mode in which the latter comes to resemble the former, I think it is reasonable to ask the profession to suspend belief in the fact of the pancreas having been protruded through a wound in the anterior abdominal wall, until anatomical demonstration places the matter beyond a reasonable doubt, and gives the observation a right to become one of the indisputable facts of Surgical Pathology. The presumptions against its occurrence are so numerous and strong, that an amount of proof, convincing and complete, in a direct ratio to these, is necessary ere the supposed facts become of any scientific value whatever. Indeed, a statement of this sort is rather prejudicial, inasmuch as it suggests an occurrence whose truth has not been established. A single doubt throws the statement into the limbo of medical uncertainties, which are the bane of our profession.

The practical lesson of these cases is, however, plain:—In protrusion, through an abdominal wound, found to be solid, ligature and strangulation is a safe and successful practice.

Jessore, 11*th September*, 1866.

STATE OF THE HEART IN ARSENICAL POISONING.

By KENNETH McLEOD, A.M., M.D., L.R.C.S.E.,
Civil Assistant-Surgeon, Jessore.

As the following case strongly confirms the observations and remarks of Dr. E. Bonavia in the last number of the *Indian Medical Gazette*, I place it on record without comment.

B. N. B., a young man of good caste and well educated, contracted syphilis, and took the disgrace of it so much to heart, that on the 8th instant he purchased and swallowed half a tolah (90 grs.) of arsenious acid. This happened about 2 p. m. The usual symptoms of irritant poisoning ensued. He exhibited symptoms of collapse about 10 p.m., and died at 4 a.m. next morning, fourteen hours after taking the poison. He was examined on the 9th at 8 a.m.

I. *External appearances.*—Body fairly nourished; conjunctivæ congested; lips livid; phymosis and chancre of penis; bubo in left groin.

II. *Cranial cavity.*—Not examined.

III. *Thoracic cavity.*—Walls normal; pleuritic adhesions old and membranous on both sides, more extensive on right side; mucous membrane of larynx and trachœa congested; lungs collapsed imperfectly; both lungs congested; tissue of a pink color; vessels emitting black blood, pericardium contained a small quantity of colorless serum; right cavities of heart much dilated; contained firm fibrinous or decolorised clot, a smaller quantity of sanguineous clot, and a considerable amount of very dark fluid blood which coagulated loosely on emission; the clot in the ventricle extended for a short distance into the pulmonary artery; valves and walls healthy; left ventricle empty; *lining membrane of a dark livid color;* this tint was deeper on the *columnæ carneæ* than between them, and was well marked over the whole surface of the cavity; the deep color extended about one-eighth of an inch into the substance of the heart, and seemed to be owing to a layer of blood extravasated beneath the lining membrane, which was quite smooth; left auricle empty; lining membrane normal; walls and valves of left heart healthy; coronary vessels moderately filled with blood.

IV. *Abdominal cavity.*—Walls healthy; peritoneum congested over stomach and intestines.

Stomach dilated; occupied both hypochondriac and epigastric regions; patches of congestion, and of a greenish color, on its surface; mucous membrane of pharynx and œsophagus congested; acute congestion of cardiac orifice of stomach; fundus of stomach inflamed; surface very red, partially abraded, covered with shreds of a yellowish or greenish pellicle; from this large patch of inflammation several processes proceeded along the walls of the organ. These surfaces presented varying degrees of congestion, inflammation, erosion, and ulceration. They were also covered with a similar soft exudation, which in some places rose into a thick gelatinous looking mass. The organ contained a large quantity of brownish fluid, with flocks of pellicle and white particles floating in it; small intestines generally congested, and contents pultaceous; large intestines not so severely congested.

Liver, fatty and slightly cirrhotic; spleen, enlarged and *engorged;* kidneys, cortical substances fatty and pyramids congested.

A QUERY.

By G. D. McREDDIE,
Medical Officer, Hurdui, Oudh.

On reading the "query" put by Dr. Lees, of Akyab, I was reminded of a somewhat similar case which occurred in my own practice a few months ago. The case is as follows:—A Mahomedan farmer, aged 35, was admitted into hospital, complaining of a painful abdominal tumour; pain paroxysmal in character, and for the time being very acute, the paroxysms not observing any regularity in their returns; they generally occurred at intervals of a few hours, and were about two or three hours in duration. When first seen, the tumour occupied the position of an enlarged spleen, extending below and to the right of the umbilicus, and on a superficial examination, it was likely to be set down as a splenic enlargement. Its margins, however, could not be strictly defined, and, superiorly and externally, the margin seemed about an inch *below* the border of the left ribs. On further examination, it was found that it did not always occupy the same site; sometimes it shifted more to the right, and sometimes it descended towards the pubis; such changes in its position were not accounted for by a change of decubitus, or the conditions of the stomach. But what was particularly worthy of remark was the *evanescent* nature of the disease. I have, for instance, examined the patient at seven in the morning, and found him quite comfortable, and his abdomen perfectly natural, without the trace of a tumour in it. When seen again after a couple of hours, he was in great pain, with the tumour distinctly perceptible. An examination under the influence of chloroform showed no change in the tumour. Both the examinations above referred to were made while the patient had an empty stomach. The conditions of the stomach, whether full or empty, did not affect the tumour.

On the supposition that fœcal accumulation had something to do with these appearances, aperients, large warm water enemata, &c., were administered, but afforded only temporary relief. The history of the case was that two months before admission he had intermittent fever, which was followed by the present disease.

Iron and opiates appeared to do more good than any other medicines.

Will any professional readers of the *Gazette* give their opinion as to the disease from which this patient suffered?

Hurdui, 14*th August*, 1866.

NOTICES TO CORRESPONDENTS.

We are extremely sorry to find, at the last moment, that we must, from want of space, keep back all *the Cases from Practice sent to us for our present number. We thus reluctantly disappoint the following gentlemen:*

1. Dr. C. M. Russell *of Gya.* 2. Dr. Beatson *of Dacca.* 3. Dr. French. 4. Dr. Garden, *Saharunpore.* 5. A. S. J. 6. Samuel P. Johns. 7. Baboo Ashootosh Goopto, *Delhi.* 8 Baboo Dinobundoo Dutt. 9. O. C D. 10. Nundo Lall Ghose, *Raipore.* 11. U. C. K., *Burrisaul.* 12. Dr. Lees *of Akyab.*

Dr. J. R. Jackson.—*Yours in our next.*

Mr. D'Souza, Neerpoor.—*Your letter was too late.*

Dr. W. J. Moore.—*Your letter was received after we had gone to press.*

Dr. James Donaldson.—*Many thanks for your letter and pamphlet just received.*

Baboo Ram Lall Dey, L. M. S., Kooshtee.—*We shall discuss the question of the education of Dhyes in our next number. Your proposal is undoubtedly a good one.*

Dr. J. L. Beyden.—*Your* last *letter reached us far too late to admit of the publication of the desired additions to your communication.*