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.

SEAMEN'S HOSPITAL, GREENWICH.

MEDICAL CASES OF INTEREST.

(Under the care of Dr. H. T. GRIFFITHS.)

THE first of the cases which are recorded by Dr. Griffiths is interesting, not only from a pathological but also from a medico-legal aspect. Cases have been known of rupture of tropical abscess of the liver during a wrestling bout, but we do not recollect any of rupture of gumma in this situation from external violence. The second is another proof of the infectiousness of typhoid fever. We refer our readers to the account of the case, and to the remarks upon it.

CASE 1.—Rupture of gumma in the liver; necropsy.—S. B—, a sailor, aged twenty, had been ashore at Patras nineteen days before admission. He had partaken freely of the raw spirit sold along the coast, and fell into a state of drunken insensibility, in which he was hauled on board by a rope passed round his waist. On recovering from the effects of drink, he had acute abdominal pain, with much swelling and some vomiting. Since that time he had been unable to do any work, and had suffered from abdominal pain, with occasional vomiting, constipation, and slight jaundice. On admission, he presented a distended abdomen, with evidence of fluid, a light tint of jaundice, coated tongue, feeble pulse of 92, and a subnormal temperature of 97°; he had an anxious expression, was emaciated and somewhat collapsed, his urine being lithatic and bile-stained, but non-albuminous. He was injected with one-third of a grain of morphia, given some brandy, with hot fomentations to the abdomen and feet. He became less depressed, and was able to sleep, and next day, when seen by the house physician, his condition was that of comparative ease. When seen by me, the abdominal cavity was aspirated, and 6 pts. 16 oz. of a dark-brown, alkaline, non-offensive, bile-stained fluid was drawn off. He was relieved for a time, but sank shortly afterwards, the temperature remaining always subnormal, no vomiting or pain being noticed in the last twenty-four hours.

Necropsy.—Emaciation marked; a light shade of jaundice apparent throughout. Heart thin-walled, valves healthy; and, with the exception of congestion at the bases of the lungs, nothing abnormal was seen in the thorax. The abdominal cavity contained a few ounces of a dark, bile-stained fluid, the intestines were covered with recent lymph, and there was general and extensive peritonitis. The liver was large and congested, and presented on the upper surface of the right lobe a large superficial gumma, the size of a walnut, being situated one inch from the anterior margin of the organ; the capsular covering had given way over the gumma, which showed deep bile-staining, with partial disintegration of its surface. The spleen was enlarged and soft, the kidneys deeply congested, but there was no evidence of syphilitic deposit in any viscus, or on any part of the body.

Remarks.—Ruptures of gummata are but rarely met with, few being placed so favourably as in the liver, and then, though nearly always in the right lobe, are generally found towards its posterior aspect. Had the gumma been in the posterior position the patient might have escaped injury, but the haul rope in this case pressed directly on the edge of the enlarged organ. Had the injury also occurred on land, and near a hospital the issue might have been different. As it was he survived the injury and consequent shock twenty-four days.

CASE 2. Infective case of enteric fever.—W. D—, a young sailor, was admitted on the fifteenth day with well-marked symptoms of enteric fever which he had contracted when on shore at Maiori in Italy. He had had much diarrhoea, and presented on admission three or four dozen spots on the abdomen, nearly all of the typical appearance. He did well,

his temperature falling to the normal on the twenty-ninth day, but, a slight relapse occurring, convalescence dated from the thirty-sixth day. He was delirious at first, and his disease, of the asthenic type, required fairly free stimulation. No complications occurred; ankle clonus was obtained on the thirty-sixth day, and lasted eight days.

Remarks.—This was an ordinary instance of a severe attack occurring in a young man, ending in recovery, as it should—our average mortality being under 3 per cent. But during the period of the acme of his disease he was nursed by a small, rather frail-looking young nurse, who presented (at the period of his convalescence) well-marked symptoms, and died. She had been assisted, though only once, by a stranger—a niece of one of the nursing sisters; and this young girl expressed her dismay at the case, going only once into the ward, but having assisted when the linen was changed. She developed enteric fever at Newmarket within twelve days, and for two days her life was in grave danger. Another case occurred in the person of a sailor, about thirty-five years of age, a convalescent from rheumatism; he was employed in bringing cups &c. into the ward, and had in that way been brought in contact with the first patient. He developed rheumatic pains, followed by much fever, and though there was no diarrhoea there was no possibility of its being anything else than enteric. There was no drain trouble at the time; no patients had diarrhoea; and though it is possible that the three later cases may have contracted the disease from independent causes, yet they group together in my mind as cases of enteric derived from the first patient.

WOLVERHAMPTON AND STAFFORDSHIRE GENERAL HOSPITAL.

IMPASSABLE STRICTURE OF THE URETHRA; SUPRA-PUBIC ASPIRATION, FOLLOWED BY TAPPING PER RECTUM OF THE BLADDER; AFTERWARDS PASSAGE INTO BLADDER OF A FILIFORM BOUGIE; FINALLY, COMPLETE DILATATION OF STRICTURE.

(Under the care of Mr. VINCENT JACKSON.)

T. W—, aged forty-seven, was admitted on Dec. 9th, 1887, suffering from partial retention, accompanied by dribbling, of urine. He had had urinary difficulty for at least seven years, and on more than one occasion his very tight stricture, situated four inches and a half from the meatus urinarius, had been dilated. He had been taught how to maintain it so by the frequent use of a soft catheter of large size. Apparently the stricture dated back to a gonorrhœal inflammation of the urethra never completely cured.

Each day after admission attempts were made, without success, to enter the stricture. On Dec. 19th, complete retention having occurred, relief was attained by aspirating the bladder above the pubes. On the 20th the operation of aspiration was repeated. On the 21st, the bladder having again filled and the stricture being still impassable, relief to the very urgent symptoms was obtained by puncturing per rectum; the cannula, having been fixed in its position by the use of Mr. Cock's instrument, was left in the bladder. On the 28th a very fine soft bougie was with difficulty insinuated into the stricture, through it, and on into the bladder, being retained there by tying in. On the 30th, after the small soft bougie had been removed, a No. ½ English elastic catheter was passed into the bladder and there kept by the usual method. The soft catheter was removed on the 31st, and a No. 3 English (old scale) substituted. The cannula, one end of which had been retained within the bladder for a period of ten days, was removed. From this date gradual dilatation of the stricture was continued until a No. 2½ French catheter was easily passed by Mr. Gough, the house surgeon, and the patient himself. On Jan. 14th the patient was discharged.

Remarks by Mr. VINCENT JACKSON.—This case is recorded as an illustration of a series of troubles which until they are combated are perilous to the patient and teasing to the most adept surgeon. Instrumentally, without doubt the stricture was from the period of the patient's admission completely impassable, although urine was squeezed through it up to the period of the first aspiration. Personally, I am not an advocate for the employment of aspiration for the relief of retention under the conditions in which we are at present considering its

existence; but in the older operation of puncturing the bladder through the rectum I have the greatest confidence; the relief afforded by the former procedure is only tentative, and unless the cause of the obstruction is overcome, its necessitated frequent repetition must certainly have a more or less baneful physical effect; whereas the latter operation is directly and permanently salutary, and the possibility of a recto-vesical fistula being established is in my experience a mere bugbear, an assertion of mere theoretical manufacture, the practical proof of which is wanting.

GLASGOW ROYAL INFIRMARY.

WOUND OF THE POSTERIOR TIBIAL ARTERY; LIGATION OF VESSEL; RECOVERY.

(Under the care of Dr. JAMES WHITSON.)

DUNCAN R—, aged fifty-six, calico printer, was admitted to Ward 29 on the morning of July 9th, 1887, in consequence of an incised wound about an inch in length on the inner aspect of the middle third of the right leg, and which had been accidentally caused by a sharp knife while at work. Copious hæmorrhage followed the reception of the injury, and after some delay an elastic rod was placed above the knee by an ambulance detachment to prevent further loss of blood during the subsequent journey to the hospital, the scene of the accident being several miles from the town. Dr. Whitelocke, the house-surgeon, when called to attend to the case, found the patient faint and weak, and complaining greatly of the pain produced by the presence of the elastic rod, which had been tightly compressing the limb for nearly a couple of hours. He therefore at once relieved the sufferer as far as he could by substituting an elastic bandage, and during the brief interval which elapsed in exchanging tourniquets it was evident from the amount of bleeding which ensued that the posterior tibial artery had either undergone a partial severance or been cut across. The knife, too, had penetrated to a considerable depth, for on making an examination of the wound the finger could follow the track made by the blade almost to the outer side of the limb.

In such a case, involving an important arterial branch, it was clear there was only one course to pursue—to cut down on and secure the bleeding points, and with this end in view the primary incision was enlarged to the extent of two inches and a half. The soleus muscle at its attachment to the border of the tibia was divided, and the inter-muscular space reached. On separating the muscles the artery was seen lying in the deep part of the wound with the nerve beside it, and when fairly exposed it was found that a slit of some size had been made in its wall, while an inspection of the venæ comites revealed the fact that they were similarly affected. Under these circumstances the artery was gradually separated from its attachments, and when sufficiently isolated a catgut ligature was applied above and below the seat of lesion, after which complete division of the parietes of the vessel at the injured point was effected with a pair of scissors. The veins were next dealt with in like manner. The elastic bandage having been removed, a number of sprouting twigs were secured, and when all hæmorrhage had ceased, with the exception of a little capillary oozing, a couple of decalcified drainage tubes were inserted at either end of the wound, and the fibres of the soleus approximated by means of a purse-string suture of catgut. Finally, the edges of the skin were brought together with stitches of the same material, and the whole dressed in the usual antiseptic fashion.

The wound was not looked at till ten days after the operation, when it was found to be healing satisfactorily, and though the patient was much depleted at the time of the accident he ultimately made an excellent recovery, and was dismissed well on Sept. 7th. I have since heard that he now suffers no inconvenience from the ligation of the posterior tibial artery, and is able to follow his usual avocation as successfully as ever.

MR. J. A. CROWE, Her Majesty's Commercial Attaché for Europe, reports to the Board of Trade that the French Legislature has recently passed a law enacting that a prize will be given to the discoverer of a simple and practical test to ascertain the presence in spirits and alcoholic drinks of substances other than pure and ethylic alcohols. The conditions under which the award is to be made will be determined by the Academy of Sciences of the French Institute.

Medical Societies.

CLINICAL SOCIETY OF LONDON.

"Idiopathic Dilatation of the Colon."—Embolism of Right Axillary Artery.—Tricuspid and Mitral Stenosis.—Heart Disease of prolonged duration.

An ordinary meeting of this Society was held on the 27th ult., Dr. W. H. Broadbent, F.R.C.P., President, in the chair.

Dr. ANGEL MONEY and Mr. S. PAGET contributed a paper on a case of so-called "Idiopathic Dilatation of the Colon." Mr. M—, aged fifty-five, an habitual drunkard, suffered from enormous distension of the colon, with dyspnoea and bronchitis; the girth was over sixty inches, and the measure from the ensiform cartilage to the pubes twenty-six inches. There was albuminuria. He was treated first by Mr. Paget at St. Thomas's Home by repeated punctures. These gave great relief; he improved so much that he refused further treatment, and returned to his drunken habits. He was admitted into University College Hospital a week later, under Dr. Angel Money, with the same enormous distension, lividity, and dyspnoea. He was much relieved with the long rectal tube, but sank and died a week after admission. At the necropsy all the signs of habitual drunkenness were found, including typical "hobnail" liver. There was enormous distension of the colon, principally of the sigmoid flexure, which formed two huge sacs extending right across the abdominal cavity. There was no organic stricture. Dr. Money thought that a potential twist of the sigmoid flexure or a spasmodic stricture may have been present; or else that some morbid state of the blood or nerves, or the mere presence of an excess of gas, may have started the disease. The bowel was hypertrophied as well as dilated. He refers to Dr. Gee's paper in the St. Bartholomew's Hospital Reports, and to Dr. Goodhart's case (Clin. Soc. Trans., vol. xiv.)—Dr. HADDEN inquired whether there had been habitual constipation. He referred to cases published by Drs. Bristowe and Peacock, and related two cases which he had observed himself. The first occurred in a girl, aged seventeen, who had severe abdominal pain and constipation of ten days' duration, unrelieved by purgatives. Abdominal section was performed, but no obstruction discovered. The sigmoid flexure was enormously distended, measuring twelve inches in circumference at the necropsy. In this case there had not been a history of chronic constipation. In the case of a female, aged thirty, suffering from mucous discharge, the sigmoid flexure was greatly distended with fæces. Although the patient complained of diarrhoea, yet no fæces but only slime was passed. She recovered under treatment.—Sir DYCE DUCKWORTH mentioned a case of enormously distended cæcum, causing tympanites and constipation; the rest of the alimentary tract was normal.—Dr. EWART inquired whether the omentum was adherent or displaced into a hernial sac, or in any way abnormal, for he believed that the omentum was answerable for many cases of dilated colon. The colon was distorted by traction or adhesion, and a valve-like obstruction thereby formed. As a physical property a small volume of gas rapidly generated assumed a large volume very quickly, owing to the development of heat.—Dr. PEARSE considered that imperfect digestion was the first step leading to the evolution of gases, and this stimulated the bowel to hypertrophy, and also caused dilatation by distension.—Dr. A. MORISON advised a not too ready resort to a diagnosis of idiopathic dilatation. He mentioned a case of intestinal obstruction in a gentleman, treated as one of idiopathic dilatation of the colon by opium and belladonna fomentations, and by injections. This turned out to be a case of transverse stricture high up in the rectum, and perfectly relievable by colotomy.—Dr. KINGSTON FOWLER inquired whether the meso-colon of the sigmoid flexure was unusually long in the case narrated. Such a condition might cause a valve-like obstruction.—Dr. BROADBENT referred to the congenital elongation of the sigmoid flexure as a cause of hypertrophy and dilatation of the colon. He mentioned a case of enormous dilatation of the transverse colon, with chronic constipation, and this was treated successfully by giving enemata, the patient resting on his elbows and knees.—Mr. STEPHEN PAGET, in reply to Dr. Broadbent,