

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

SEAMEN'S HOSPITAL, GREENWICH.

SPASMODIC TORTICOLLIS; RECOVERY AFTER EXCISION OF PORTION OF SPINAL ACCESSORY NERVE.

(Under the care of Dr. JOHN ANDERSON and Mr. W. JOHNSON SMITH).

RATHER more than a year ago, in THE LANCET of March 26th, 1892, we published an annotation on operation for spasmodic torticollis. In this we referred to the variations met with in different cases as regards the muscles affected, the nerves which require to be found, and to other points to which attention required to be directed. Nerve stretching, even when thoroughly carried out, has not been attended with success, and simple division of the nerve has given no better results. Surgeons are now dealing with these cases by simple excision of the nerves supplying the affected muscles, removing the nerves as near the central ends as possible. In 1891 M. Petit recorded twenty-six cases of excision of a portion of the spinal accessory nerve; in thirteen a successful result was obtained, seven were much improved, two were slightly better, three were benefited temporarily and one died from erysipelas. Later in the year we brought forward cases in THE LANCET of June 18th, under the care of Mr. Owen, Mr. Appleyard, Mr. Gould and Mr. Smith. In most of these operation had been followed by considerable success; some cases had apparently been cured; in others it was rather too early to give a decided opinion. In THE LANCET of June 25th, 1892, Mr. Southam's experience in ten cases was given; in four, which were still under observation, where intervals varying from eight to two years had elapsed, the relief from spasm had been permanent. In the case which is here given the relief so far has been very marked and the patient has improved immensely by operation, so much so that, even if the improvement were not fully maintained, the operation is more than justified.

The patient, who was a short, thick-set man, aged thirty-one, was admitted to the Seamen's Hospital on Sept. 7th, 1892. He had been at sea for the greater part of his life and had enjoyed good health up till five years ago, when he was attacked with malaria at Bombay. Since then he has had malarial attacks from time to time. Eight weeks before admission, after returning from a voyage and when stopping at Cardiff, he was seized with quotidian ague. A fortnight later spasmodic movements of the head and neck to either side suddenly developed and have persisted since with but little intermission. At the same time there was some pain in the back and sides of the neck. He had never suffered from anything of the kind before. There was no history of neurosis in his family, both his parents being alive and healthy.

On admission he was found to be suffering from spasmodic rotary movements of the head to either side, but more particularly towards the right. These movements were very constant and were increased on exertion; they ceased during sleep. There was some complaint of pain in the back of the neck. The hands were somewhat tremulous and the knee-jerks brisk and equal on the two sides. The movements soon took place only towards the right, from frequent clonic spasm of the left sterno-mastoid.

On Sept. 12th the condition was much as follows: The head was frequently drawn over to the right side, twenty or thirty times a minute, so that the chin touched the acromion. At the same time the head was somewhat retracted and the eyebrows were slightly raised; some spasm was present at the right angle of the mouth and the right shoulder was elevated. During the next month various kinds of sedatives were tried, including injections of morphia, without giving any relief. The patient became low and despondent and had great difficulty in taking food, as attempts at mastication increased the spasm. The left sterno-mastoid muscle had become very

considerably hypertrophied. Owing to the malarial history quinine was also given, but without benefit.

On Oct. 5th chloroform was given and several old stumps were removed from the right upper jaw. This seemed to do some good for a short time, but the condition soon became as bad as ever. The actual cautery applied along the course of the left spinal accessory nerve and on the back of the neck was followed only by temporary relief.

On Jan. 20th, 1893, chloroform was administered, and Mr. Johnson Smith performed neurectomy of the spinal accessory. An incision about three inches long was made on the left side of the neck, commencing just below the mastoid process, and carried downwards along the anterior edge of the sterno-mastoid. The nerve was exposed above its entrance into the muscle and about half an inch of it was excised.

The wound healed rapidly; almost immediate relief followed the operation. There was at first some slight spasm of the neck towards the right, when the right hand was used, but this soon passed off. The patient had for many months been nearly entirely confined to bed, and at first, on getting up, there was very great weakness. He soon, however, regained his strength and on March 13th was able to leave the hospital. On discharge he was quite free from spasm of the neck muscles, except for slight movements at times when he used his right hand in washing himself. Mastication was carried on without difficulty and he was entirely free from pain.

GENERAL HOSPITAL, WOLVERHAMPTON.

NERVE INJURIES COMPLICATING FRACTURES OF THE UPPER EXTREMITY, WITH SIX CASES.

(Under the care of the Honorary Surgeons.)

(Concluded from p. 864.)

WE published the first three cases of this series in THE LANCET of last week. They were as follows:—1. Fracture of both bones of the forearm; paralysis of the posterior interosseous nerve. 2. Fracture of both bones of the forearm; paralysis of the median nerve. 3. Compound fracture of the right humerus; paralysis of median and ulnar nerves; exploratory operation. We now continue these interesting examples of the occasional nerve complications of fracture of the forearm or humerus by three short records of fractures of the humerus with paralysis of the musculo-spiral nerve.

CASE 4. *Fracture of left humerus; paralysis of musculo-spiral nerve; operation; no recovery after two years.*—A boy aged thirteen sustained a fracture of the left humerus in two places. After the fracture had united it was found that he had wrist-drop. The upper fracture having been in the neighbourhood of the musculo-spiral groove it was thought that the nerve might be involved in callus. It was accordingly exposed in this situation and was found lying between two ridges of new bone and adherent to the periosteum. It was freed from adhesions. The wound healed readily, but the patient was discharged unimproved. When first seen by Dr. Deanesley two years later there were complete paralysis and wasting of all the dorsal muscles of the forearm except the supinator longus, which acted feebly. There was complete loss of electric excitability, both faradaic and galvanic. The triceps was unaffected.

CASE 5. *Separation of lower epiphysis of left humerus; paralysis of musculo-spiral nerve.*—A boy aged eight years. The accident, which was caused by a fall on Feb. 18th, 1892, was recognised by the usual signs. After reduction the elbow was immobilised at a right angle by plaster-of-Paris. When this was removed at the end of four weeks there was much bony thickening about the lower end of the humerus and the elbow was very stiff. There was also complete paralysis of all the muscles supplied by the musculo-spiral below the elbow. These muscles gave no response to faradism, but responded to a smaller minimal galvanic stimulation than the corresponding muscles of the opposite side. No loss of sensation could be detected. Friction, passive movement and the galvanic current were employed daily. Recovery of voluntary power began in the supinators on March 9th and was complete in all the affected muscles on May 2nd, although then and for long after there was no recovery of faradaic excitability. Redundant callus having been absorbed it was found that the displaced fragments had not been perfectly reduced, the lower end of the shaft being in front of and overlapping the lower fragment, forming a prominence