convulsions occurred, and death took place suddenly from cardiac failure.

The poison is said to produce a burning sensation in the mouth. In this case it is remarkable that the mistake was unnoticed until the third mouthful had been taken, which the patient expectorated. He stated that he had made himself vomit but for four or five hours he must have had a considerable quantity of the poison in his stomach. He never described his sensations and only remarked after the second attack of collapse that "the stuff he drank was coming out all through him" and so probably perceived the odour in his breath. Almost up to the time of his death he was able to answer questions. The free vomiting seemed temporarily to relieve him but the poison must have continued to act after the removal of the contents of the stomach. The bottle containing the fluid from which he had taken his draught had been thrown overboard when I sent for it. The reason why this fluid had been taken on board the tug was never discovered. Most of the symptoms observed follow closely the description of the poison given in the text-books, but I have been unable to find another case in which such a large quantity of this substance has been taken and in which serious symptoms have been delayed so long as four or five hours.

Ireland Island, Bermudas.

STRANGULATION OF AN INFANTILE UMBILICAL HERNIA.

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ASSISTANT SURGEON TO THE BELGRAVE HOSPITAL FOR CHILDREN, CLAPHAM-ROAD, S.W.; DEMONSTRATOR OF ANATOMY AT GUY'S HOSPITAL.

THE patient, a well-nourished child, aged 17 months, was taken to the out-patient department of the Belgrave Hospital for Children on June 22nd, 1905, with the following history. An umbilical hernia was noticed soon after birth but the protrusion was never great and it was always easily reducible by the mother. On the morning of June 21st the swelling was noticed to be larger than usual; shortly after, the child, who previously had been in good health, was in great pain and she vomited 12 times in the 24 hours preceding admission. The bowels acted at 5 P.M. on the 21st after a dose of castor oil but no motion was passed between that hour and the time of admission, 11 A.M. on the next day. The child then looked very ill, the pulse was 136, and the temperature was normal. Immediately beneath the umbilical scar was a tense swelling, measuring about two inches in length by one inch in breadth, and connected by a narrow pedicle to the abdominal wall. The skin covering it was stretched and bluish in colour and there was no impulse when the child cried.

When the child was anæsthetised an unsuccessful attempt was made to reduce the hernia by taxis. An incision was then made and the sac, which was found to have a very narrow neck, was separated from the surrounding tissues and then opened, allowing a quantity of odourless serous fluid to escape. No bowel was found but a piece of omentum, which was discoloured and which showed a number of small petechiæ, was so tightly constricted at the neck of the sac that this had to be divided before any healthy omentum could be drawn from the abdominal cavity. The omentum was ligatured and removed, the sac was cut away, and the small gap in the abdominal wall was closed by silk stitches. There was no vomiting after the operation and the bowels acted in the evening of the same day. With the exception of some slight superficial suppuration convalescence was uneventful and the child was discharged with the wound healed on July 12th. She remained perfectly well until Nov. 30th when she was seen by Dr. O. F. F. Grünbaum at the Belgrave Hospital for an attack of vomiting with constipation which it was thought might be due to some obstruction from adhesions following on the operation. She was admitted but the bowels acted well after an enema and she soon recovered and has remained perfectly well since. The scar is perfectly sound and there has been no protrusion since her discharge last July.

Three varieties of umbilical hernia may be distinguished, of which two occur in children. 1. The congenital umbilical hernia in which a loop of intestine is found outside the abdominal cavity projecting into, and distending, the proximal part of the umbilical cord. This, however, is not a true hernia but is due to the persistence of the condition found in fœtal life before the third month where a loop of intestine developed from the mid-gut always projects well beyond the abdominal cavity. 2. The infantile umbilical hernia which is due to a yielding of the umbilical cicatrix and may appear very soon after birth. This variety of hernia undoubtedly tends to disappear as the child grows older and it is very unusual for it to persist till adult life. The third variety is the umbilical hernia of adults, which rarely appears before the age of 25 years. The congenital hernia usually contains a loop of ileum and usually a portion of colon with the cæcum and appendix and, as might be expected from its development, a Meckel's diverticulum when this structure is present. The infantile hernia usually contains omentum and frequently also a loop of ileum or colon.

Strangulation of an umbilical hernia in a child is a rare occurrence. I find that 79 cases of strangulated umbilical hernia have been treated at Guy's Hospital during the past 25 years. Of these 77 were in adults, the youngest patient being 33 years of age while two occurred in children, aged five days and one day respectively. These, however, were both cases of the congenital variety and though classified with strangulated hernias the trouble appeared to be, at any rate in part, due to sloughing of the coverings of the sac with subsequent peritonitis in the older child, while in the other the evidence of strangulation is doubtful. Both these children were operated on, the intestine being replaced, but in each case the child died. A number of similar cases have been recorded by Mr. W. G. Spencer[1] and Mr. D'Arcy Power,[2] while Mr. J. H. Ray[3] records a case in which he was unable to return the loop of intestine to the abdominal cavity owing to the large size of the former and the small capacity of the latter. The loop of intestine was accordingly excised, but the child, who was only five days old, died from peritonitis. Indeed, when symptoms of obstruction have appeared in a congenital hernia the result is almost invariably fatal, the cause of death usually being peritonitis. In a number of cases, however, the intestine has been placed within the abdomen before any such symptoms have appeared with a successful result. The case which I have described, however, differs from these in that it was undoubtedly an infantile umbilical hernia, and strangulation of this form of hernia is a very rare occurrence. I can suggest no reason why it should have occurred except that the neck of the sac was extremely narrow, not more than one-third of an inch in diameter, and the margin of the ring very sharp. There was no point of interest about the actual operation, but it was satisfactory to find that in spite of the suppuration there had been no recurrence of the hernia five and a half months afterwards.

St. Thomas's-street, S.E.

TWO CASES ILLUSTRATING SCIATICA OF ABDOMINAL ORIGIN; LAPAROTOMY.

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THE two following cases are interesting and are recorded, not so much from the standpoint of the actual lesions themselves as for the remote conditions to which they gave rise. The cause of the sciatica in both instances was only recognised when other subsequent, independent, and direct symptoms (apart from sciatica) drew attention to, and caused the sufferers to seek advice for, a condition of affairs existing within the abdominal cavity which had not hitherto been suspected as giving rise to the nervous affection. The first case is one illustrative of what may be called the true sensory physiological reflex nervous response of one spinal segment to peripheral irritation existing in the area supplied by another adjacent spinal segment. Ovarian reflex pain was ably handled by Dr. G. Ernest Herman in his address to the Gynæcological Section of the

[1] Transactions of the Pathological Society of London, vol. xlix.
[2] Ibid., vol. xxxix.
[3] Proceedings of the Society for the Study of Diseases of Children, vol. ii.

British Medical Association at Oxford in 1904[1]; and he quotes sclero-cystic disease as an alleged cause of ovarian pain and attaches some importance to the existence of peritoneal adhesions, which were conspicuously absent in this case. Dr. J. Inglis Parsons,[2] in the discussion following the address, cites a case of fibroid ovary causing pain in the absence of peritoneal adhesions which ceased on removal of the offending organ. Dr. Cuthbert Lockyer furnished a careful and well-thought out contribution to the same discussion[3] on ovarian reflex pain in the area supplied by the tenth dorsal segment, the result of painful, though moveable, ovaries. Lastly, this case is typical of a condition described by Mr. Alban H. G. Doran in an admirable paper entitled "Painful and Tender Incipient Ovarian Tumours."[4]

CASE 1.—The patient, aged 43 years, married, a multipara, consulted me a year ago for menorrhagia with a profuse leucorrhœal discharge during the intervals of hæmorrhage. Incidentally she informed me that she had suffered for the past six or seven years from constant pain in the tenth dorsal area accompanied by attacks of sciatica which had been attributed to gouty neuritis. Examination revealed a small papilloma of the cervix with accompanying erosion and an ill-defined resistance in the left pelvis. Removal of the papilloma for histological examination was advised and also at the same time a thorough examination under an anæsthetic in order to clear up the condition existing in the left pelvic area. I removed the papilloma, together with a large wedge of cervical tissue, the histological report on which was that it was benign. At the time of this operation a small tumour was clearly made out in the left pelvis and was suspected to be of ovarian origin; it was freely moveable.

Three weeks afterwards Mr. Alban Doran and Mr. J. D. Malcolm, who kindly consented to see the case with me, both concurred in, and advised, removal of the tumour. I opened the abdomen and removed a small, exceedingly tense, central cystic tumour of the left ovary of about the size of a small orange. There were no peritoneal adhesions anywhere to be seen and the patient made an uneventful and uninterrupted recovery. At the present moment she is in excellent health and expresses herself as never feeling better in her life; the sciatica has entirely departed, as well as the pain in the tenth dorsal segment, after fluctuating a little, due, in my opinion, to the slight irritation set up in the pedicle by the silk ligatures which have now quite settled down.

The specimen showed, both macroscopically and microscopically, the ovarian tissue equally distended on all sides by a central cyst, the pressure of which on the nerve endings in the ovary no doubt gave rise to reflex symptoms, of which the persistent sciatica was the most distressing.

The second case is a type of the usual pressure-symptom case on both sciatic nerves, clearly one of mechanical causation. There were no reflex nervous symptoms other than those attributable to pressure on both sciatic nerves, and there was certainly no referred pain to either ovarian region (tenth dorsal area) though both tubes at the operation were found to be occluded and in a condition of multiple cystic hydatidiform degeneration. The ovaries were matted but not diseased. There were present in the pelvis numerous peritoneal adhesions connecting the bowel, tubes, and ovaries with one another and with the tumour, which was a myoma of the anterior lip of the cervix uteri of four and a half pounds weight, impacted in the pelvis and bound down with adhesions.

CASE 2.—The patient, a widow, aged 47 years, a multipara, consulted me for persistent and continued metrorrhagia. The previous history of the case was that seven years ago she had had some inflammation after her last confinement and that during the last four years she had had persistent and increasing symptoms of intense pain down both legs and cramps in her calves. She also had difficulty in obtaining adequate action of the bowels though her bladder had not caused her any trouble. She was exceedingly weak, emaciated, and anæmic as the result of the repeated uterine hæmorrhages. Examination revealed a tumour of the cervix uteri which was of about the size of a five months pregnancy. Her bladder could be felt pouched out on both sides of the tumour which was low down in the pelvis and only very slightly moveable, causing much discomfort when attempts at movement were made. Owing to the precarious condition of the patient as the result of loss of blood it was deemed advisable to endeavour to palliate matters till her condition was somewhat improved, but a further persistent and uncontrollable loss of blood occurring immediate operation was decided on. I opened the abdomen and removed with the utmost difficulty the entire uterus. It was impacted low down in the pelvis and was adherent in every direction by dense adhesions, the separation of which, and the securing of the blood-vessels, proved a formidable and lengthy task. The patient's previous condition and the necessary severity of the operation proved too much for her recuperative powers and she subsequently sank and died.

The specimen showed a large myoma of the anterior lip of the cervix encroaching upon the body of the uterus, the right and left cornua of which were clearly seen surmounting the tumour. A sulcus between the halves corresponded to the lumen of the elongated cervix which was patulous. The hæmorrhage, though profuse, was, as is common to nearly all these cases, one which proceeded from the general mucous lining of the uterus, as no focus or vessel or opening into any vessel could be found to account for the loss of blood. Palliative measures were quite futile, for the reason that the pressure on the veins of the pelvis and broad ligament led to obstruction and passive congestion of the mucosa which ultimately was so great as directly to simulate a hæmorrhage of an arterial character. This case was clearly one where the previous sciatica was purely mechanical in causation and as such forms an interesting contrast with the first case both as regards lesion, symptoms, fitness for, and ability to rally from, operation, and ultimate result.

Harley-street, W.

[1] Brit. Med. Jour., Oct. 22nd, 1904, p. 1055.
[2] Loc. cit.
[3] Loc. cit., and Practitioner, September, 1905.
[4] Journal of Obstetrics and Gynæcology, May, 1904.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

RECURRING EPISTAXIS WITH MULTIPLE TELANGIECTASES OF THE SKIN.

BY C. O. HAWTHORNE, M.D. GLASG., M.R.C.P. LOND.

IN the *Johns Hopkins Hospital Bulletin* for November, 1901, Professor W. Osler described three cases of recurring attacks of epistaxis in association with multiple telangiectases of the skin and mucous membranes; two of the patients were brothers and several other members of the same family were reported to be similarly affected. This condition is stated by Professor Osler to be an extremely rare one and his search through medical literature resulted in the discovery of only a single reference. In these circumstances it seems desirable to secure a record of every recognised case and as one has recently been under my observation I submit the following note.

The subject was a woman, aged 49 years, and the mother of nine children. Since her first pregnancy she has been aware of the presence of "red spots" on her face and also on several of the finger tips of her right hand, and from one of the latter, situated just under the free edge of the nail, bleeding, presumably as a result of slight injury, had often occurred. A mere glance at the woman's face was sufficient to show a number of bright red telangiectases scattered over both cheeks and a few were also seen on the fingers of the right hand; none were recognised elsewhere, but as the woman came to the hospital merely as a friend of one of the patients and objected to further examination the condition of the nasal and other mucous membranes could not be ascertained. In answer to inquiries bearing on her personal history she volunteered the remark that since childhood she had suffered from repeated attacks of "bleeding at the nose" and that on one occasion it had been necessary to plug the nostrils. Her father also and a sister were, so she said, troubled in the same fashion and each of these, as well as her eldest daughter, had "spots" which she recognised as similar to those present on her own face. Further, every one of her own children had had more or less numerous attacks of epistaxis

These facts are sufficient to show that the family belongs