

AN UNUSUAL CASE OF SUICIDE.*

BY A. ELLIOT PAINE, M.D.,
Medical Examiner of Brockton, Mass.

IN the early part of the evening, Nov. 7, 1908, I was called to an adjoining town to view the body of a man fifty-eight years old. He had carried on farming and dealt largely in wood. The son informed me in the summer his father had received an accident which resulted in amputation of the left leg above the knee; since then he had been despondent and attempted suicide, so his mother had watched him closely. After breakfast the deceased told his wife he was going to call on a friend, and as he did not come to dinner she supposed he was with the friend, but at supper time his absence caused her to notify the son, who lived across the street. He, with a hired man, started to find the deceased, when the hired man said when he went to feed the horses at noon time he saw him lying on the hay, as he supposed, asleep. He did not waken him as he was afraid of him. They went to the hay loft and there found the body nearly covered with hay, and sent for me. I had some difficulty in getting up the rude stairs, which were pieces of boards nailed to the studding on the side of the barn, the steps being about eighteen inches apart, then through an opening less than two feet square. I found the head and upper part of the body exposed, the head well covered with dry blood, and rigor mortis well marked, the lower part of the body and legs burrowed under solid hay some two feet deep. Near the body, with light hay covered over them, we found his crutches, with spots of dry blood on them. The body was lowered down through the opening and then we found spots of blood on the steps. On the ground floor a piece of oak about thirty inches long and two inches wide, with sharp, ragged edges, was found with dry blood and some short hairs, corresponding to deceased's hair. As we had only a lantern to see with, I had the body taken to the undertaker's, where I made a full examination. Above the right ear found a crescent-shaped wound three inches long, tearing the scalp upwards; no fracture. Near this wound were several small wounds, none of them going through the scalp; the head and face and both palms covered with dry blood.

From the history of the case and the position of the body I judged this to be a case of suicide, as I could not see how any one or two men could have taken him up in the loft, and the cause of death was probably cerebral hemorrhage. I reported the case to the assistant district attorney, and he ordered an autopsy, which was made on the 10th. The report of the autopsy is as follows:

External appearance.—A well-nourished male, 5 feet 10 inches in height, weighing about 150 lb.; left leg amputated at lower third of femur. Several bruises on right side of head, one being one inch from median line just above the forehead; a slight bruise on outer side of right eye; three inches above the right ear, a crescent-shaped wound three inches long, the scalp turned upwards; on the under side of the scalp, bruises corresponding to the external ones; over the occipital protuberance a bruise one inch in diameter (none found external), the right temporal muscle filled with fluid blood.

On removing the calvarium, no fracture was found, the dura was deeply engorged, as well as the whole right hemisphere. The blood vessels were softened, no hemorrhage in the brain. The lungs were normal, no adhesions. Normal fluid in pericardium; right heart filled with fluid blood. Valves and structure of heart

normal. The stomach contained about one-half pint of dark fluid, which was taken for further examination. The mucous membrane was of a dark-mahogany color. All the abdominal organs were normal.

After finishing the autopsy, a son-in-law gave me a half-pint bottle, the inner side being coated with a green powder. He said he found it in the hay near where the body was found.

The examination of the contents of the stomach showed blood and a large quantity of arsenic. The return of death was arsenical poisoning suicide.

This case was one of great interest to me, showing what severe injuries could be self-inflicted: how, with the aid of his crutches, he had pulled himself up the rude stairs and then taken the Paris green (which was the cause of death); also to learn there had been a case of suicide in nearly every generation, which recalled to my mind that some twenty years ago I viewed the body of his uncle, who hung himself in his hay loft.

A CASE OF INTUSSUSCEPTION.*

BY CHARLES W. TOWNSEND, M.D.,
AND
FRED T. MURPHY, M.D., BOSTON.

A BOY nine years old was seen in consultation with Drs. J. P. Torrey and E. M. Greene on Sept. 15. Never robust, he had had typhoid fever five years before, and his stomach was always easily upset. About two years before he had vomited constantly for two days following etherization for a trifling operation on the eyes. Three weeks before I saw him he had a sudden attack of vomiting after eating some green apples, followed by diarrhea, which took on a dysenteric character at the end of the second day. There was a moderate amount of blood in the stools, together with mucus, and there was slight tenesmus and general abdominal pain. These dysenteric symptoms ceased after two more days, and the blood in the stools never recurred throughout the illness. Pain and tenderness were practically absent most of the time after this.

The vomiting, however, continued and it was believed that for the entire three weeks no food was retained, and, furthermore, that no fecal matter appeared in the stools. Bismuth had been given by the mouth, but had failed to appear in the stools. Occasionally he would retain food for several hours, when it would all be returned.

His temperature had been normal, or only a degree elevated for a short time, and subnormal occasionally.

On examination, the boy appeared pale and emaciated, with feeble pulse; there was a distinct sausage-shaped tumor in the right lower abdomen. The tumor was very evident, both to touch and sight, at the first examination in the evening, but could not be found the next morning before the operation, and repeated careful examinations before this had also failed to find it. There was some tenderness over this tumor as well as generally over the whole abdomen. Rectal examination showed nothing definite.

The case had appeared at first to be one of prolonged nervous or cyclic vomiting following a digestive disturbance, but the existence of the tumor and the evident complete obstruction of the bowels suggested that the blood, mucus and tenesmus, which very naturally had been con-

* Read before the Massachusetts Medico-Legal Society, Feb. 3, 1909.

* Read before the New England Pediatric Society, Nov. 27, 1909.

sidered to be symptoms of dysentery, were in reality symptoms of intussusception. The fact that the tumor was at McBurney's point suggested the possibility of appendicitis. In any event an operation was demanded.

SURGICAL REPORT.

BY DR. FRED T. MURPHY.

Dr. Townsend has told you the medical history of the case. I saw the patient on the evening of Sept. 15. The temperature was 97° by rectum, the pulse 90 and of very poor quality. Except for the absence of the typical facies, the general appearance was that of a peritonitis. As Dr. Townsend has said, a tumor was felt and seen in the right lower quadrant. There was no visible peristalsis, and no large amount of free fluid could be demonstrated. While an operation seemed imperative, the general condition was such that I felt sure that any shock would prove fatal. Proctoclysis was started as soon as possible with a pressure of four to five inches. Although the rectum had been intolerant of enemata, after the first pain of the insertion of the rectal tube there was no further complaint, and in the first three hours a pint and one-half of normal salt solution was absorbed. During the night between four and five pints were taken up. As nothing was given by mouth there was little vomiting. In the morning the general picture had changed markedly. The pulse was of better quality and the subnormal temperature had become normal. The flesh was less dried out. Care was taken to prevent loss of body heat during the operation, and as little ether as possible was given. A right rectus incision was made and the edge of the muscle pulled inward. Exploration of the region of the cecum failed to show anything pathological. There was no free fluid in the peritoneal cavity. There was no evident distention or contraction of any portion of the intestinal tract. Beginning at the rectum, I ran over the intestine, taking care not to lift it outside of the peritoneal cavity and to keep the field of operation moist with salt solution. About four inches below the duodenum I found a perfect intussusception about an inch long. There was absolutely no tissue change as evidenced by swelling, adhesions or fibrin. Almost without traction the intussusception disappeared, leaving a perfectly normal intestine so far as I could see. In fact, after the reduction it was not possible to say just what part of the jejunum had been involved.

Palpation and inspection gave nothing to clear up the etiology.

The abdominal incision was closed in layers and the child gotten back to bed as quickly as possible. Practically no shock followed the operation. There was no post-operative vomiting and within twelve hours he was taking liquids in good amounts. For the first few days no cathartic was given lest a too vigorous peristalsis be started. The convalescence was uneventful.

Since the operation there has been no more vomiting and the boy is now back almost to his normal weight.

Three points are, it seems to me, of especial surgical interest.

The uneventful recovery after so long a period of apparently absolute obstruction.

The tolerance of proctoclysis after enemata had been rejected, and the large amount of normal salt solution which was absorbed.

The finding of an intussusception without tissue change, with a clinical history extending over three weeks.

I am very positive that that individual intussus-

ception had not been present for more than a few hours. In order to explain the clinical picture, it seems to me necessary to suppose that there had been multiple intussusceptions, such as are seen in infants and young children post-mortem, and that during the period of three weeks these had been forming and reducing themselves.

If this assumption is based upon fact it would furnish a pathology for certain cases of the so-called cyclic vomiting which simulates a mechanical obstruction but for which there is no pathological basis.

On the theory that the condition found was due to an overactive peristalsis, it is easily conceivable that the trauma of handling the intestine might have broken this reflex and re-established the normal.

Medical Progress.

REPORT ON OBSTETRICS.

BY ROBERT L. DE NORMANDIE, M.D.

MOMBURG'S METHOD FOR CONTROLLING HEMORRHAGE.

CÆSAREAN SECTION IN PLACENTA PREVIA.

TREATMENT OF SEPSIS WITH BACTERIAL VACCINES.

PRINCIPLES OF OBSTETRIC PRACTICE.

TREATMENT OF GRAVER FORMS OF PUERPERAL SEPSIS.

A RATIONAL PUERPERIUM.

PUBIOTOMY.

INDUCTION OF LABOR AT TERM.

DRYING UP THE LACTATING BREASTS.

TYPHOID FEVER COMPLICATING PREGNANCY.

THE RELATION OF THE THYROID GLAND TO THE TOXEMIA OF PREGNANCY.

MOMBURG'S METHOD FOR CONTROLLING HEMORRHAGE.

MOMBURG¹ recommends a rubber tube the size of a finger or thumb about the patient's waist between the ribs and the pelvis in order to stop hemorrhage from the lower part of the body. He makes use of the elasticity of the rubber and surrounds the patient with from two to four circles. The tube is pulled tight enough so that the pulsations in the femoral artery are not felt. He says the procedure is not dangerous. All injuries to the intestines are excluded because the pressure is diffused by the abdominal muscles, and for this same reason the ureters are not pressed on. In loosening the rubber tube, the legs should be placed high up, and for a short time there may occur an alteration of the heart's action, but by placing a rubber bandage on the thighs and legs this can be avoided. The rubber tube should be gradually, not suddenly, loosened. There is no disturbance of respiration. Momburg tried this tube on sound men for five minutes without narcosis with no untoward results, and he reports briefly two surgical cases where it was used for forty-three and eighteen minutes successfully. Sigwart,² following Momburg's report, tried it in a case where the placenta had to be removed manually and hemorrhage from an atonic uterus followed. The tube was put twice around the waist and pulled tight. The hemorrhage ceased and the blood came only in drops, contraction of