Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTES ON A CASE OF LARYNGEAL GROWTH WITH THYROTOMY.

By W. H. KELSON, M.D. LOND., F.R.C.S. ENG.,
ASSISTANT SURGEON TO THE LONDON THROAT HOSPITAL.

THE following case seems to be of interest from the fact of its long duration.

A man, aged 49 years, came to the London Throat Hospital in August, 1901, complaining of difficulty in breathing and loss of voice. He stated that as a lad he was husky, but he quite lost his voice about 1869, when he went to Golden-square Throat Hospital and became a patient there under the care of the late Sir Morell Mackenzie. Small portions of growth were at this time repeatedly removed from the left cord. This continued for about a year, when his voice being a little improved and feeling somewhat tired he suddenly ceased to attend and avoided all active laryngeal treatment for 31 years. During this period he had always had great huskiness and more or less difficulty in breathing. He said that during the last few months he had lost about two stones in weight and his breathing had become much worse. He was a spare man of somewhat cyanotic appearance; his voice was a hoarse whisper and there was stridor directly he exerted himself. There was no history of syphilis in himself or tubercle or malignant disease in the family. On examination of the larynx the left arytenoid was seen to be motionless and the upper orifice of the larynx was almost blocked by a warty growth. The left vocal cord could not be seen; the right was normal. The exact point of origin of the growth from the left side could not be determined; it felt hard to the finger and forceps. No ulceration could be seen and what little discharge there was contained no tubercle bacilli. Considering the rapid loss in weight and increase in symptoms the last few months the question arose as to whether malignant disease was now present. Mr. E. B. Waggett, who kindly saw the case, thought that it was a simple tumour of some kind and the pathological report on a piece removed was, "A papillary growth probably not malignant." A week after admission to hospital the patient's breathing one afternoon became very much worse, and as asphyxia appeared imminent I had to perform tracheotomy rapidly. A few days after this I introduced a Hahn's cannula and, assisted by Mr. Waggett, performed the operation of laryngo-fissure, when the growth was seen to be a large single papilloma (of the size of half a walnut and weighing 30 grains) arising from the left cord; there was not the slightest sign of infiltration. The growth was removed and the larynx was closed. The patient has now a very fair voice and has resumed his occupation as cabman. The question of recurrence is of course as yet in abeyance.

Old Burlington-street, W.

TREATMENT OF WHOOPING-COUGH BY NASAL IRRIGATION.

By EDWARD MAGENNIS, M.D. R.U.I., D.P.H. R.C.S.I.

FORMERLY the treatment of whooping-cough was most unsatisfactory, but now I think it may be hoped that a method has been found of combating and conquering this serious and distressing disease. I have for a long time been of opinion that the origin of this complaint was located in the Schneiderian membrane and this belief has been strengthened by the report of a case published by Dr. E. M. Payne in a medical journal some weeks ago. Acting on this hypothesis I have recently treated two cases, a girl, aged two years and three months, and her brother, aged 10 months, by irrigation of the nares with warm carbolic lotion. There can be little doubt that the disease is produced by a specific organism, as Afanassjew discovered large numbers of bacilli in the sputum in this disease, and

Hewlett in his Manual of Bacteriology says: "Koplik, by sowing the pellets on solidified hydrocele fluid, obtained a pure culture of a small and delicate bacillus measuring 0.8 to 1.7 μ in length." The bacilli being found in the sputum could be accounted for by the escape of mucus by the posterior nares or by the extension of the disease from the Schneiderian membrane to the pharyngeal or laryngeal membranes. The strength of the lotion which I used was 1 in 40 with a little glycerine added. I procured a two-ounce syringe with an indiarubber nozzle, so that when it was in the nares it could not do any harm, no matter how the child struggled. Three syringefuls were injected into each nostril three times a day. I had only once to show the mother how to use the syringe and afterwards she and the nurse had very little trouble in using it. It is a good plan to bind down the arms with a towel or binder before using the syringe. The result of detailed daily notes of the paroxysms and amount of cough tended to prove in both cases that treatment directed to the Schneiderian membrane by thorough irrigation diminished the frequency of the paroxysms and cough and greatly reduced the duration of the disease. Of course, in this mode of treatment there is a risk of some of the fluid getting into the Eustachian tube.

Dublin.

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.

WEST LONDON HOSPITAL.

A CASE OF TETANUS NEONATORUM.

(Under the care of Mr. W. McADAM ECCLES.)

AT present it cannot be doubted that practically all cases of tetanus neonatorum are the result of infection with the tetanus bacillus, and this is especially true if the disease is epidemic; but it is possible that some of the cases which have been thus named are examples of convulsions the result of cerebral injury at birth; at least, this has been the opinion of careful observers, such as Marion Sims, and certainly in some cases injury at the base of the brain can be found. However this may be, the vast majority of the cases are examples of true tetanus. The case recorded below is of great interest in that the antitoxin was employed and the successful result is noteworthy. For the notes of the case we are indebted to Dr. J. John Abramston.

An infant, aged 14 days, was admitted to the West London Hospital on July 29th, 1901, under the care of Mr. McAdam Eccles. The mother stated that up to the previous Tuesday (July 23rd) the child was breast-fed; after that he refused the breast and took food by teaspoonfuls. He passed urine freely the first week after birth, but since then he had done so with difficulty. His bowels had been confined for two days previously to admission. He was brought to the hospital because the mother found suddenly that she could not get the child's mouth open to feed him, and that he was seized by "fits" every time he was touched.

After admission the child was found to have a fit eight times within an hour. Between the fits the abdomen was very rigid, as were also the muscles at the back of the neck and the muscles of expression. The legs and arms were not so much involved but were more rigid than normal. The pulse was 120 and the respirations were 90. The temperature on admission was 98°F. Each fit started with a cry, the abdomen became as hard as a board, the legs and arms were drawn up into the foetal position, and the hands were clenched so firmly that a finger placed in the child's palm previously to the attack was gripped so that the whole body could be lifted *en masse* by it. When the open palm was placed under the child's heels the body could be lifted from the bed in one piece until he stood on his head. The face and forehead were puckered into a painful grin, respiration

stopped, and the whole body became cyanotic. Each fit lasted for about 10 seconds; then the face lost its grin, the child became of a better colour, the sterno-mastoids relaxed somewhat, and the arms could be moved from the shoulder and slightly from the elbow. The legs did not get so relaxed but the orthotonos disappeared.

The seat of the trouble was a septic and pervious umbilicus. But in addition there was severe ophthalmia neonatorum. The umbilicus was curetted and dressed antiseptically under chloroform and the ophthalmia was treated with silver nitrate (two grains to one ounce). An attempt, however, to grow the tetanus bacillus from the umbilical pus was not successful. Three cubic centimetres of anti-tetanic serum were injected every four hours and the child was fed by the rectum during the first day, as every attempt to pass the nasal tube brought on a very severe fit. Two grains of bromide of potassium and one minim of liquor morphinæ hydrochloridi were added to each four-hourly feed.

On July 30th the temperature had been rising steadily since admission, reaching 103° 2' at 2 A.M. on the morning of the 31st. Fits occurred every five minutes. The patient was fed by the nasal tube under chloroform. 18 cubic centimetres of anti-tetanic serum were injected during the day (three cubic centimetres every four hours). On the 31st a pink rash due to the antitoxin came out all over the body. The child seemed better, however, as the respirations were not so hurried, the fits were less frequent, and the rigidity between the attacks was not so well marked. The temperature, however, had been going up, reaching 106° at 2 A.M. on the morning of August 1st—the highest point reached during the acute stage. He was fed by the nasal tube without anæsthetic, though each time an attack was brought on. 18 cubic centimetres of serum were injected during the day. On August 1st the temperature had fallen to 99° during the night. The fingers could be moved slightly and trismus was not so constant. On the 2nd the patient was fed by the stomach-tube. On the 3rd the temperature was subnormal for the first time. The serum was discontinued. The breathing was much easier. He still had a fit each time he was fed, but he had no other fits between. There were no fits on the 5th. The abdomen and limbs were still rigid. On the 6th he took one ounce of milk extra by the spoon. On the 11th he was fed by the bottle and on the 28th he was discharged recovered.

Remarks by Dr. ABRAHAM.—The comparative rarity of tetanus neonatorum, its almost constant fatal termination, and the usually unsatisfactory results obtained from injection of anti-tetanic serum in acute cases, justify me in recording the above case in which recovery took place, and the serum appeared to have done some good. The disease would seem to be fairly common in tropical countries, especially in the West Indies, but it is comparatively rare in European countries. It is stated, however, that one out of every six children born in the Rotunda Hospital, Dublin, in 1782 died from the disease. In more recent times it was exceedingly fatal in St. Kilda in the Western Hebrides, where it was known as the "eight days' sickness"—84 out of 125 children dying within 14 days (Osler); but with this exception it is now very rare, as, according to Ware, "a case has not been admitted to St. Bartholomew's during the period covered by the statistical reports."¹ As to the fatality, no exact statistics are obtainable, the infantile form being included in the general statistics of tetanus. These show that for an incubation period of 10 days 4 per cent. of the patients recover, and for an incubation period of from 11 to 15 days 27 per cent. recover (Rose). With regard to the serum treatment, the general consensus of opinion, voiced by Kanthack, Roux, Nocard, and others, is summed up by Rose thus: "In man it has not been conclusively proved that recovery has ever been due to serum. Local antiseptics, narcotics, and strengthening treatment hold out the best hopes of recovery."²

EASTERN FEVER HOSPITAL.

A CASE OF PURPURA FOLLOWING DIPHTHERIA.

(Under the care of Dr. E. W. GOODALL and Dr. CONRAD BASAN.)

THE rarity of post-diphtheritic purpura is very great. We are so little acquainted with the essential cause of any form of purpura that it is of little value to speculate on the

method of production of the purpura in this case. It is probable, however, that in all cases there is a modification, not only in the coagulability of the blood, but also in the walls of the capillaries.

A girl, aged 11 years, was admitted to the Eastern Fever Hospital on Sept. 16th, 1901, for diphtheria, of which the symptoms had appeared on the previous day. On the day of admission there was a thick layer of membrane on each tonsil, the cervical glands were enlarged, and the temperature was 103° 6° F. Antitoxin (6000 units) was injected and the fauces were flushed with an alkaline solution every four hours. The progress of the disease was favourable and on the 22nd the membrane had quite disappeared. On the 23rd and 24th there was urticaria of the trunk, face, and limbs, without any rise of temperature, but on the 25th this rash had disappeared. On the 26th there was again a slight erythematous rash but no pyrexia. On the 27th a purpuric eruption made its appearance upon both the upper and lower extremities, chiefly about the elbows and the front of the legs. There were a few spots on the trunk and there was some hæmorrhage beneath the right conjunctiva. Mixed up with the spots on the skin was a circinate erythema. There was also bleeding from the nose and mouth, and pin-point hæmorrhages were observed in the buccal mucous membrane. The temperature was 100° 2° and the pulse-rate was 130. On the 28th fresh purpuric spots appeared on the face as well as on the trunk and extremities. After this no further spots came out. Most of the spots were cutaneous, small in size, and of a purple hue, but a few were subcutaneous, larger, and of a blue colour. A few days prior to the attack of diphtheria the patient had been vaccinated on the left arm and at the time the purpura appeared the pocks were in the vesicular stage. Hæmorrhage now took place into and around the pocks, which after a day or two looked as if they would slough, but no such event occurred and the scabs separated in the usual way on Oct. 7th. In addition to bleeding from the mouth and nose bright blood was on two or three occasions passed per anum on Sept. 27th and 28th. On the 29th the hæmorrhages were already beginning to fade and the larger ones were of a greenish-brown hue, like old bruises. On this day the circinate erythema was still present. During the day the patient complained of pain in some of the joints and her temperature rose to 102° 6° F. The pains in the joints were worse the next day, the large joints being chiefly affected. There was, indeed, some effusion into the right knee-joint. By Oct. 3rd this joint affection had quite gone. On Sept. 27th and 28th, while the hæmorrhages were coming out, the girl was very restless and anxious, complained much of thirst, and slept little. There were also nausea and occasional vomiting. On Oct. 1st the temperature became normal. After the 3rd recovery was fairly rapid, though from the 5th to the 15th there were pain and tenderness along the course and distribution of the ulnar nerve. There was never albuminuria at any time during the patient's stay in the hospital. She was discharged well on Oct. 24th. As for the treatment, calcium chloride, five grains every four hours, was given on the appearance of the purpura and was continued till Sept. 30th. Pain was relieved by opium and phenalgine. The nausea and vomiting necessitated the administration of food by means of nutrient enemata for two or three days.

Remarks by Dr. GOODALL.—I have ventured to record this case for two reasons. Firstly, because of its rarity; I have seen only three such cases, including the present one. The account of the first will be found in Vol. L. of the "Guy's Hospital Reports"; and of the other in Appendix I. to the "Report on the Antitoxin Treatment" made by a committee of the Clinical Society of London in 1898. A similar but more severe case was published in THE LANCET of July 20th, 1901, p. 132, by Dr. C. W. Buckley. Secondly, these rare cases of purpura following diphtheria must be distinguished from those common cases in which hæmorrhages, both into the skin and from mucous membranes, occur during the acute stage of the disease (hæmorrhagic diphtheria). Practically every case of hæmorrhagic diphtheria is fatal, whereas in cases of post-diphtherial purpura the prognosis is by no means always grave. In fact, my three cases all recovered, as also did that reported by Dr. Buckley. Dr. Buckley raised the question whether antitoxin has any share in the production of the purpuric symptoms. I do not think it has. My first case occurred before the antitoxin treatment was introduced, and I have met with a similar purpura following scarlet fever where also no antitoxin had been given.

For the notes of the case I am indebted to Dr. Basan,

¹ St. Bartholomew's Hospital Reports, vol. xxxvi., 1900.

² Der Starrkrampf bei Menschen, 1897.