

As this patient was of such an advanced age I thought the case not unworthy of record.

Harley-street, W.

MUSCULO-SPIRAL PARALYSIS FOLLOWING INJURY; RECOVERY.

By W. N. CLEMMET, M.R.C.S. ENG. &c.

ON Jan. 20th, 1892, a seaman aged forty-one was admitted to the Bootle Borough Hospital, under the care of Dr. Forbes. The patient stated that a fortnight previously while on board ship he had been thrown against the bulwarks and received a fracture of the lower third of the right humerus. It had been set by the captain and on examination was found to be in apparently good position. While in hospital union occurred and subsequently he attended for a short time as an out-patient. Shortly before his discharge signs of musculo-spiral paralysis were noted, and this tending to become worse the galvanic current with massage was periodically applied. No improvement followed and on March 30th he was readmitted for operation. A long incision was made on the outside of the forearm and the musculo-spiral nerve exposed between the supinator longus and brachialis anticus. On tracing it upwards it was found to be invested in callus at the seat of fracture. As regards the fracture itself, the lower fragment was rotated inwards and displaced upwards and forwards, so that there was formed a recess in which the nerve was lodged and compressed. About two inches of the nerve were involved in the surrounding callus which, being somewhat soft, was gouged away and the nerve exposed and completely freed. The operation was completed by closing the wound after the insertion of a drainage tube. Four days later he had pricking over the area supplied by the nerve, in those places where previously there had been anæsthesia. Fourteen days later he complained of severe pain from the wrist to the finger ends. Power of extension of the second and third phalanges was first noticed eighteen days after the operation—it of course being very slight. To aid the extensors (by preventing the opposing action of the flexors and also the natural tendency of the hand to fall pronate), a splint was kept on the flexor aspect of the arm and hand. By the time the patient was discharged three and a half months after the operation he had but partial wrist drop, while now he has completely recovered with almost full power over his hand and forearm, shown by the fact that he has resumed his ordinary occupation as a sailor.

Bootle.

PERFORATIONS THROUGH THE ANTERIOR PILLARS OF THE FAUCES.

By WALTER FOWLER, M.A., M.B. CAMB., F.R.C.S. ENG.

IN THE LANCET of July 16th, 1892, Dr. Morrice quotes a previous contribution of mine in these pages (Nov. 30th, 1889) and brings forward evidence to prove that these lesions may be caused by diphtheritic ulceration as well as by scarlet fever mischief. Whether diphtheria is responsible for the majority of the perforations or whether scarlet fever occupies the premier position is immaterial to the practical side of the question, although interesting from an etiological standpoint. The object I had in view when publishing my memorandum on Nov. 30th, 1889, was to show that these perforations were no evidence *per se* of syphilis. Dr. Morrice having actually observed them in several cases, being caused by diphtheritic sloughing, corroborates my view, and his cases and remarks are exceedingly interesting and valuable. Perforations through the anterior pillars of the fauces are discovered very frequently when investigating ear complaints. At first I certainly considered them as evidences of syphilis, but being struck with the great frequency with which they were bilateral I was led to investigate their origin; hence my contribution to THE LANCET on Nov. 30th, 1889, wherein I described their clinical features. I do not for one moment wish to assert that a unilateral perforation is *not* syphilis; where one occurs careful attention should be paid to the history, and the diagnosis of syphilis should not be inferred on this one fact alone. On the other hand, a perforation through the soft palate (a subject not now under consideration) may be confidently taken *per se* as evidence of syphilis, notwith-

standing that this lesion may be very rarely caused by lupus; and also, according to Dr. Morrice, scarlet fever (which must also be rare). I may add that since my previous contribution on this subject was published I have actually seen a perforation through an anterior pillar that remained permanent, caused by the bursting of a tonsillar abscess (idiopathic); and have likewise had frequent opportunities of verifying my previous views, which I must now extend, thanks to Dr. Morrice, by the inclusion of diphtheria as one of the causes of these lesions.

Echuca, Victoria.

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.

LONDON HOSPITAL.

PHOSPHORUS NECROSIS OF THE UPPER JAW; CHRONIC
ABSCESS OF THE BRAIN.

(Under the care of Mr. FREDERICK TREVES.)

THERE are many circumstances which make it probable that the necrosis in this case was the result of exposure of the patient to phosphorus fumes. In the absence of other causes, a slowly extending necrosis of the upper jaw in a patient with a history such as this may safely be ascribed to the effects of the phosphorus. It is luckily unusual at the present day to meet with necrosis of the maxillæ due to this cause, the effect of Larinier's paper on the subject in 1845, the contributions of Wilks, Bristowe, Simon and others in this country being to clearly demonstrate the cause and point out the remedy. Suppurative meningitis is rarely a cause of death in these cases, but a case is recorded which was under the care of M. Hervieux at the Hospital Necker, in which the patient, a lucifer-match maker, had necrosis of the lower jaw, the upper jaw and afterwards of the bones of the palate, the bones entering into the orbit and the frontal. He died with brain symptoms. Pus was found between the dura mater and the brain.¹ For the notes of this case we are indebted to Mr. H. M. Speechly, house surgeon.

A dipper in a Scotch match factory was admitted into the London Hospital on Oct. 11th, 1892. His age was forty-nine, but he had the appearance of being much older. He was thin and anxious-looking. He had worked at his trade for thirty years without suffering any inconvenience therefrom until about nine months previously to admission. The first symptom complained of was toothache in the right upper jaw, which troubled him continuously for four months. He then had some decayed teeth removed. Shortly after the gum tissue sloughed off the jaw, part of which became exposed. On May 9th some dead bone was scraped away, which gave him some relief. Gradually, however, the necrotic process spread, and a very offensive discharge, previously slight, caused him much distress during the interval between the month of May and the time of his admission into the London Hospital. For six months previously to admission he complained continually of severe headache in the frontal and occipital regions. He could bear no hard covering on his head, so he always wore a soft cloth cap. The headache was almost constant and prevented him from sleeping. His pupils were normal. On Friday, Oct. 14th, Mr. Treves operated. The sequestrum was found to include the whole of the right upper jaw, below the level of the infra-orbital foramen, and was bathed in pus of the foulest description. The cavity, after being washed out, was stuffed with iodoform gauze. The after treatment consisted in irrigating the cavity hourly with a lotion of carbolic acid (1 in 80) and the patient was placed on a liberal diet. From Oct. 11th to the 23rd the temperature was never high; it varied from 97.6° F. as the lowest

¹ System of Surgery, Holmes and Hulke, p. 477, vol. ii., 1883.