forehead; Hutchinson's teeth; double interstitial keratitis; deafness (oto-sclerosis?).

She remained a patient for ten years, and only once previous to her fatal illness had it been necessary to send her to bed for any physical ailment, and then because of some septic condition of the toes. On the afternoon of January 4th, 1912, she seemed in her usual health, but shortly after tea she had a sudden and brisk hæmatemesis and became considerably collapsed. She was transferred to an infirmary ward, but a satisfactory examination was impossible owing to her restlessness. Three days later hæmatemesis again occurred. Her general condition was better, however, and one could examine with more freedom. The abdomen was somewhat tumid and dully tympanitic, except in the epigastrium, which was distinctly dull to percussion. Deep palpation could not be performed as tenderness was extreme and rigidity obtained. Liver dulness was rather depressed. Treatment was continued on the previously formed assumption that the case was one of gastric ulcer, but on the 14th she had a third attack of vomiting, fully a pint of dark blood being put up. During the next twenty-four hours recurrences took place, and on the morning of the 15th she had a sudden collapse and died.

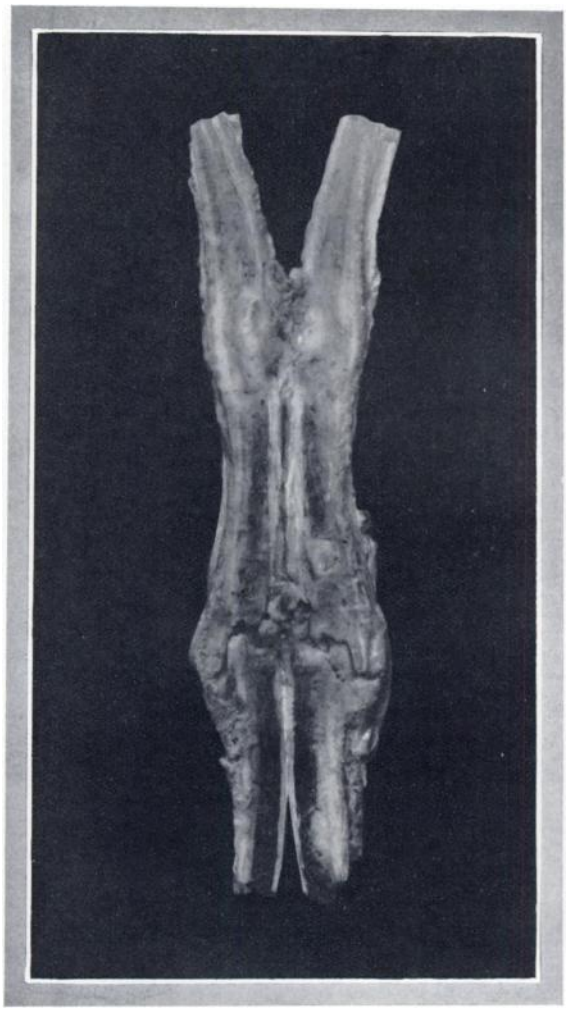
The cause of death was found in the liver, which was in a state of coarse cirrhotic distortion, due to gummata. Contraction of the fibrous tissue had divided the organ into numerous rounded masses—an approximation to the "botyroid" type. In the right lobe anteriorly much of the degenerated gummatous tissue had become quite mortar-like, and required a saw to section it. The portal vein was partially obliterated, and as a consequence the lower œsophageal veins had become dilated and tortuous, and there were many points from which blood had recently oozed. The stomach was atrophied, and contained a small amount of altered blood, but the wall was quite free from any ulceration. Kidneys were slightly congested, and showed some dilatation of the pelves and adherences of the capsules. There was perisplenitis, but the organ was not enlarged. Uterus was healthy, and evidence of scarring on the os or vaginal wall absent. The amount of peritoneal fluid was normal.

Recurrent hæmatemesis, due to ulceration of varicose œsophageal veins, is common enough in ordinary hepatic cirrhosis, but as a rule one finds one or more concomitant physical signs—œdema of legs, ascites, enlargement of spleen, albuminuria, etc. The absence of these and the unusually localised nature of the venous obstruction was due presumably to compensatory union between the portal system and the systemic veins.

Fracture of Four Ribs in Sequence due to Tubercular Disease.

By D. McKINLAY REID, M.B., Assistant Medical Officer, Horton Asylum.

S. J. B—, æt. 24, had been admitted into Horton Asylum as a case of dementia præcox on July 12th, 1905. She had well-marked persecutory ideas, and was for the most part turbulent, resistive, and impulsive.



Rib showing tubercular disease, with complete fracture caused by the lower deposit.

To illustrate Dr. McKinley Reid's paper.

Adlard & Son, Impr.

https://doi.org/10.1192/bjp.58.243.636 Published online by Cambridge University Press

but she at times showed katatonia, and had on occasions to be sent to bed on account of cyanosis and swelling of the feet. On May 2nd, 1910, she was found to be suffering from phthisis affecting both apices, and so rapidly did the disease progress that two months later only the right lower lobe was unaffected. On August 12th while the chest was being examined she complained of pain in the right side. A small, slightly raised swelling was detected over the middle of the third rib. It had a "boggy" consistence, and very slight pressure on it gave rise to crepitus. Tenderness and crepitus were elicited in the fourth rib also. Careful inquiry was made about any recent injury. It was thought that she might have been struck a few days previously by the patient in the next bed when they had had a verbal set-to; but she had never complained of pain, and at the time of examination there was no evidence of bruising. Accordingly a diagnosis of pathological fractures was made, the presumption being that the ribs had become secondarily invaded by tubercle. Within the next few months her general condition became much worse and undoubted signs of secondary tuberculosis manifested themselves. She died on December 30th.

At the autopsy the second, third, fourth, and fifth right ribs showed tubercular deposits, these having caused complete fractures in the case of the first three. In the fifth caseous material had replaced only one side of the dense bone and separation had not occurred. The third rib (*vide* photograph) contained two separate foci, and in one of these uniform softening had taken place with the formation of a cold abscess subcutaneously, the bone having been split raggedly across. In the other a condition similar to that in the fifth rib was found. The ribs on the left side were quite sound.

The case is interesting for several reasons. It affords a good example of the deep anæsthesia found frequently among the insane. Even making allowance for the poor chest expansion which she had, it is surprising that pain was complained of for the first time only when pressure was applied and that possibly some time after the fractures had occurred. In spite of the frequency with which phthisis and its secondary developments occur in asylums an affection of rib appears to be rather uncommon, and of several rare. It seems not unlikely that the peculiar sequence was due to direct infection from the neighbourhood, probably the pleura.

Occasional Notes.

Legislation for the Feeble-Minded.

I VENTURE to offer to the Editors a few notes on the present phase of legislation for the feeble-minded, for the benefit of

https://doi.org/10.1192/bjp.58.243.636 Published online by Cambridge University Press