Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTES ON A FATAL CASE OF ANGIO-NEUROTIC OEDEMA.

BY HENRY BAZETT, M.R.C.S. ENG., L.R.C.P. LOND.

I WAS called up in the early hours of Monday, Sept. 23rd, to go to a man of whom the message said that he "had had a tooth out on the Saturday and was choking." I arrived in about ten minutes to find a man in the prime of life dead from suffocation. The eyelids of both sides were so swollen that it was difficult to get any view of the pupils; the cheeks were swollen and the lips very much so, the lower lip especially; the neck appeared to be nearly twice its natural size. The remainder of the body was unaltered and was that of an ill-nourished man, aged 33 years. With the finger it could be felt that the structures round the faucial aperture were swollen. The swelling of the external parts increased rapidly during the time I was present after the death, and the relatives informed me that it increased to a far greater extent on the following day.

When I made a post-mortem examination 42 hours after death this swelling had almost entirely subsided, but the oedema of the larynx was still most marked, principally on the aryteno-epiglottidean folds. All the organs were healthy so far as could be judged by the eye, except for some congestion which could be accounted for by the suffocation. The urine passed just before death was normal. The history of the case given by the relatives was as follows. The patient, who was a gardener by occupation, dated his illness from an attack of scarlet fever at six years of age. Since then he had been subject to regularly recurring fortnightly attacks of most violent abdominal colic. The widow described his appearance in these attacks as "like a woman in labour." They did not last over 24 hours. Never, apparently, accompanying them, but often preceding them by one or two days, and sometimes unassociated with them, occurred sudden swellings of various parts of the body, subsiding in the 24 hours, usually in the hands, or the thighs, or the scrotum. The thighs would then meet in the middle line, though, as I saw them, they were miserably thin. These swellings were apparently induced by any slight injury or by chill. They were so tense that they "felt as if the skin must burst." In childhood they had sometimes attacked the face and throat, but never since. No medical treatment had been of any avail. Patent medicines "of all sorts" had procured temporary intermission in the fortnightly colics, the benefit ceasing as soon as the freshness of the treatment had worn off. On the evening of Sept. 21st a bicuspid tooth which had been aching was extracted by a skilful local practitioner, leaving a healthy looking gum. On the morning of the 22nd the mouth naturally felt sore and there was a little external swelling on the cheek of that side but the patient felt quite well and took a long cycle ride. Later in the day the swelling had extended over that side of the face, including the eyelids of that side. Towards night the neck began to swell and then the throat. The patient was not alarmed as he said "it would go down as it had before." He went to bed and fell asleep, but breathed heavily. About 2 A.M. on the 23rd he suddenly woke choking, sprang out of bed, and called excitedly to his wife to put a spoon, her finger, or something down his throat, then tried to put his own finger down, then lay on the bed, and while she rushed for help passed away. There is no family history obtainable pointing to any hereditary influences. My friend Dr. A. J. Whiting, dean of the North-East London Post-Graduate College, was present at the necropsy with Mr. W. Bower and Mr. F. W. Andrew of Hendon, and they all concurred in the diagnosis.

Hendon.

NOTE ON THE MEGAPHONE IN CASES OF DEAFNESS.

BY E. CRESSWELL BABER, M.B. LOND.

THE megaphone, a funnel-shaped tube, which is largely used by sailors and soldiers for conveying the voice to a distance, has proved itself of value to me in speaking to

deaf persons. It has several advantages. It is quite independent of the patient and avoids the necessity of putting any tube or ear-piece into his ear, a procedure which deaf persons often object to and find irritating after a short while. It also acts on both the patient's ears and possibly on the bones of the skull. One can speak to a deaf person by means of it without first drawing his attention. The instrument is very inexpensive. The size which I have found most useful measures about 12 inches in length, $6\frac{1}{2}$ inches in diameter at the large end, and about 2 $\frac{1}{4}$ inches in diameter at the mouthpiece. It is made of glazed cardboard or metal. The megaphone may also be employed as a hearing trumpet if the smaller end be applied to the patient's ear. The combination of two megaphones—one used as a hearing trumpet and the other as a speaking trumpet, as I understand they are sometimes used at sea—is of course more powerful still. In speaking to a deaf person it is necessary to be careful to point the instrument directly at his or her head. The megaphone has no doubt been used in cases of deafness before, but I do not think it has received the attention which it merits.

Brook-street, W.

Medical Societies.

ÆSCULAPIAN SOCIETY.—A meeting of this society was held on Oct. 4th. Dr. W. Langdon Brown, the new President, delivered an address on Some General Principles in Gastric Therapy. Recent physiological investigations enabled them, he said, to get a much clearer impression of the factors in gastric secretion and hence to understand and to treat gastric diseases. While the secretion of gastric juice was initiated by the vagus which was stimulated by appetite and taste, it could be continued by chemical means, for the absorption of products of digestion by the pyloric glands caused a renewed secretion by the fundus glands. Corresponding to the histological difference of structure in these two parts of the stomach there was a distinct difference of function. The importance of appetite in starting secretion should lead them to attach great importance to the personal equation in constructing a dietary for their patients. They tended to be too anxious to control their patients' metabolism in chronic diseases by restrictions of the diet which very often had no sanction either from physiological or clinical observation but were often merely dictated by fashion. Quite opposite methods of restriction had sometimes produced good effects in the same case. This was because many people ate too much, and by depriving them of variety in their food we diminished their appetite. While the pepsin in gastric juice was fairly constant, only disappearing in atrophic gastritis, the hydrochloric acid was subject to marked variations. Yet the hydrochloric acid was essential in that it activated pepsin, was antiseptic, regulated the pyloric sphincter, and stimulated the flow of pancreatic juice. If there was no structural change in the stomach it was the hydrochloric acid which held the key to the situation. Simple methods were described for detecting mineral and organic acids in the vomit or in the results of test meals. The results of a defect and an excess of hydrochloric acid in the gastric juice were considered and also the clinical conditions under which such variations occurred. If the hydrochloric acid were diminished it was clearly wrong to give alkalis after food to relieve the acids of fermentation, for this would completely stop digestion and thereby increase the fermentation. Alkalis before meals were useful to dissolve the mucus which was often abundant in these cases. Meat extracts should be employed merely as stimulants of gastric juice, particularly of the hydrochloric acid. In the cases where hydrochloric acid was already in excess alkalis after meals were rational and the bismuth lozenge slowly sucked was a convenient form in which to give them because they led to the swallowing of much alkaline saliva. Meat extracts were contra-indicated. The treatment of gastric ulcer was then dealt with. Hale White had shown that many cases of hæmatemesis in young girls were due to oozing of blood without definite ulceration and on this point the statistics of St. Bartholomew's Hospital would support his view. The medical treatment of true gastric ulcer was disappointing in that relapse was so common. Gastro-jejunostomy was indicated in cases where there was persistent pain with objective findings, recurrent