in which are embedded several chorionic villi and masses of fetal epithelium. As the corresponding Fallopian tube is free of the gestation sac, it is very probable that the specimen represents an ovarian pregnancy. However, it is too much damaged for a positive opinion on this point."

From all the facts considered together, it seems reasonable to presume that this was a case of very early ovarian pregnancy.

Sidcup, Kent. R. R. Law, M.D.Cantab.

REPORTS
ON
MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF THE BRITISH EMPIRE.

RADCLIFFE INFIRMARY, OXFORD.

A FATAL CASE OF PERITONITIS AND SEPTICAEMIA, PROBABLY PNEUMOCOCCIC IN ORIGIN.

(By H. C. Lecky, M.A., B.M., B.Ch.Oxon., late House-Physician.)

A. B., aged 27, was admitted on November 22nd, 1905, to the Radcliffe Infirmary, Oxford, under the care of Dr. Brooks. The patient complained of pains in the "stomach," which he had had for about four weeks and were now getting worse. He did not appear to be very ill, and could give a clear account of his illness. He stated he was a labourer in the fields, and had been quite well and in his usual good health up to October 22nd, 1905. He then caught cold and stayed in bed for two days. On the first day he had two severe attacks of shivering followed by sweating; on the second day he had one similar attack. There was no vomiting. At the same time he had some sharp pain in the right flank, which was severe enough to double him up. He went to his work daily for the next three weeks—that is, up to November 14th—but the whole time he had a bad cough, and the pain in the right side was almost continuous. It sometimes left off for an hour or so. Sometimes the pain was so severe that he had to stop work and lean over something to obtain relief. On November 14th he went to bed and remained in bed for the greater part of every day up to November 22nd, when he came into the infirmary. There was never any sickness. He had severe headaches from time to time, and there was a general aching in his limbs from November 14th onwards. He had four shivering attacks in the week before November 22nd. The bowels were open regularly every day, and nothing abnormal was noticed in the faeces. He had never been jaundiced, and the urine had never been coloured red. He had had no dyspnoea, and no severe pain on coughing or on taking a deep breath. The patient's past history was a good one, and threw no light on the present illness. The family history was not obtained.

State on Admission.—The patient was lying comfortably in bed, and was well nourished in appearance. The face and ears were hot, flushed, and slightly cyanosed, so much so as to immediately arrest one's attention. No rash on any part of the body. Tongue slightly furred. Temperature 101°; pulse 100, tension and volume normal; respirations 28, but in no way embarrassed; arteries a little thickened. No physical signs of disease were discovered in the chest, with the exception of a short systolic murmur, best heard over the inner end of the third left intercostal space. The lungs appeared quite normal. No signs of thickened pleura or fluid. The abdomen looked quite normal, and palpation was easy. There was some abnormal tenderness in both loins and in the right flank, but it was more especially marked in the right renal region. No tenderness at all in the right iliac region. No mass could be felt anywhere. The spleen and liver were not felt. No haemorrhages were seen in the skin. No typhoid spots. Knee-jerks brisk and equal. There was a slight cough. Urine showed a cloud of albumen, an excess of urates, no casts, and no pus cells.

Progress.—For the next six days the patient's general condition did not alter. The temperature chart was very irregular, varying between 100.5° and 103°, but on two occasions dropped to 98.4°. The pulse varied between 80 and 100. The respirations were always a little rapid, varying between 28 and 36. The patient sweated very profusely at night, but the skin was generally dry during the day. The extraordinary flushing and slight cyanosis of the face continued as a marked feature in the case. The stools were rather loose, contained mucus, were light yellow in colour, and certainly suggested typhoid; generally about two motions a day. He passed about 45 oz. of urine a day. He always slept well, and never had any headache. Mind always perfectly clear.

On November 28th, 1905, the abdomen was found to be slightly tender all over, but especially so below the costal margin in the left axillary line, where there was also some resistance. The spleen and kidneys were not felt. On November 30th a slight impairment of resonance at the right base was detected, with some increase of fremitus and vocal resonance. On other occasions some very slight signs were detected, which would probably never have been noticed if the diagnosis had been certain. On these slight lung signs, the increased rate of respiration, the flushing and cyanosis of the face, the pyrexia, and the absence of other symptoms, Mr. Gibson made a diagnosis of pneumococcic septicaemia. The blood showed a leucocytosis of 23,480 whites, 7,320,000 reds, 103 per cent. haemoglobin. The differential count showed 83 per cent. polymorphonuclear leucocytes. The Widal reaction was negative. The hands of the patient, and to a less extent the whole body, had a very peculiar musty smell. The tongue remained always slightly furred.

On December 4th the stools quite altered in character, and became more formed and darker yellow, almost brown in colour.

On December 7th a definite mass could be felt below the left costal margin between the mid-axillary and the nipple lines. It was very tender and did not move on respiration. There was no bulging or fullness in the left loin. In the next few days this rapidly increased in size, and on December 11th the mass was incised by Mr. Symonds, and a large quantity of very foul-smelling thin pus was evacuated. The mass was found to be retroperitoneal, and on account of its position, and the very foul smell, it was thought to be a perinephritic abscess, infected from the bowel.

The wound continued to discharge a large quantity of foul pus, which for the first few days had a distinctly faecal smell. The temperature varied between 101° and 98° up to December 26th. It then began to come down, and was normal from January 1st to the 7th. On January 8th it rose to 100°, and a fluctuating swelling appeared above and just outside the right sacro-iliac synchondrosis. This was incised, and a small amount of thin purulent fluid was evacuated. As this did not heal up the incision was enlarged, and a long sinus was found leading down to bare dead bone. Shortly after this he began to complain of a good deal of pain in the right leg, which he kept slightly flexed on the abdomen. His general condition became very much worse, with a rising temperature. There were no rigors. On January 30th a fluctuating swelling appeared in the right groin, which was opened above Poupart's ligament, and was found to have an extensive area in front of the iliacus muscle, and following its course down into the leg. A very large quantity of pus was removed.

The patient collapsed very shortly after this operation, and died on the same day.

Leave was not obtained for a complete *post-mortem* examination. The operation wounds were enlarged, and the abdomen and its contents were examined. The coils of small intestine over the lower half of the abdomen and the pelvic cavity were extensively matted together with old and recent adhesions. There was no free fluid. The most marked change was at the brim of the pelvis, where the descending colon was also involved in the matting together of the intestines. The coils of intestine in the upper half of the abdomen were quite free from any infection, and their surface was smooth and shiny. The alimentary canal—stomach, small and large intestine—was opened from end to end, and no evidence of ulceration was found anywhere. The appendix and caecum were healthy. In one or two places the wall of the intestine looked extremely thin, not unlike old healed typhoid ulcers. Microscopical examination, however, did not show any loss of substance or presence of fibrosis. The kidneys and spleen were rather large but otherwise

healthy to the naked eye. No renal stone was discovered. The bladder was healthy.

It was impossible to trace out the connexions of the various retroperitoneal abscesses owing to the scope of the examination being limited. Microscopically the diagnosis was cleared up by finding diplococci—which morphologically could not be distinguished from pneumococci—in the adhesions between the coils of intestine. No other organisms were found in the sections, and none were seen in the kidneys or spleen.

REMARKS.—The case is interesting owing to the difficulty of diagnosis, as well as to the comparative rarity of the condition. The history of the attacks of pain on the right side pointed to either appendix trouble or to renal colic; but it is noticeable that there was never any vomiting, and, in addition, that there were definite rigors, which, as a rule, are not associated with the commencement of either of these conditions. When seen in hospital, the cyanosis of the face, which remained so persistently, and the increased rate of respiration, were signs which pointed to some other diagnosis. The slight diarrhoea, with almost peasoup stools, and the pulse-rate disproportionately slow to the temperature, made one keep typhoid fever in view. But the presence of leucocytosis, the negative Widal reaction, and the general condition of the patient, were points against this conclusion. When the abscess was opened the diagnosis appeared to be clear: either an appendix abscess which had tracked up or a perinephritic abscess. However, the gradual decline of the patient and the opening up of several more abscesses showed that there was some much more general agent at work. The nature of this was only revealed by the microscope, when Mr. Gibson's original diagnosis was confirmed.

I am indebted to Dr. Brooks and to Mr. Symonds for permission to publish these notes.

SUNDERLAND INFIRMARY.

A CASE OF COCAINE POISONING.

(Reported by CECIL B. F. TIVY, M.B., B.Ch., B.A.O., R.U.I. Senior Resident Medical Officer.)

THE following case is of some interest as an addition to the already-published cases of cocaine poisoning, and may serve as a warning to younger members of the profession who might overlook the danger of using the drug in their anxiety to save their patients pain.

A patient, T. H., male, 56 years of age, was admitted to the Sunderland Infirmary on Sunday evening suffering from retention of urine caused by a stricture. He was sent up by a local practitioner who had made unavailing attempts to pass a catheter, and in so doing had caused considerable haemorrhage. My colleague, Mr. Laverick, made a further attempt at catheterization, but failed, and he reported to me that there were one or more false passages, and that the urethra was in a very inflamed condition. The patient was then given a hot bath, followed by a morphine suppository gr. ¼, and was then able to pass a little urine. This process I ordered to be repeated later, and the patient gained sufficient ease to enable him to get some sleep.

On visiting him in the morning, I found that the patient was still in great pain and his bladder quite full, being palpable a handbreadth above the pubes.

I resolved to get a small catheter or bougie into his bladder if possible, and to save the patient some of the pain and so facilitate the process, I decided to inject some solution of cocaine into the urethra beforehand. I therefore injected half a drachm of a 10 per cent. solution of cocaine hydrochloride with a glass syringe into the urethra in the ordinary way, telling the patient to hold the penis in his fingers to prevent escape.

I then left the patient with the wardsman who was attending me, and turned to wash my hands, but before I could get to the end of the ward the man called to me, and I returned immediately. I then found the patient in a state of clonic convulsion, with his back arched, and jumping up off the bed. His jaws were moving spasmodically, and he had bitten his tongue. His face was somewhat cyanosed and his breathing very spasmodic and slightly stertorous. The eyeballs were fixed and the lids half closed. I could not feel a pulse at the wrist, but his arms were jerking so forcibly that it was not easy in any case. I put my ear to the chest and heard the heart beating. His breathing rapidly became shallower and the convulsions lessened in force, and in about a minute respiration ceased, the cyanosis increasing; I put in a gag, pulled out his tongue, and began artificial respiration, and the Sister brought me a hypodermic syringe of brandy which she injected while I continued the respiration. I also had a hot stupe put over the heart, but when I listened again the beats had ceased. I persevered with artificial respiration for a quarter of an hour and had the brandy repeated but with no effect, as the patient never rallied, and was, I believe, dead in about three minutes from the time of injection.

I made a *post-mortem* examination the next day and found all the organs fairly healthy. The kidneys were congested but not diseased, the spleen was enlarged and fleshy, and the liver showed signs of cirrhosis. The heart had apparently stopped in systole, as all the chambers were empty. The heart muscle was a bit flabby, but otherwise healthy, and all the valves were normal.

An inquest was held and a verdict of death from cocaine poisoning returned.

I have not had much opportunity of looking up authorities on cocaine poisoning, but I have come across a record of one case of a similar nature where the patient had 2½ gr. injected into the urethra with fatal effect. My patient had 3 gr.

I may add that I have used this solution on several former cases; in fact, I had some doubts as to whether it would serve my purpose in this case, as I had used some out of the same bottle for two cases about six months ago, and I expected it would have deteriorated. I believe the patient must have been unusually susceptible, and the laceration of his urethra caused by the instruments used, made the absorption very rapid. The dose was hardly an excessive one, in the light of my former experience, and I find that Caird and Cathcart (*A Surgical Handbook*) recommend that 2 drachms of a 5 per cent. solution should be used for this purpose, which is double what I used.

British Medical Association.

CLINICAL AND SCIENTIFIC PROCEEDINGS.

JAMAICA BRANCH.

AT a meeting held on Monday, March 26th, Dr. BRONSTORPH related a case of removal of the prostate in a man aged 92. For ten years he had suffered. He had been taught by his medical attendant to pass a soft gum elastic catheter, and so he relieved his occasional attacks of retention of urine. On April 3rd, 1905, he passed the catheter for the last time, and on withdrawing it was, to use his own words, washed in blood; no urine came. On the 4th Dr. Bronstorph saw him, and on examination found his prostate enlarged, bladder extended to his umbilicus, and blood issuing from his meatus. He passed a large-eyed French gum elastic catheter into the bladder (the old man had no stricture); only blood came. The bladder was filled with urine and large blood clots. A perineal section was performed, but the finger could not reach the bladder on account of the enlarged prostate, and no urine came through the large rubber tube passed through the perineal wound into his bladder. The bladder was at once opened suprapubically, the clots of blood turned out, and with a gush the bloody urine escaped. The capsule of the prostate was then nicked with a pair of scissors, and with his index finger Dr. Bronstorph enucleated the gland, which, when removed and weighed, was found to be 5 oz. The bleeding was not very severe; the abdominal wound was stitched up, leaving the bladder free. A large-sized drainage tube was passed through the lower angle of the abdominal wound into the bladder, a safety pin run through the tube to prevent it slipping in, and a pad of gamgee tissue put over all, and kept in place with a binder. The recovery was uninterrupted, and the temperature never rose above 100° F. Except to bathe his perineum Dr. Bronstorph took no notice of the wound in it. The drainage tube kept slipping out of his bladder, and caused some annoyance, but it was always replaced. Dr. Bronstorph never washed out the bladder, and did nothing more than keep the old man clean and dry. His sleep every night was sound; in five days he could sit up unaided in bed, and