Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

CYST OF VENTRICULAR BAND.

By CHARLES W. HAYWARD, M.B.

WHILE attending the cliniques of Professors Schrötter and Schnitzler in Vienna, I had the good fortune last December to have assigned to me for treatment a patient who had come to the clinique of the latter professor. She was about forty-three years of age and of healthy appearance, but her voice was markedly affected with a harsh hoarseness. This, she stated, had first commenced rather more than six months previously, and had gradually got worse. On examining the larynx, the parts were found normal with the exception of the left true cord, which showed a large cyst. (See woodcut.) This cyst occupied the middle three-fifths of

the cord for its entire breadth, and was rounded, sloping off at the ends, and at the middle being about one-eighth of an inch in thickness. It presented a translucent slightly striated appearance, and during phonation was seen to interfere seriously with the accommodation and vibration of the cord.

The treatment adopted was as follows. Having painted the throat with a 10 per cent. solution of cocaine, I incised the cyst with Schrötter's guarded intra-laryngeal knife. A clear mucus-like fluid exuded. I attempted to obtain some of this for microscopical examination. I introduced a brush and pressed the contents out of the cyst, but, owing to the gagging of the patient, the examination was not reliable, the specimen obtained consisting of ordinary mucous secretion and some blood. I then, by means of Schrötter's pincette, pulled away the cyst wall, and then touched the site of the cyst with solid nitrate of silver. On returning next day, the patient stated that the pain had been very slight, and that she felt the throat improved. The site of the cyst was occupied by a white eschar from the nitrate of silver. The larynx was pencilled with nitrate of silver solution (10 per cent.). The pencilling was repeated for a few days with a weaker solution (5 per cent.), and by about the fifth day the white eschar was gone and the cord getting to look normal again. For three or four days the pencilling was made with chloride of zinc (chloride of zinc, 16; distilled water and glycerine, of each 240) instead of the nitrate of silver, and in about a fortnight the patient returned to her home with the hoarseness almost entirely cured.

The case excited great interest among the English and American doctors attending the clinique, and they will no doubt remember it should they peruse these notes, as they watched its progress all through, and envied me the good fortune of securing such a case.

Liverpool.

A CASE OF OPIUM POISONING.

By WILLIAM EASBY, M.D.

ON Sept. 5th I was called to the police station in Peterborough to see A. B—, aged thirty-seven, a tailoress. I saw her at 1.30 P.M., and was told that she had swallowed half an ounce of tincture of opium an hour before I saw her. A two-drachm bottle was found in her possession, which she stated had been filled twice. This

was also verified by the druggists who sold it. She had been drinking during the morning, and had quarrelled with a man she had lived with for the last six years. When I saw her she was excited, face flushed, pulse quick, and pupils normal. I made her swallow half a pint of warm water, and then injected into the left arm ten minims of a solution of apomorphia, which contained one-tenth of a grain of the drug. She was violently sick in about two minutes, the vomited matter smelling of laudanum. The stomach was then well washed out with warm water introduced through a syphon tube, and she was kept moving about for several hours. My reason for reporting this case is to record the fact that a solution of apomorphia will keep good for some years. The solution I used was procured five years ago, and is as potent as ever. Some authorities appear to think that age decreases its powers, and when the solution becomes dark green it is inert. My solution is a deep green, and several hours after the drug was injected the site was plainly visible by a dark green stain under the skin. After washing out the stomach, I injected the 120th of a grain of atropine, and she was well walked about for some hours. At 7 P.M. she was giddy and drowsy, but able to walk about alone, and at 9.30 P.M. she was locked up for the night. The next morning she was complaining of some headache, and had been sick; with these exceptions she was quite well. From inquiry at the druggist's where the tincture was purchased, they informed me it was of pharmaceutical strength.

Peterborough.

REMOVAL OF HORNY GROWTH FROM THE DORSUM OF THE HAND.

By ERNEST H. ELLISON, M.R.C.S., L.R.C.P.

IT may possibly be of some interest to the readers of THE LANCET to have brought before them the case of Mr. S. W—, aged seventy-nine, resident in Castleton, Derbyshire, from whom on July 19th last I removed a growth entirely horny in consistence, presenting very much the appearance of a lamb's horn, measuring at the widest part of its base an inch and a half, and at its apex about three-quarters of an inch; the length of the horn being three inches, and curved from base to apex; the growth being freely movable with the integuments, and situated over the tendons of the extensor communis digitorum close to the metacarpo-phalangeal joints of the fore, middle, and ring fingers of the right hand. The patient stated that the horn originated from a small wart about six years ago, which had frequently been subjected to irritation. Prior to removing the growth the tissues beneath its base were injected in three places with five minims of a 10 per cent. solution of cocaine. The removal was effected by two oval-shaped incisions, the patient describing the operation as perfectly free from pain. The wound was dressed antiseptically until Aug. 29th last, at which date cicatrization was complete.

Should any other member of the profession have met with a similar growth on the same part of the human body, I shall be glad to be informed of it.

Castleton, near Sheffield.

INTERESTING CASE OF EMPYEMA.

By J. HORATIO DRAKE, L.R.C.P., L.R.C.S. Edin., &c.

J. B—, aged twenty-three, came under my care on May 13th, 1887, suffering from left-sided pleurisy, with effusion. Aspiration had been attempted three times previously, twice with partial success, but the last time unsuccessfully. The pain was severe; the temperature 103.5°. There was absolute dulness over the whole of the left side, and the apex beat could be seen and felt just to the right of the right mammary line. The pulse was very feeble and irregular, and beating about 120 times a minute. The breathing was considerably embarrassed, and the expression careworn. I attempted to aspirate, but without success, so an early operation was advised, which was agreed to. The next day chloroform was administered, and I made an incision in the fifth interspace, in the mid-axillary line, and penetrated to the depth of an inch without obtaining any fluid. I then inserted a director and carefully penetrated deeper, till at the depth of two inches fluid was

reached, and over seven pints drawn off. The fluid which flowed first was sero-purulent, but towards the end it was truepus. At the termination of the operation the temperature fell to 102.5°, the breathing and pulse improved, and the apex beat was felt at the left of the sternum, but still in the fifth interspace. A drainage tube was inserted, and the wound dressed with carbolic acid.

May 15th: Temperature 101°; pulse 100, gaining in strength and steadier. Cavity syringed with a 1 per cent. solution of carbolic acid and dressed as before. A mixture was administered of bicarbonate of potash and compound tincture of cinchona.—16th: Temperature 100°; pulse 100, steadier. Cavity syringed and dressed as before.—17th: Temperature 102°. Found drainage-tube blocked; removed it, and inserted a larger one, Cavity syringed and dressed daily.—18th: Temperature 99.5°; pulse 90. Going on well. After this the temperature never rose above 100°, and the patient progressed very satisfactorily.—On July 5th, 1887, the left side of the chest was found to measure 14.5 in., and the right side 16.5 in. The left lung was partially collapsed. There was a sinus about two inches deep, which continued to discharge. I endeavoured to close this by injecting a weak solution of iodine, but though the discharge lessened, the sinus did not entirely close. The patient, however, is now able to walk a couple of miles without feeling fatigue, and to do a little light work in his capacity as gardener.

Uffculme.

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.

MIDDLESEX HOSPITAL.

CASE OF PERI-RENAL MYXOMA; RETRO-PERITONEAL ABDOMINAL NEPHRECTOMY; RECOVERY; REMARKS.

(Under the care of Mr. GOULD.)

THE difficulties in diagnosis presented by this tumour were very unusual, and Mr. Gould in his remarks points them out and explains the reasons for their occurrence. We would draw special attention to the method of treating the peritoneum in this operation. By it the risks of peritonitis would seem to be diminished, and this of itself is a most important gain, especially as the shock of the operation does not appear to be increased, even when the peritoneum is stripped off over a large area. The importance of this will be obvious, as, in his statistics on abdominal nephrectomy, Gross places peritonitis next to shock as the commonest cause of death, ascribing 21 per cent. of the deaths to it. For the notes of the case we are indebted to Mr. F. C. Brodie, house surgeon.

A. C—, aged thirty, a railway porter, was admitted on May 1st, 1888, with a large abdominal tumour. Family history good. The patient had been a soldier for four years. He left the service eight years ago, and ever since had been employed as a railway porter. He stated that he had been married eight years, and had four children, all healthy. He had been quite well till January, 1888; he was then seized suddenly with severe cramping pains in the abdomen, which completely laid him up, lasted one day, and then as suddenly disappeared, but were followed by slight diarrhoea. In March, 1888, he was in the goods yard and was squeezed between two buffers, the coupling chain being tightly drawn across his abdomen. This caused him slight inconvenience for two days. A week later he had another attack of diarrhoea, which continued till April 3rd, the motions being of a light colour and rather offensive. He also noticed a swelling about the size of a Tangerine orange just below the umbilicus, which rapidly increased in size. There was a good deal of pain in the back, shooting down to the right testicle, which, he stated, had been painful and somewhat swollen for a month. He had for the same length of time had some difficulty in holding his urine, being disturbed several times during the night to pass it.

For four months he had suffered from dyspnoea, and had frequently noticed blood in his motions. The urine had never been abnormal in appearance. On April 9th the tumour was aspirated at a point two inches and three-quarters below the costal arch in the nipple line, and four ounces of viscid mucoid and apparently blood-stained fluid drawn off. He had no pain following this, but an attack of acute tonsillitis, lasting several days, supervened.

State on admission.—Patient is a well-developed muscular man, with sallow complexion and rather melancholy expression. Pulse 86, regular, of good character; respiration 20. Tongue moist and slightly furred. Thoracic percussion note resonant, and equal on the two sides; it extends in the mesial line to within an inch of the xiphoid, in the right nipple line to the fifth rib, in the right axillary line to the seventh rib, and at the right back to the tenth rib. Heart's apex displaced slightly to the left, being in the fourth space in the nipple line. Abdomen: On inspection there is a large, somewhat ill-defined swelling, situated to the right of the middle line and causing some bulging of the lower ribs on that side. It is apparently continuous with the liver, as no resonant note can be obtained between them. The hepatic dulness commences above at the seventh rib, and the lower border of the tumour corresponds to a line drawn from the anterior superior spine of the ilium to a point two inches below and to the left of the umbilicus; from here it ascends in a double curve to an inch above the xiphoid (determined by dulness on percussion), and hence well back into the right loin, where, however, there is very little increase of resistance as compared with the left side. It is smooth on the surface, and not painful, but is slightly tender on manipulation, especially just below the umbilicus. The margin of the tumour below is rounded, and the whole mass moves slightly with respiration; fluctuation is distinct, especially in the anterior axillary line. The percussion note over the above area is dull; over the rest of the abdomen somewhat tympanitic. Splenic dulness normal. The girth of the abdomen at the umbilicus is thirty-four inches. The right spermatic cord is enlarged, due to fulness of the veins. There is no œdema of either leg. Urine clear; sp. gr. 1020; acid; no albumen.

Operation.—On May 12th, the patient having been anaesthetised, an incision was made through the skin in the right linea semilunaris about four inches in length, and the tissues were divided down to the peritoneal cavity, behind which the tumour was found to be situated. The lower thin edge of the liver was seen in about the normal situation overlapping the upper border of the tumour, whilst crossing its lower margin in front the collapsed colon was seen. The incision was now prolonged both upwards in a straight line and downwards in a curved line, the concavity being downwards and to the right. The peritoneum was then separated from the abdominal wall on the right side of the incision, and off the front of the tumour; and the original wound in it was united by a continuous suture of catgut, so as to close the peritoneal cavity securely. A syphon trocar was next introduced into the most prominent part of the tumour, and a few ounces of brown mucoid fluid escaped; as this did not run freely, the opening was enlarged after removing the trocar, and a large quantity of clot and soft gelatinous material removed with ovum forceps. The cyst wall, which was very thick and tough, was freed all round with the fingers, and the renal artery and vein exposed; these were tied separately with kangaroo tendon, after which the ureter was treated in the same manner. After several bleeding points had been stopped, the whole tumour was removed, and with it, but behind and only attached to its surface, the right kidney. Lastly, the cut end of the ureter was stitched to the skin at the lower end of the wound. There was but slight hæmorrhage, and the parts having been well irrigated with perchloride of mercury solution (1 in 2000), the edges of the incision were united by four deep sutures of fishing gut and eleven superficial ones of catgut, a large drainage tube was inserted, and the wound dressed with iodoform, boracic lint, and sal alembroth wool, fixed in place by strapping. On examination of the tumour after removal, it showed a thick capsule of fibrous tissue enclosing fluid and gelatinous substance. The wall was adherent to the kidney cortex, which was compressed and wasted by its pressure. The kidney itself was small, but not at all involved in the tumour. On microscopical examination by Mr. Roger Williams, there was found a ground substance composed of mucin and loose fibrous tissue,