Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF INTUSSUSCEPTION IN A CHILD EIGHT MONTHS OLD ; RECOVERY.

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BEFORE leaving for a country round on Oct. 5th I received a message to see a child in a neighbouring village, who had been taken very ill in the morning. On reaching the place I found that the patient, a baby aged eight months, had been suffering from dyspeptic symptoms for some time, but that the child had been taken much worse during the last twelve hours. The child now appeared to be in a good deal of pain, the pulse was very rapid, and the patient had the appearance of being very ill. The child vomited every few minutes, the vomit consisting of undigested milk. I examined the abdomen carefully and could detect nothing abnormal, so left to continue my journey, intending to call again, as I should pass the house on my way home. About two hours afterwards I again visited the child. I found the patient a good deal worse, and a slight discharge of mucus and blood was expelled from the anus every time the child strained at stool. I examined the abdomen again and found in the left iliac fossa a sausage-shaped tumour which extended also into the hypogastrium. The tumour was soft and elastic and seemed to vary in size at different examinations. On examining per anum I found protruding into the rectum a body which moved each time the child cried and seemed to approach nearer the anal orifice at each expulsive effort. This body was soft and elastic and the finger could pass all round it, but could not reach its attachment. The lower part of the rectum was full of blood-clots and some mucus. The child had passed a normal motion in the morning prior to my visit. The sickness continued, but was more frequent. The abdomen was very lax, and palpation therefore extremely easy. I borrowed from a neighbour a syringe and proceeded to give the child a copious enema of soap and water; this seemed to give relief and a good deal of blood-clot and mucus was washed out. The intussusception receded several inches after injection, but being unable to reduce it altogether and having no suitable instruments with me I sent for my father, who arrived in about an hour, bringing with him a metal syringe, &c. We then gave the child a large injection of olive oil. Having supported the buttocks on pillows one manipulated the abdomen while the other used the syringe. After all the oil had been expended we continued to inject air, and after about ten minutes, having my hand on the abdomen, I detected some gurgling in the hypogastrium; the injection was continued for some time longer with intermissions to prevent the intestines becoming too much distended with air, and the pump was then removed. On examination all trace of the tumour had disappeared and nothing could be felt per anum. The child was somewhat restless after the operation, and a sedative mixture of bromide and hyoscyamus was administered. No more blood was passed by the rectum and the child seemed relieved of all pain. With the exception of a severe attack of vomiting on the following night the patient presented no further serious symptoms and recovery was complete. It is now a week since the injection was used, the child has free use of the bowels, takes the breast very well, and, with the exception of some patches of thrush on the tongue and fauces, is in very good health.

Great Torrington.

AN UNCOMMON MIDWIFERY CASE.

By JOHN JARVIS, L.R.C.P. LOND., M.R.C.S. ENG.

THE patient was twenty-five years of age and was the mother of one living child a year old, at whose birth the use of forceps was necessary, and the perineum having been

ruptured was sutured but failed to unite. I was called to see her for the second time on Oct. 6th. On arriving I found at the vaginal orifice a dark, livid tumour projecting three inches and having the size and shape of an extra large fist. In the middle of this was the os uteri; the pains were strong, and every succeeding one pushed out the tumour, dragging down the recto-vaginal septum. The membranes were unruptured and the head was presenting in the first position. Forceps not being available, turning was decided on, and under chloroform this was easily done, the os uteri rapidly dilating under the pressure of the hand. Prior to this the tumour had been returned inside the vagina. Delivery was effected by traction on the foot, whilst the os and cervix were pressed back by the other hand. There was no difficulty with the head. A dose of ergot was given, and the placenta came away easily, being followed by complete contraction of the uterus. Abdominal examination showed that the uterus was in its normal position. An interesting feature in this case is that the father and mother are both deaf and dumb, although the first-born child is not. The second cried lustily on birth.

Bath.

THE AGE-LIMIT FOR CATARACT EXTRACTION.

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Is there an age beyond which it is not permissible to operate for cataract? I should say not; all things being equal, if a patient is in moderate condition, even though bedridden or mentally afflicted, there is no reason why he should not be operated on at any age. I have in the course of my very considerable experience operated upon a great number of persons over eighty years of age, two over ninety years of age, and a short time ago I extracted the lens from the left eye of a patient in his ninety-sixth year. These latter have all done well and the last patient has already good sight. I prefer to operate without iridectomy, so that after a time there is no trace (as I have frequently demonstrated before learned societies) of operative interference. Such eyes, according to my experience, bear the wear and tear of life much better than eyes operated on by the combined method, and of course sight is better. Otto Becker's researches have shown that where iridectomy is performed there is always prolapse at the angles of the wound and the lens capsule is apt to be trapped, an accident which never happens with simple extraction. The central and movable pupil, too, fulfils its natural function of excluding rays of light much better than one that has been deprived of a portion of its sphincter, and, as in aphakial animals, compensates for the absence of the lens.

Nottingham.

THE TREATMENT OF ACUTE TRAUMATIC SEROUS SYNOVITIS BY ELASTIC PRESSURE.

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THE value of elastic pressure in the treatment of acute traumatic serous synovitis is worthy of more consideration than at present it receives. Many of the surgical textbooks recommend cold applications and the immobilisation of the injured joint till the acute stage is over, the treatment by elastic pressure receiving but scanty notice, if, indeed, it is mentioned at all. Having during the last twelve months treated a considerable number of cases of acute synovitis following injury I have come to the conclusion that the method of treatment by elastic pressure gives, in a large majority of cases, the best results, affording a more immediate relief of pain and a speedier cure. By elastic pressure the absorbent powers of the synovial membrane are stimulated and thus the distension of the joint capsule, which is the chief cause of the pain, is rapidly relieved. By checking mobility and affording a firm, uniform, and even support to the injured tissues, it relieves the reflex spasm of the muscles acting on the joint. And, again, by supporting the bloodvessels further effusion into the joint is prevented. The pressure should be perfectly uniform, gentle, and elastic. All the hollows around the joint should be carefully packed with absorbent or wood wool, or, better still,

sheep's wool, which retains its elasticity under pressure. Then several layers should be placed around, the whole extending for some distance above and below the joint, and over all a moderately tight bandage of elastic webbing. There is no need for a splint. The limb may be swung in a Salter's cradle or tied up in a cushion. The dressing should be taken down at the end of twenty-four hours, the joint passively moved, and the pressure readjusted. In cases of acute synovitis of the knee-joint following a primary dislocation of a semilunar cartilage it seems desirable to keep the joint fixed for four or five days in order that, if possible, the displaced cartilage may become fixed. The results obtained by this method of treatment have been exceedingly satisfactory. The painful tension and reflex muscular spasm quickly disappear and the effusion undergoes speedy absorption.

Macclesfield.

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.

GREAT NORTHERN CENTRAL HOSPITAL.

A CASE OF LATERAL SINUS PYÆMIA FOLLOWING CHRONIC SUPPURATIVE OTITIS MEDIA; TREPHINING; RECOVERY.

(Under the care of Mr. W. R. H. STEWART.)

A BOY aged eleven years was on Feb. 26th admitted to the hospital, under the care of Mr. Stewart with the following history. He had had scarlet fever when he was four years of age, and there had since been a discharge from both ears. Five days before his admission he complained of earache; he was shivering and he seemed to be ill. On the following day he vomited, and two days later the discharge suddenly stopped. He was delirious off and on and did not sleep. On admission he complained of great pain in the head and he looked very ill; the temperature was 97° F. and the pulse was 120 and regular. There was a good deal of swelling and tenderness behind the ear, together with slight swelling of the right disc with full veins. The antrum was opened and a good deal of pus escaped from the cavity and from around the tip of the process. On the next day he was better; the swelling had subsided, the temperature was normal, and the pulse was 100 and regular. Some very offensive pus was removed from the antrum. On the following day he became restless and had a good deal of pain; the wound looked foul and sloughy and the optic neuritis had increased. Mr. Stewart, therefore, having first thoroughly cleansed the wound, trephined over the lateral sulcus and antral wound. The sinus was tapped and a firm healthy clot was found. The bone was then cut away with forceps in an upward and backward direction. The membranes bulged into the opening and no pulsation could be felt. On incising the membrane a large amount of serous fluid escaped. A director was then thrust into the temporo-sphenoidal lobe in every direction, but no pus was found. The wound was dressed with blue gauze. The same evening the patient had a rigor, the temperature rising to 104° F., but he passed a good night and on the next day Mr. Stewart found him sitting up in bed eating his food and much improved in every way. That evening he had another rigor and the temperature reached 104·2°. As it continued to rise to 104° every day and the optic neuritis was persistent Mr. Stewart re-explored the temporo-sphenoidal wound and examined the cerebellum, but he could find no pus. He also slit up the lateral sinus and thoroughly scraped out the clot (which was perfectly sweet) and plugged the wound with antiseptic wax. The wound healed remarkably well, but for quite a month afterwards, although it remained healed and the boy seemed in other respects quite well, taking his food and sleeping well, he had a temperature of 104°, with an occasional rigor, nearly every day. On April 6th, notwithstanding the temperature, Mr. Stewart told the house

surgeon to get the patient up and let him run about. From that time the temperature fell and never rose again. The boy has remained well ever since.

Remarks by Mr. STEWART.—I think the case is interesting from the somewhat unusual character of the symptoms. If now, if there is the slightest suspicion of there being any mischief beyond trouble in the antrum, open the latter and the lateral sinus at the same time by trephining over an area sufficiently large to include both. The temporo-sphenoidal lobe is then easily reached by chipping upwards with bone forceps. The cerebellum should, I think, have a separate trephine hole. This is a modification of Dean's operation.

SUSSEX COUNTY HOSPITAL.

TWO CASES OF GENERAL PERITONITIS FOLLOWING GANGRENOUS APPENDICITIS; LAPAROTOMY; REMOVAL OF APPENDIX.

(Under the care of Mr. WILLOUGHBY FURNER.)

WE are pleased to give these cases publication in the columns of THE LANCET, for examples of recovery from acute suppurative general peritonitis are not very frequent. We must undoubtedly ascribe recovery in one and temporary recovery in the other to the prompt and thorough intervention of the surgeon. In both cases the nature of the disease and its extreme gravity were recognised, more especially in Case 1, where we read the patient was immediately sent to the hospital after he was examined and no palliative treatment attempted. The symptoms in the second case were less acute and justified a judicious medical treatment before operation. At the operation on each patient adhesions were found in the region of the appendix, making it probable that the generalised inflammation was the result of bursting of an abscess into the general peritoneal cavity, and that they were not of the kind known as "fulminative." In both cases the cleansing of the peritoneum was very thoroughly carried out and the appendix vermiformis removed. For the notes of Case 1 we are indebted to Mr. A. H. Buck, house surgeon, and for those of Case 2 to Mr. East Apthorp of Burgess-hill.

CASE 1.—A man aged twenty-seven years was admitted to the Sussex County Hospital on May 16th, 1895, complaining of severe pain in the abdomen. On the evening before admission the patient, after some slight abdominal discomfort while at work during the day, was seized suddenly with severe general abdominal pain and vomiting. He was subsequently seen by Mr. H. H. Taylor and sent immediately to the hospital. On admission he was somewhat collapsed and writhing about in bed with pain. The tongue was dry and brown. The pulse was small and wiry, numbering 93; the respiration was 27, the chest alone moving; and the temperature was 100·6° F. The bowels were open once during the night, but since then there had been no passage of flatus. Vomiting commenced at 11 P.M. on the previous evening and had continued once or twice every hour since; the vomit was brownish in colour and slightly stercoraceous. The patient said that two years ago he suffered for several days from severe pain in the abdomen accompanied by sickness. The abdomen was hard, tympanitic, not moving with respiration, and very tender all over, especially in the right iliac fossa. Immediate operation having been decided upon, Mr. Furner made a median incision four inches long below the umbilicus. On opening the abdomen blood-stained fluid with flakes of puriform lymph escaped. On passing the hand to the right iliac fossa a mass of matted intestines was felt. The incision was then enlarged upwards until finally it extended from one inch above the pubes to one inch below the ensiform cartilage. With the space thus afforded the appendix was seen lying adherent between adjacent coils of intestine. There were two gangrenous openings on its free anterior surface, but no calculus was found. The adhesions were separated, the appendix freed, and a circular ligature having been applied to its base it was removed. The intestines, which were now chiefly outside the abdomen, were thoroughly cleansed with boiled water and weak boracic solution, as were also the abdominal and pelvic cavities, and all adhesions were separated. The wound was then closed, and a glass drainage tube carrying a strip of cyanide gauze was left in the lower end. Twice during the next twenty-four hours the fluid in the tube (amounting to