

growth of the sound bone, which will go on till its cartilage ossifies.

Sometimes the converse takes place, especially after a fracture of the shaft, and by means of the marrow or periosteum the cartilage is stimulated instead of being irritated, so that increased growth and lengthening of the bone follows. Apart from this question of alteration in normal growth, non-union may occur and generally follows imperfect fixation, as when the injury was thought to be only a sprain, but permanent deformity due to imperfect reduction is more often seen. It must be remembered that there is always some enlargement of the diaphyseal end after repair, which disappears in a few years in most instances.

PERSISTENT THYMUS IN AN ADULT: SUDDEN DEATH.

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About a month ago I was asked by the police to make a post-mortem examination on the body of a young married woman who had died suddenly whilst at a dance. There were no suspicious circumstances connected with the case, and the following was the available history:—

A.J., at 20 years, married, with two children, the youngest being eighteen months old and just being weaned.

Deceased had seen a doctor in Ararat a month or two previously, who said she was "suffering from a misplaced womb, and was run down."

As a child she had suffered from chest trouble, but not recently. On the day of her death she complained to a friend of pain below the left breast, but it was not severe enough to prevent her attending a dance that evening. Whilst dancing she suddenly gave a gasp, dropped to her knees, and fell back apparently quite dead.

The post-mortem examination showed that the body was that of a well-nourished woman of small stature. Rigor mortis had set in. There was milk in the breasts and a discharge from the vagina of menstrual blood.

On opening the chest, the heart appeared to be normal in size, the right side containing more blood than the left; it was not enlarged, the muscle appeared healthy and the valves clean. No clots were present, and the blood was dark and fluid.

The right lung was scarred at the apex from old healed trouble, and was adherent to the chest-wall from an old pleurisy. No recent trouble was discovered in either lung, but there was slight enlargement of the glands at the sulcus. The liver was somewhat pale and friable.

The spleen was about twice the normal size, friable and engorged. There were signs of slight inflammatory change in the kidneys. The uterus was very large and retroverted, and there were no signs of recent pregnancy or abortion.

The gastro-intestinal tract and brain appeared to be healthy.

There was present a full-sized thymus gland.

No obstruction of the larynx was present.

In the absence of any other cause sufficient to account for death, I put down the case as one of those rare ones occurring in an adult in whom the thymus had not atrophied normally.

The examination was conducted single-handed in a little badly-lighted room, on the floor, so I could not make it as complete as I should have liked under the circumstances. The important points seemed to me to be the presence of the thymus, large spleen, fatty liver, early nephritis, and fluidity of the blood; the latter and careful examination negating the probability of embolism.

According to Hewlett [Pathology: General and Special, p. 207], the cause of death in such cases has been ascribed to (1) suffocation from pressure, (2) intravascular clotting, and (3) toxæmia. Now, the first two can in this case be almost certainly excluded, and the state of the liver, kidneys and blood seem to be in favour of the toxæmia theory.

About two years ago I made a post-mortem on the body of a strong healthy-looking man of about 35 years of age, who also possessed a full-sized thymus, but he had died by strangling himself with a belt from the foot of a bed, evidently after drinking. Unfortunately I have forgotten exactly the p.m. appearances in his case as I kept no note, but it would have been worth while noting the size of his lymph glands and spleen.

The important bearing of such cases on the administration of anaesthetics and their rarity makes it important that they should be recorded, and that is my excuse for doing so.

Blood-pressure in Scarlet Fever.

J. D. Rolleston (Brit. Journ. Chil. Dis., Oct) says:—

(1) In a series of cases of scarlet fever the blood-pressure was found to be subnormal in 25 per cent., the extent and duration of the depression being as a rule in direct relation to the severity of the initial attack.

(2) In the great majority the highest readings were found in the first week; there was also a predominance of the lowest readings in the same week, but in a large minority the lowest readings were found in the second week. The normal tension was usually reestablished by the fourth week.

(3) In the majority of cases the blood-pressure was lower in convalescence than in the acute stage.

(4) In 48.4 per cent. of the convalescent cases the readings in the recumbent and erect positions were the same, or the recumbent was higher than the vertical record until convalescence was firmly established (hypotension of effort).

(5) With the exception of nephritis complications had little, if any, effect upon the blood-pressure.

(6) In only a minority of the nephritis cases—12 out of 33—was the blood-pressure above normal, and the hypertension was never extreme nor of long duration.

(7) Sphygmomanometry in scarlet fever, as in most of the other acute diseases, is of little practical importance in the acute stage, but in convalescence may give some indication of the severity of the renal lesion which may be of value in subsequent treatment of the patient.

(8) Pronounced arterial hypotension, especially if accompanied by other signs of acute suprarenal insufficiency, should be treated by adrenalin or suprarenal extract.