Clinical Notes

opening was made for drainage above the outer malleolus. A secondary abscess on the inner side of the foot formed and was evacuated. Eventually, however, all this cleared up, leaving a healthy, granulating cavity, which gradually closed. The patient lost his anaemic look and melancholy aspect, improved in health, increased in weight, and became one of the cheeriest men in hospital. He got about on crutches and eventually with a stick, and when, on July 10th, he was transferred to Pretoria, we were quite sorry to lose him.

Note.—The case is interesting from the probable sequence of events which brought it about. Evidently a traumatic aneurism was formed at the time of the injury. The entrance wound apparently healed by first intention, thus shutting off risk of septic infection from above. Evidently the exit wound became infected some time subsequently to the formation of the aneurism, during his wanderings on the veld. Septic infection must have travelled upwards, not giving rise to much disturbance at first, as the man's wound was painless, and almost free from discharge, and his temperature normal on first admission to hospital. Under the influence of septic infection, however, I imagine, eventually, the lower part of the aneurismatic wall became disintegrated, probably a haemorrhage took place into the substance of the limb, between and among the torn muscular structures, which might otherwise have reunited without much loss of substance. This probably occurred at the time when he had a rigor and rise of temperature, viz., on April 26th, or, in fact, coincidentally with the first indication of the mischief going on in the limb. Up to this date the limb appeared normal. There was no pain, discoloration or swelling, and the man's temperature was normal. There was nothing apparently wrong, except the small unhealed exit wound of the bullet, which had been slightly suppurating before his admission.

CASE OF RUPTURED BLADDER COMPLICATED BY ALCOHOLIC POISONING.

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PRIVATE X., of the Royal Field Artillery, aged 35, was brought up to the Station Hospital, Colchester, on a stretcher on the morning of August 9th, 1904, complaining that he was unable to get out of bed. He stated "that he had fallen down some stone stairs the night before, and that he had been drinking for the past week." The symptoms pointed to alcoholism, together with severe general bruising and a considerable amount of shock. There was some tenderness over the right lobe of the liver, and the skin was bruised down the right side. There was no
abdominal tenderness, neither were there any signs of free fluid or air in that cavity. There was, however, dulness in the right lumbar region. The patient frequently vomited bile-stained fluid, and the stomach was slightly dilated. He was said to have passed urine before he fell down the stairs. In the evening he developed marked nervous symptoms, and appeared to be on the verge of delirium tremens. He now complained of pain in the right lumbar region, where the dulness before noted had increased. As he had not passed urine during the day a No. 12 soft catheter was passed, and a large quantity of blood-stained urine drawn off, which relieved his lumbar pain. As the vomiting had not ceased, tinct. iodi. m. iii. was ordered, followed, a few hours later, by tinct. opii. m. xv. The next day patient's general condition had slightly improved, in spite of his not having had a good night. He still had marked tremor, and was restless. His pulse was irregular and just over 100. Temperature 99.8°. A catheter was again required, and the urine drawn off was still well mixed with blood. The following day, the third after admission, the man became very collapsed; his pulse was 120, irregular and feeble, he had an anxious, pinched expression, widely dilated pupils, tongue dry and brown. He vomited occasionally, and complained of pain in the epigastric region. His abdomen moved freely with respiration; was not tender nor distended. He had tenderness over the region of the right kidney, and there was still some dulness in the right lumbar region, but all other regions of the abdomen were resonant. His urine was less blood-stained, but had to be drawn off. A consultation was held as to the advisability of performing an exploratory operation, but was decided against, as, except for the lumbar dulness, there did not appear to be any definite signs of intra-abdominal injury, the remaining symptoms being thought to be due to alcohol, and the blood in the urine to a contusion of the right kidney. Towards the evening the patient became very restless, continually trying to get out of bed, and picking at the bed clothes, but the tremor, which had been so marked previously, had nearly ceased. In the afternoon he passed two ounces of urine, and stated that he had no pain. Trional gr. xxx. was ordered, and the hypodermic injection of strychnine, which had been given throughout the day, continued. His temperature now rose from 100.6° to 103°, and the heart-sounds became very feeble, the first sound being much shortened. The patient died at 1.15 a.m. The post mortem revealed an intraperitoneal rupture of the posterior surface of the bladder. There were numerous pockets of foul-smelling urine shut off by the matting together of intestines by recent lymph adhesions. The lower part of the right kidney was contused. The pericardium contained some turbid fluid, but the heart was normal.

We think that the chief points of interest about this case are: The absence of any local signs of peritonitis, as shown by rigidity, distension, &c., of the abdominal wall. The absence of any desire to micturate,
which is so usual in a case of ruptured bladder; also that the patient only complained of pain in the epigastric and lumbar regions, instead of the hypogastric region; also that the patient was able to pass two ounces of urine, without any pain, the third day after the injury was received. As to how much the patient's general condition was due to alcohol, how much to shock, the result of an injury, it was rather hard to determine, as his appearance and nervous symptoms were all in favour of commencing delirium tremens, as was also thought the inability to pass urine. The result of the post mortem points to an error of judgment in not having performed an exploratory operation when a correct diagnosis was a matter of considerable uncertainty.