On admission, the patient was found to be in a very weak and anæmic condition—he evidently suffered much from continuous pain—the bladder was in a very irritable condition, and large quantities of foul-smelling pus escaped with the urine. On the left side of the perineum was a cicatrix in the usual position, following a lateral lithotomy with a small fistulous opening from which pus escaped and some urine, about its centre.

The bladder was injected with saturated boracic acid lotion for three days, and then, owing to his great distress, and notwithstanding his emaciated condition, it was decided to operate. Under chloroform a stone (phosphatic) was crushed and evacuated without difficulty. On sounding, however, though nothing could be discovered in the body of the bladder, something like an enlarged prostate, but which was without doubt a stone, could be felt with the finger in the rectum between it and the sound. A small-sized lithotrite failed in grasping the stone, but with the finger in the rectum a full-sized one was more successful; the stone was grasped, but could not be moved into the bladder, but had to be crushed where it lay encysted. The operation was finished without further trouble, and what had appeared to be an enlarged prostate had disappeared. The stones weighed in all 1½ oz. Beyond a rise in his temperature to 102.5° F. on the first day and 100.2° on the second, the patient did remarkably well, and he left the dispensary on June 14th with no pain, almost clear urine, and no signs of stone.

Taken in all its bearings this case is probably unique. The cystocele occupied roughly two-thirds of the trigone towards the right; its upper margin appeared to form, especially towards the left, a very firm crescentic-shaped projection from the bladder, which had resisted all attempts to move the stone upwards. The incision made in 1889 must have not only passed to the left of this projection, but probably also by severing its attachments allowed it to fall forwards, and so completely cover the stone. That the operation relieved him of his trouble was to be expected, as it resulted in permitting a free drainage of the bladder behind the projection, and for the time being cured him of his cystitis.

HINTS ON SEA VOYAGES FOR PATIENTS.

By GEORGE WALTER BARBER, M.R.C.S.ENG.,
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Surgeon P. and O. Service.

WHILE serving at sea I have been struck by the number of people sent away for the benefit of their health with absolutely no directions as to the precautions that should be observed in the tropics, and as to matters which greatly conduce to the comfort and well-being of the patient.

In the first place, it is well that an entire cabin should be secured, especially for phthisical patients, as they are at once a source of infection and also a great annoyance to those occupying the same cabin, and should their complaint become serious it is a necessity.

A crowded ship should be avoided, as, unless the patient has an attendant, he or she cannot have the attention from the stewards and stewardesses that a severe case demands. These last make most excellent nurses, but naturally they are extremely busy in a crowded ship. The cabin selected should be amidships, where the motion and vibration are least felt, and for a voyage *via* the Suez Canal should be on the starboard side homeward bound and the port side outward bound.

The patient should be told not to neglect to wear a cummerbund over his pyjamas (not nightdress), as the neglect of this precaution frequently leads to severe abdominal pain and diarrhoea, and often colitis, owing to the free perspiration which occurs in the tropics being suddenly checked by a stream of cold air from an open port, hatchway, or punkah. This, of course, greatly militates against the good done by a trip.

The patient should never sleep on deck, especially if suffering from a throat disorder, and as soon as he arrives in the tropics he should be told to wear a solar tope, which protects the neck, as those in indifferent health are particularly liable to sunstroke, sun headache, and thermic fever. I

have recently had a patient under my care who was sent away for the benefit of her lungs, which it was feared might become tuberculous. In Cairo she suffered from sunstroke, and two months later came under my care at Colombo suffering from thermic fever and hñl diarrhoea contracted up country, all of which might have been avoided with ordinary care. The patient should be told to keep on deck as much as possible, and not stay below as they so often do; but they should not sit under a single awning which allows the sun's rays to penetrate. Clothing should be suited to the varying climates, warm clothes for the Atlantic and Mediterranean (according to the time of year) and flannel for the tropics.

I think all alcoholic cases should be put under the charge of the ship's surgeon at the commencement of the voyage, as he is able to see that they get no liquor. The morning bath should be taken warm by those who are in delicate health and malarial cases, especially those suffering from enlarged spleen. Very strict orders should be given about diet, as passengers generally eat too much and take too little exercise in spite of the best advice. In the P. and O. service any diet can be procured on the recommendation of the ship's surgeon.

A good deal has been written about sea sickness lately. I have found the following prescription of great value: R chloroform. pur. ℥j; tr. nucis vom. ℥j; tr. lavand., ℥x; aq. ad ʒj. M. ft. mist. To be well shaken, and one teaspoonful taken every hour until the nausea is relieved, and liquor morphini acetatis ℥v if there is much pain. A tight binder will often relieve the pain due to straining, especially in uterine cases. Alcohol is unnecessary in most cases, and I think many people take too much if left to themselves. Milk and soda, beef tea, beef jelly, should be given in small quantities at frequent intervals, and crushed ice given to suck.

I think many patients would derive considerably more benefit from the voyage if medical men made it a rule to give them a few hints before sending them on board ship, and also not to neglect to give them a letter describing their cases, which they may hand to the ship's surgeon should they find it necessary to consult him.

CONVULSIONS AND PHLEBITIS IN MEASLES.

By EDWARD MACKEY, M.D.,
Physician to Children's Hospital, &c., Brighton.

CASE I.—A boy of 10 years, healthy but "nervous," came home from dayschool on July 13th, 1895, with sickness and headache, but was at church next day and out also on July 15th, if not July 16th, when a rash was noticed. On July 18th, when first seen by Mr. Morgan, measles were fully developed and no unusual symptoms presented. When left at 10 p.m. he expressed some fear of "robbers" (attributed to his story books). At 3 a.m. he was heard moaning and found unconscious. A few hours later we saw him together—comatose with some stertor, insensible corneæ, dilated pupils, retracted head, spastic rigidity of limbs, contracture of fingers and toes. The temperature was 105°. The heart's action fair, no dulness over lungs. There were dark maculæ on various parts, some not fading on pressure; no urine was obtainable. Calomel, mustard pack, two leeches over each mastoid, and hypodermic injection of pilocarpine were used, and he became quieter and able to swallow, but died of asthenia at 8 p.m. *Post-mortem* examination of the head only was allowed. The brain bulged out, large and soft, free from coarse change, but the veins were congested. Under ¼-inch lens sections showed capillaries densely crowded with corpuscles, which suggests that perhaps freer and earlier bleeding with perhaps saline injection would give the best chance to a similar case. Toxins circulating in the blood and overwhelming nerve centres—this seems the only explanation.

CASE II.—A girl of fifteen months, teething, got a slight general convulsion for two or three minutes on August 8th. Two previous babies were said to have died of tuberculous meningitis, but this one had thriven remarkably well on sterilised milk, etc., in healthy surroundings (large detached house in grounds) and with every care. She rallied well, but on August 10th had much cough and hurried breathing with *râles* and some dulness of the right base. On August 11th

the chest signs were better, but an obscure papular rash was noted over the front of the chest, and next day over the legs. Not till August 13th was there a characteristic rash of measles on the face. There were still some twitchings but no vomiting, screaming, or eye symptoms or head pain. The cervical glands, especially the left submaxillary, were enlarged. There was no sore throat, but the gums being swollen and tender were lanced. Sleep was fair, food was taken, the bowels were open. The child was given some saline with aconite, and once or twice daily phenacetin with bromide. Temperature continued high, 102° to 103° or more. The chest symptoms were moderate. On August 15th the temperature was normal for a few hours, but by evening it was again 103° without definite cause. (On this day the only other child, a boy of 8, developed measles of ordinary type, which he passed through without giving a moment's anxiety.) On August 18th the right foot and left hand were oedematous, rather hard but pitting on firm pressure. (Small doses of sublimate and iodide were now ordered, also stimulants.) Next day the foot was less, but all the left arm was swollen and brawny (but not dead white). The pulse was unaffected and there were no streaks or cords of veins or lymphatics; a few drops of serum exuded on puncture through the very tough skin. The child was in much pain, requiring some chloral. The temperature was 104°. No sweating, diarrhoea, or vomiting, and the nervous symptoms were less marked, so that one could now exclude tuberculous meningitis. On August 22nd Mr. H. Taylor met me to consult as to possible surgical interference, but decided against any the diagnosis being "septic phlebitis with thrombosis." Ecchymosis now appeared at the bend of the elbow, extending to the axilla, and vesicles came on the wrist. Hot packs and stimulants were employed, but death came rather suddenly on August 23rd from heart failure.

Dr. Ringer says, "convulsions not uncommonly" usher in measles in children without being serious; this may apply to a single initial convulsion, though one may doubt its being common. Meigs gives 5 instances in 314 cases, but all agree they are rare when occurring in the course of the attack, and practically fatal. I have never seen a case like No. 1 before, and am cognisant of only one other. In scarlatina I have known three such.

The unfortunate termination of Case 2 by phlebitis without apparent reason is, in my experience, unique, and such a "complication" is not mentioned by authorities, even in the long list in Ziemssen. Hence I am anxious to record it, with the query whether any serum injection might avail in such a case, for no medicines will. At present—I quote from Steinberg's *Bacteriology*, 1896—our knowledge of this science as applied to measles is vague, but streptococcus pyogenes has been found in morbillar pneumonia (Mosny, Netter).¹ Is it possible that the antistreptococcus serum, used with such brilliant success in a few recent septicæmic cases—for example, the case recorded by Mr. Ballance and Mr. F. C. Abbott in the *BRITISH MEDICAL JOURNAL* of July 4th, 1896, p. 2—might help also such a case as this?

A CASE OF FATAL CEREBRAL HÆMORRHAGE IN A YOUNG ADULT.

By C. R. SALISBURY, L.R.C.P. LOND.,
Stanningley.

F. S., aged 21, a labourer in a foundry, was first seen by me on September 10th, 1894, and he had been complaining of general *malaise* for three or four weeks. His complaints on the above date were: Pain in the back, aching pains in the limbs, a catching pain over the left lower ribs, and feeling cold and shivery. He had no headache and his temperature was 101°. No pleuritic friction sound detected, but there was some tenderness on pressure over the painful area. The urine was high coloured and loaded with urates, but free from albumen. The heart was normal. He was sent to bed and felt much better next day.

On September 12th he came to my house, in spite of contrary advice, and complained of feeling cold, and that he was

spitting blood. He expectorated some rusty sputum then, and his temperature was 100.5°.

On the following morning, September 13th, there had been no hæmoptysis, but free epistaxis. The temperature was normal. There were no physical signs in the chest, but he still complained of the pain in the left side of the chest.

From September 14th to 20th there was pretty free epistaxis, and on the last-mentioned day the gums were bleeding. The motions had been tar-like, due probably to the blood which he swallowed.

On September 21st the epistaxis was much less, and he said that he felt better.

On September 22nd he was pretty well during the day, but at 5.30 P.M. he complained of severe headache (vertical) and began to be drowsy. He became quite unconscious at 7 P.M. I saw him at 8 P.M. He was then quite comatose, breathing stertorously; the pulse was rapid and feeble, skin moist and clammy. The pupils unequal, the right being dilated and the left normal. There was no apparent paralysis of the face muscles, but a general relaxed condition of the limbs, with occasional spasmodic movements and rigidity. He remained unconscious and died at 11.30 P.M. There had been little or no epistaxis during the day.

Remarks.—The patient had never been strong. He had never been a meat-eater, nor had he eaten any vegetables. His diet had nearly always been tea and bread and butter, with an occasional apple or pear. There was no history of any previous hæmorrhages, and there were no purpuric spots. His father died aged 60 from cardiac failure, six weeks after an operation for strangulated hernia. Mother alive and well. It is not possible to obtain any history of the parents of the mother, nor was it possible to make a *post-mortem* examination.

There were no degenerative changes in the arteries. Is it possible that there is any analogy between this case and that of purpura hæmorrhagica, as a sequel to influenza, related by Sir T. Grainger Stewart in the Address in Medicine at Bristol? or could it be a result of a scorbutic condition, due to the abnormal dietary of the patient? The treatment adopted was compound tincture of benzoin as a local application for the epistaxis, and liquor ferri perchloridi internally with lime juice. The patient would not take any broths or similar preparations.

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

INDIAN HEMP POISONING.

On October 10th H. M., aged 23, came to me suffering from nervous prostration and general debility, for which a mixture containing Indian hemp was prescribed in combination with strychnine and quinine. This was taken regularly thrice a day up to November 3rd, and without any toxic symptoms beyond that of a feeling of drowsiness after the first few doses. On the night of November 3rd he took his usual dose (which happened to be the last in the bottle), and a few minutes afterwards his face became very pale, and, to use his own expression, he "wanted more air." As I happened to be in the house at the time I was able to watch the subsequent symptoms. He said he felt he was mad, that he could see and hear me one minute and then the next minute I had gone. I walked him out into the fresh air, and gave him stimulants in the form of chloric ether and sal volatile. He recovered himself sufficiently to say he felt well again and would go indoors. After remaining there a few minutes he jumped up again and the previous symptoms were repeated, but with the addition of a distressing sense of impending death. His pulse was 128 and very feeble; tongue dry and covered with a thick whitish-brown fur. He complained of his tongue swelling and his jaw becoming fixed. His hallucinations were frequent and far from the pleasant ones recorded in the textbooks after small doses of Indian hemp. He further became suicidally inclined, but was easily restrained.

¹ Bulloch, *Lancet*, January, 1896; and Sims Woodhead, *BRITISH MEDICAL JOURNAL*, October 3rd, 1896.