diseases it may be distinguished only by a careful examination of the case and attention to the special diagnostic features characteristic of these diseases.

SNAKE-BITE; TREATMENT BY STRYCHNINE—DEATH.

By SURGEON-CAPTAIN H. SMITH, I.M.S.

ASSISTANT-SURGEON LAW reports:—On Christmas Eve, 1893, a man came to Panir Hospital about 7 o'clock, stating that he had been bitten by a snake in the toe about three hours previously. He complained of burning heat and pain in the affected foot, which was swollen. He had then no other symptoms. An incision was made at the seat of the injury, and permanganate of potash rubbed in the cut surface. There being no prominent symptoms, strychnia was not used until 10 o'clock at night, when in addition to the above-mentioned pain he became somewhat drowsy. Thereupon liq. strychniæ (B. P.) m. xv was injected hypodermically, after which the drowsiness passed off. He developed no further symptom until 6 o'clock next morning, when he suddenly became very drowsy, but was conscious, and could be roused to answer questions. Liq. strychniæ m. xv was again injected hypodermically, and he again rallied. Four hours later tendency to become comatose supervened, with drooping of the eyelids, whereupon three successive injections at intervals of 20 minutes were given. He vomited after the last injection a thin glairy fluid, and had twitching of the muscles of the face, forearm, and hand. The comatose condition passed off slightly. He could also keep his eyes open a little better and could speak a little. The pain in the foot was still complained of. At about 2 P.M. he suddenly collapsed.

The total quantity of strychnia used between 10 P.M. and 2 P.M. on the following day was ʒii B. P. Liquor.

Strychnia seems to have had some controlling influence over the poison of the snake in this case.

The variety of the snake is not known.

FATAL SWORD-WOUND OF THE ABDOMEN.

By SURG.-CAPT. TOWNSEND SHAW, M.B., GOONA.

AT 3 A.M. on 16th ultimo a woman was brought to the dispensary by the Police from a village some 25 miles away. Throwing herself between two men who were fighting she received a sword-thrust midway between the umbilicus and ensiform proc. The cut was 2 inches long, clean, and oblique from below up and inwards. A coil of small gut protruded; over this a piece of cotton wool had been placed. Thirteen hours elapsed before she arrived at hospital, where she was seen by the Hospital Assistant. She supported the protruded gut with her hands. Shock was not marked. Under chloroform the Assistant cleaned and returned a normal-looking button of omentum and an inflamed-looking knuckle of small gut, applied four sutures, pad and bandage and gave morphia. I saw her at 8-30 A.M. She was restless, in pain. Temperature 102·4°. Pulse full and bounding, 116 per minute. She gave me the impression of suffering from marked reaction rather than shock. Acute peritonitis was probable. At 3 P.M. that day (16th) she was more restless. Temperature 105·2°. Pulse 135. When I heard of her condition (at 5 P.M.) I ordered preparations to be made for a laparotomy early next morning.

At 6-45 that evening I found her moaning, restless, rather delirious. Temperature 106.° Pulse 144—weak and growing imperceptible. To operate in the dispensary (with a considerable delay and rapidly failing light) seemed hopeless. I suspected internal bleeding. A saline injection was given per rectum but not retained. Also hypoderm of æther, and stimulating measures ordered. She died at 3 A.M. on the 17th—thirty-six hours after she got wounded. I could not get any history, so knew nothing as to the fullness or emptiness of the stomach at the time of injury. She never vomited.

Post-mortem 6 hours after death.—Body well nourished, edges of wound united. Parietal peritoneum near injury intensely injected. The whole of the small gut and parts of the peritoneum looked as if they had been dusted over with cayenne pepper in patches. A good deal of sanguineous fluid, but not blood, lay amongst the coils, also a few small blood clots were seen. There was no wound of intestine, stomach, liver or spleen. In Douglas' pouch about 10 ozs. (not more) of blood were found. The sutures had failed to catch the edges of the peritoneum and the deep parts of the muscle (rectus), leaving an oval space about 1¾ inches long and 1½ inches broad. The bleeding alone was, I think, quite insufficient to account for death, it had come from some small omental vessels. Death was due mainly to acute septic peritonitis. An immediate operation might have saved her life. As, however, I thought she was suffering from acute reaction rather than shock, I elected to wait, trusting that to-morrow would not be too late. Rejecting the idea of hæmorrhage, I had to face the question of immediate laparotomy for acute peritonitis. König lays down the rule that a penetrating wound with signs of peritonitis demands instant operation. I publish this case as a warning against delay. It will be noted that the wound was above the umbilicus and the intestine was not wounded (Senn).