On examination there was tenderness and pain referred to the neck, no displacement apparent and none felt on deep pressure. Complete paralysis, motor and sensory, of lower extremities. Sensation was only impaired at the digital extremities, where anaesthesia was complete. Temperature 99°, pulse 65; respirations diaphragmatic and hurried. Treatment: he was placed on a water bed; pain relieved by morphia hypodermically and cold applications applied to the neck. Urine drawn off by catheter. On the following morning dyspnœa increased; he gradually fell into a state of coma and died.

Post-mortem examination.—Heavy muscular man, no external bruising. An incision extending from the occiput to below the seventh cervical vertebra was made, exposing freely the spinous processes. On inserting the finger a spinous process was found to be detached. Further examination revealed a simple fracture through the base of the fifth cervical spinous process. There was extensive hemorrhage and rupture of the dura mater and the anterior spinous ligament, there was no pressure of bone on the cord, but the hemorrhage was marked, and this, added to inflammatory effusion, was evidently the cause of death. The fact of the patient only falling from a height of eighteen inches from his bed cot, did not lead one to expect that he had fractured his spine. No signs of displacement were apparent, nor could crepitus be elicited. It was thought to be probably concussion of the spine or hemorrhage causing pressure. On this account no operative measures appeared to be indicated and such a rapidly fatal issue in little more than twenty-four hours, was not anticipated. Complete paralysis of the lower portion of the body extended up at first only to the middle of the breast. From the situation of the lesion and its relation to the brachial plexus, it might be expected that paralysis of the upper limbs would have been present, but there was scarcely any loss of power till just before death. Gurlit's tables show this paralysis to have been present in less than one-fourth of cases. Probably the incompleteness of paralysis is due in most cases to conservation of nerve fibres, although the medullary portion of the cord is compressed or completely crushed.

The case is of interest as showing how grave an injury can be produced by an accident apparently so trifling as falling out of bed from a height of only eighteen inches.

FISH BONE IN THE LUNG.

By Major H. S. Peeke.
Royal Army Medical Corps.

Gunner C., R.G.A., was admitted into hospital on May 11th, complaining of pain in the chest and cough. Temperature 100°, pulse 90, respiration 20. He was anaemic and looked distressed. Previous health good. No history of any particular chill. On examination friction
sounds were audible on right side about sixth interspace in mid-axillary line. Resonance was impaired and respiratory murmur diminished. Coughing caused great pain. Expectoration was copious, viscid, tenacious. His progress was unsatisfactory, pyrexia with exacerbations continued, dyspnoea increased.

On the 16th signs of pleural effusion were present; the effusion appeared to be localised.

On the 19th he coughed up a large amount of muco-purulent sputum. This contained a large amount of muco-pus, many strepto- and staphylococci; no diploococci, pneumonia or tubercle bacilli were found.

On the 23rd, as his condition did not improve, it was decided to open the pleura. This was done by Lieutenant, now Captain, Barbour. Chloroform was administered and an incision made along the upper border of the sixth rib in mid axillary line, exposing the pleura. This was opened. On exploring deeply with the finger pus was reached. It was found on breaking down a few adhesions that there was a fairly small loculated abscess of the lung involving the pleura. This was swabbed out and a drain inserted. Wound dressed with iodoform gauze.

The recovery was uninterrupted and he was discharged to duty on August 1st. During convalescence he coughed up a considerable quantity of pus, and it was very evident that pus was being evacuated by the lung through the mouth. When discharged from hospital he still had a cough.

A fortnight later he reported himself and showed me a “bone,” which he stated he had coughed up with great difficulty the previous evening, after a severe paroxysm lasting six or seven minutes. He told me that he felt much relieved about the chest and that his cough had left him since he had got rid of the “bone.” On going into his history further, he stated that at Sheerness twelve months previously, while eating fish, a bone “went the wrong way” he felt discomfort at the time but it had not troubled him since. The foreign body was 1½ inches in length and ½ inch in breadth at widest part, slightly curved and flattened bilaterally with a small groove at its lower border. It gradually tapered off at one end into a point as sharp as a needle. Colour greyish, with the appearance of bone.

Professor Girdwood of McGill University, to whom I am indebted for kindly examining the specimen, reports that “chemically the substance consists of phosphate of lime principally, with a little carbonate of lime and fatty organic matter. This is the composition of the concretionary matters that are found in the lungs of those who have recovered from an abscess of lungs. The healing process is by caseation and disposition of calcareous matter, so that it is quite possible that one of the smaller bronchial tubes has been obliterated with caseation and ossification of the residue, and this may have been the result of the abscess. On the other hand, it may have been the fish bone inhaled into the lung
and worked its way out to the surface along a line of least resistance. Against such a supposition is the irritation and cough you would expect with occasional hemorrhage as the pointed fragment worked its way outwards, and then fish bones are so easily digested and absorbed that you can hardly suppose it likely to have been carried so far without being absorbed, but it is just possible.”

It is open to question how this foreign body got into the lung. I am inclined to favour the supposition that it was the bone previously inhaled, and it had the appearance of having partially undergone absorption. The history of it having been inspired, and the abscess of lung which followed its expulsion, point to this. The main concensus of opinion of those at the meeting of the Nova Scotia Branch of the British Medical Association before whom I brought the case, also favoured this theory.

A CASE OF CEREBRO-SPINAL MENINGITIS.

By Captain H. ENSOR, D.S.O.,
Royal Army Medical Corps.

AND DR. A. BALFOUR, M.D., B.Sc., D.P.H., &c.

CEREBRO-SPINAL meningitis is endemic in the larger native towns of the Anglo-Egyptian Sudan, and is the disease from which the Mahdi is said to have died at Omdurman, 1885. In the autumn of 1899, a severe epidemic broke out among the black Sudanese regiments stationed in Khartoum and Omdurman, and we are informed that the loss of life from this cause was very severe, but, unfortunately, exact information concerning this epidemic is not now obtainable. Medical officers who were serving with the troops stationed in the district during the occurrence of the epidemic, have informed us that all the cases with one exception occurred among the negroes of the Sudanese battalions. The exception referred to was one of the orderlies, an Egyptian, Medical Corps, who was on duty in the wards reserved for cases of the disease. Cerebrospinal meningitis being of comparatively rare occurrence in the British Isles, among adults at any rate, the following account of a case may be of some interest: On the afternoon of January 25th, 1903, Private S. K., 15th Sudanese, was brought to the Station Hospital, Khartoum, in a semicomatose condition. He was quite unable to give any coherent account of himself, but his wife stated that on the day before he complained of headache, which became very severe on the morning of the 25th, and that he had fallen into the condition in which he was brought to hospital about noon of the same day. On examination, little or nothing could be made out. The patient lay on his right side with his right hand under his cheek, and the head itself bent forward on his breast. He could be roused, but was unable to say more than a few words coherently, and he resented being moved about. He had no sign of injury to his head; his