sion, so that no fistulous channel was left. In the only other case that we remember to have seen, which occurred some years ago in the practice of Mr. Cæsar Hawkins, a fistula was left; and the cause of it was only recognised at the operation. In that case, the patient was quite unaware of the accident which had led to his complaint.

An elderly woman, aged 68, of intemperate habits, was admitted under Mr. Barker's care, on account of suppuration in the right nates, near the rectum. On inquiry, it was found that she had been eating a sole for dinner, when a bone stuck in her throat, and would neither go up nor down for some time. Finally it went down, and she thought no more about it, only that she felt an occasional uneasy sensation about the epigastrium. This occurred more than a fortnight before admission. When admitted, she was low and feeble, and erysipelas was extending over the surface of the skin in the neighbourhood of the diseased parts. No distinct fluctuation could be felt, but the presence of deep seated matter was indicated by the doughy sensation presented. A deep incision was accordingly made by the side in the rectum; and, in doing so, a foreign body was found, which grated against the knife. Pressure was made to evacuate the matter; and a fish-bone, two inches in length, protruded from the wound. On this being extracted, the patient related the foregoing history. The wound healed very quickly, and no fistulous communication was left. The patient was soon in perfect health.

ST. MARY'S HOSPITAL.

POISONING BY ACONITE-ROOT.

[*From the Hospital Post-Mortem and Case-Book.*]

THE following case is reported in order to put on record the *post mortem* appearances which follow the operation of this poison, and of which few, if any, perfectly full accounts appear to have been yet published. The case is otherwise of no particular interest, as the patient (who was nominally under Dr. Alderson's care) was seen far too late for any good to be expected from any kind of treatment.

James D., aged 58, was admitted, under the care of Dr. Alderson, on July 11th, at five minutes before one in the morning. He was a gardener, and acquainted with the properties of plants; and, being in great distress, had dug up a quantity of aconite-root, and dried it, with the intention of committing suicide. This intention he carried into effect on the night of admission, about eight o'clock, by eating a quantity of it. At eleven, being in very severe pain, he called some of his neighbours, and told them what he had done. The person who was with him said that he had most severe pain in the stomach, with vomiting and purging; occasionally he seemed very dizzy, and lost consciousness for a few seconds, but at other times was quite sensible. When admitted, about five hours after taking the poison, he was in a state of collapse, very pale; the skin was cold and perspiring; pulse slow, intermittent, and scarcely perceptible; the bowels were relaxed. He was quite conscious. Stimuli and animal charcoal were administered, but he died twenty minutes after admission.

On *post mortem* examination, thirty-seven hours after death, the following appearances were noted. The body was that of a muscular man, of middle height. The head was much thrown back; the muscles of the neck were prominent and rigid. There was no rigor mortis of the upper extremities, slight of the lower. The face and skin of the body were pallid. The vessels of the brain did not contain much blood; its substance was pale, but firm and healthy.

On removing the sternum, dark fluid blood flowed from the divided vessels. The pericardium was nearly concealed by the lungs; it contained about half an ounce of serum. The heart was rather large, weighing fifteen ounces. There was a good deal of fat on its surface. The cavities on the right side were quite flaccid, and nearly empty; they contained about an ounce of fluid blood, and a small black coagulum was removed from the auricle. This was the only trace of clot which was found, the blood throughout the body being very black and fluid. The left ventricle was firmly contracted, and, with the auricle, contained about three ounces of blood. All the valves were natural. The lungs did not collapse when the thorax was opened; they were emphysematous everywhere, and inflated; the left most so. Both lower lobes were slightly congested. There was an old cretaceous tubercle, of the size of a bean, on the anterior surface of the left upper lobe.

The liver was healthy; the gall-bladder perfectly empty and collapsed. The spleen was dark and congested, but otherwise natural. The kidneys were congested—rather softer than usual; the capsules peeled off easily. Both contained several small cysts. The bladder was firmly contracted, and contained about half an ounce of urine, milky from lithates. The stomach contained about three ounces of thick grumous fluid, which had a reddish tinge: it was highly congested on its inner surface, having a bright scarlet hue. There were four or five ridges of mucous membrane, passing longitudinally, which were more intensely reddened: here and there were minute patches of extravasated blood, from the rupture of small vessels. The natural rugæ of the stomach were less distinct than usual. This bright colour extended past the pylorus, which was rather firmly contracted, into the first portion of the duodenum, and gradually assumed a dark colour, becoming nearly brown before it ceased, which it did at the upper part of the jejunum. The rest of the small intestine was natural, paler even than usual, which was the case with the large intestine, except a small patch in the transverse colon, where it was slightly congested. The solitary glands were very distinct. The large intestines were distended with flatus; they contained fluid, but natural, fæces. The duodenum contained several ounces of thick reddish fluid, mixed with small solid pieces; the jejunum contained similar matter, but not so red; in the ileum it was stained with bile. The œsophagus was injected, and tinged with a most beautiful violet colour, which extended upwards to the pharynx and fauces. The tongue was black from charcoal.

Original Communications.

LUMBAGO.

By W. NEWMAN, M.B.Lond., Fulbeck, Grantham.

IN the ordinary routine of medical practice in an agricultural district, I have met with numerous cases of lumbago; and may plead the frequency of its occurrence, with the attendant suffering, as sufficient reason for noticing it in the pages of the BRITISH MEDICAL JOURNAL. The disorder is far from being uncommon; and the placards at railway stations exhibiting some pitiable figure, worn and bent with pain, with hand on hip and contracted brow, only serve to tell how much the public and the quacks are interested in the malady.

The cases of painful affection of the lumbar muscles (excluding, of course, those due to organic disease or chronic derangement of health) range themselves in two tolerably well marked groups.

1. *Rheumatic Lumbago.* By this term, I would refer to that series of cases where the symptoms come on more or less slowly, and take some time to develope themselves; where the pain is described as dull and aching, not relieved by pressure, and not of necessity by posture, and accompanied by more or less of general constitutional disturbance, by rheumatic pains in the limbs, or by effusion into some of the joints. It occurs frequently in persons who have hereditary tendency to rheumatism, well nursed by their occupation and mode of life. As a rule, it owns exposure to cold as the immediate cause of its onset.

Microscopic examination of the urine, which is high coloured, of high specific gravity, and scanty, will show the existence of large and abundant crystals of uric acid, with accompanying amorphous urates.

The treatment is that of rheumatism—alkalies and sedatives, with colchicum, warm and opiate applications, etc.

2. *Neuralgic or Myalgic Lumbago.* The pain comes on in this kind more suddenly than in the other form. It may show itself first after some sudden exertion or rapid movement; or it may occur without apparent cause. It is of more acute character than ordinary rheumatic pain. Stooping is difficult; but the exertion of rising after stooping is almost intolerable. Shooting pain is complained of in the course of the spinal column. There is no accompanying rheumatic affection. The pain is relieved by pressure, by lying down, or by resting in an arm-chair. It generally occurs in those who are debilitated by some prior ailment, or depressed by mental or physical over-work. Instances of this form are much more common than those of the first division.

Microscopic examination of the urine shows crystals of oxalate of lime, singly, or co-existent with triple phosphate crystals and amorphous urates.

A few doses of quinine, with or without steel, will act almost magically. Rest and good diet should be added, if possible. Several instances, where the quasi-heroic plasters and liniments of croton oil and tartarised antimony (though, be it understood, from no want of apparent potency) have failed to relieve the patient, I have found to yield at once to the above named remedies. Internal antirheumatic alkaline or depressing agents do not, so far as I have tried them, exert any favourable influence whatever.

The characters of the urine might almost be spoken of as diagnostic in each instance. Repeated examinations of urine from patients of each class have made me believe that their respective characters are very fairly constant; and that from this circumstance alone, the appropriate treatment might be deduced.

I do not think that the distinction of the two classes with the widely different treatment is sufficiently recognised or acted on. Poor as this modicum of contribution is, I yet believe that it has some trace of correctness for its basis; and I shall be interested to know how far those members of the Association, who have worked out muscular affections much more thoroughly, are inclined to agree with the division suggested.

PATHOLOGICAL CONTRIBUTIONS TO MEDICAL JURISPRUDENCE.

By William Boyd Mushet, M.B.Lond., late Resident Physician at St. Marylebone Infirmary.

IV.—Fracture of Ribs and Sternum from Direct, and of Vertebra Dentata from Indirect Violence; Rupture of Liver; Disease of Ovaries.

S. T., aged 24, was brought to the Marylebone Infirmary at 11 P.M., on December 21st, 1856. She was dead, but warm. The face was pale and collapsed; the pupils were dilated. There was considerable ecchymosis over the chest; and a fracture of the sternum and ribs of the right side was palpable through integuments. There was some emphysema of the cellular tissue in the neighbourhood. The injury resulted from the deceased, whilst sitting in a Hansom cab, being driven violently against the pole of an omnibus.

Post Mortem Examination thirty hours after death. The body was well formed and fat. Rigor mortis was well marked. There was a scalp wound, about two inches long, over the vertex extending to the bone, with corresponding detachment of the pericranium to some extent. No fracture of skull. The brain was healthy; but there was slight extravasation into the meshes of the pia mater over the posterior left lobe of the hemisphere, and over the superior median line of the cerebellum. The head was very mobile; and, on passing the finger through the foramen magnum into the spinal canal, irregularity could be detected; and, on opening the nucha from behind, and removing a portion of spinal column, a fracture of the axis was discovered—the body, odontoid and transverse processes (or anterior half of the bone) being broken off from the laminæ (or posterior half). The head, with the atlas and anterior segment, was consequently thrown forwards, and the spinal column and posterior fragment backwards. There was some extravasation into the muscles around the seat of injury, but no clot effused.

Chest. There was extravasation into the right pectoralis major. The sternum was fractured obliquely upwards from left to right, about an inch from the *incisura semilunaris*, between the second and third ribs. The third, fourth, and fifth ribs, on the right side, were broken irregularly midway between the sternum and spine, the pleura being perforated, and the fractured extremities lacerating the anterior lobe of right lung. About eight ounces of fluid blood were found in the right pleura, and two or three ounces in the left. The lungs were collapsed, especially on the left side, so that the anterior surface of the pericardium was quite uncovered. There was effusion into the areolar tissue of the posterior mediastinum. The heart weighed ten ounces; it was firmly contracted and empty, apparently healthy.

Abdomen. The right lobe of the liver was torn through its whole substance nearly from the superior border to its lower margin. The torn surface was granular, rugged, uneven, and much darker than sections made elsewhere. There was no injury of the vena cava or of the aorta. Between forty and fifty ounces of fluid blood were found in the peritoneum. The uterus was virgin, and healthy. The ovaries were in a cystic state (multilocular), especially the left; each was of about the size of a walnut; the left rather the larger. Limpid fluid escaped on section. Other organs were healthy. The state of the catamenial functions could not be ascertained.

Remarks. The foregoing case is detailed, as it offers one or two points worthy of comment. 1. As an example of fracture of the axis from indirect violence. 2. From the disease of the ovaries, which were almost symmetrically affected, and would, I presume, have precluded impregnation. This young woman was remarkably comely and well proportioned, and seemed, as regarded her physical appearance, unexceptionably fitted for the conjugal state. Nevertheless, the morbid alterations in the sexual system, unusual at her early age, would doubtless have entailed permanent sterility. To medical jurists this is interesting, as, if diagnosticable during life, it might furnish grounds for release a *vinculo matrimonii*.

CASE OF ANEURISM OF THE INNOMINATA.

By John Watson, M.D., Southampton.

On October 12th, 1858, I was asked to visit John K—tt, a gardener, aged 84. I found him complaining of pain in the lower part of the abdomen, which he attributed to having eaten an apple the night before. He has never entirely kept his bed, though for some months past his strength and spirits have been failing, and for two or three years he has had a swelling in the right side of his neck, to which my attention was now directed.

Its *history* was, that some four years ago he suffered a severe shock from the sudden death of a nephew, which brought on a violent tremor; and that shortly afterwards he began to complain of pain at the lower part of the throat, and difficulty of swallowing. No cause for these symptoms could be discovered; but a blister was applied across the throat, with partial relief. Subsequently, the pain extended to the right side and back of the neck, and was then called rheumatism. A swelling now (two years and a half ago) gradually presented itself in the situation in which I found it; but for many months its growth, if any, had been very slow. Its *present condition* was that of a hard globular tumour, the size of an orange, extending upwards and backwards, from beneath the clavicle, and occupying the clavicular part of the posterior triangular space of the neck. Its pressure caused considerable turgescence of the veins of the neck and sternum. It pulsated synchronously with the systole of the heart, and this pulsation was attended with a loud *bruit*. The action of the heart was irregular, with great impulse, and its first sound accompanied with a distinct *bruit de scie*. A sense of constriction at the upper part of the chest was complained of, and much shooting pain was felt at intervals in the back parts of the head and neck. The breathing was stridulous; he required to be propped up in bed; and there was a pretty copious expectoration of frothy mucus. His voice was clear; swallowing was difficult, and described as if the food or drink passed from the left to the opposite side. No difference was noticed between the pulse in the two wrists.

The old man died on October 17th, apparently from debility, the state of the heart and arteries having only an indirect influence on the cause of death. I was disappointed at being refused permission to make any *post mortem* examination; but though the case is thus left imperfect, it is not, I think, altogether without interest—illustrating, as it does, the mechanical effects of a somewhat infrequent form of disease; and shewing also, what is of more frequent observation, the power of retarding morbid changes which the system acquires in advancing life, so that long-standing disease of a vital organ is perfectly compatible with death from other causes.

Testimonial to T. H. Barker, M.D. The meteorological contributors to the Registrar-General's Quarterly Returns, and others, have presented a handsome striking skeleton clock to Dr. Barker of Bedford. The subscriptions were limited to five shillings each, and the following inscription sufficiently indicates the occasion of the testimonial:—"Presented to Thomas Herbert Barker, M.D., F.R.C.S., by the officers and members of the British Meteorological Society, and others, as a memorial of their esteem, and a recognition of his successful exertions in obtaining for them the re-circulation of the Reports of the Registrar-General, which had been withdrawn by a Treasury minute."