.

A man, aged 50, was admitted to the Auckland Workhouse in the afternoon of February 15th. I saw him in the evening, and found him suffering great pain, a good deal collapsed, and with the abdomen much distended. I ordered alcohol to be given frequently during the night, and next morning opened the abdomen to the right of the middle line. Over two quarts of stinking pus escaped. After well washing the cavity I found the appendix much enlarged, and bound by firm bands both to the intestine and the abdominal wall. As the cæcum had a most unhealthy appearance, I decided not to remove the appendix, but placed a drainage tube in the lowest part of the incision, suturing the rest of wound in the usual manner. The tube was removed at the end of forty-eight hours. For the next ten days there was a slight discharge of healthy pus from the opening. On the eleventh day there was a free discharge of faecal matter, which continued in decreasing amount for a week. From that time the wound gradually closed without any bad symptom. The man was well and walking about on March 20th, four weeks and three days after the operation, and went out of the workhouse to resume his occupation at the end of ten weeks.

In this case drainage was of course a necessity owing to the condition of the appendix and cæcum, but the point that I wish to emphasise is that the short time for which the drainage tube remained was amply sufficient to leave a safety valve for the discharge of both the appendix and faecal matter until the fistulous opening in the cæcum was healed, the whole process being unaccompanied by any constitutional disturbance whatever.

Bishop Auckland.

MARK WARDLE, L.R.C.P.

INFLUENZA AS A SPECIFIC NERVOUS FEVER.

It has been pointed out that influenza in many instances appears to fall with severity on the nervous system. After a fairly large experience of the complaint I should be prepared to argue that it is a specific nervous fever. My reasons for calling influenza a specific nervous fever would be:

1. Like cerebro-spinal fever, it is infectious and accompanied by most of the symptoms and liable to many of the sequelæ of that complaint.
2. The catarrhal symptoms are in most cases trivial.
3. The backache is spinal, and is not affected by posture or ordinary movement in the same way as lumbago. The pain in the limbs ranges from severe neuralgia to mere nerve fatigue or exhaustion.
4. The headache, delirium, tinnitus, etc., are due to implication of the cranial nerves.
5. The vomiting and diarrhoea are probably reflex.
6. The complications are mainly nervous—(a) temporary blindness from optic neuritis; (b) suspension of the sense of smell, taste, and hearing; (c) menorrhagia in females, vasomotor disturbance.

With the most fatal complication—pneumonia—there may be more connection traceable when we know more about pneumonia itself. At present, to bear out my argument, I would only say that pneumonia is a recognised complication of any exhausting disease.

I think we may take it that considering the enormous number attacked the increased mortality from pneumonia is no more than *pro rata*.

The sequelæ are mostly nervous: Insomnia, neuralgias (supraorbital especially), temporary inco-ordination, paresis (from peripheral neuritis) down to simple pricking or numbness in the fingers and toes, loss of memory, impotence,