Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF BROW PRESENTATION IN RICKETY PELVIS, CONJUGATE THREE AND A QUARTER INCHES; TURNING TWENTY-SEVEN HOURS AFTER RUPTURE OF MEMBRANES.

By CHARLES S. PATTERSON, M.B. EDIN., M.R.C.S. ENG.

I WAS called on Sept. 2nd at 8.30 A.M. by Dr. W. J. Spettigue to see a multipara. This was her second labour. Her first was premature (seven and a half months) and the child was stillborn. On asking about the progress I was informed that the waters had come away at 5 A.M. on the preceding day. The high forceps had been applied, after digital dilatation of the os, at 11 P.M. and again at 6 A.M. but without any result. On examination, the os was found to be widely dilated, the promontory was very marked, and the occiput hitched against it, causing a brow presentation; the occiput lay to the right posteriorly. The patient had passed into a condition of powerless labour. Dr. Spettigue administered a little chloroform, and as the head had not properly engaged at the brim an endeavour was made to bring down the occiput by the use of the axis traction forceps and to press up the forehead and thus convert the case into a vertex right occipito-posterior one, but the endeavour was futile. Further measurement showed the conjugate to be only three and a quarter inches, and as the child was alive it was decided to endeavour to turn and deliver alive if possible, the only other alternative being craniotomy. Chloroform was then administered to the full surgical degree. The hand could not at first be passed owing to tonic spasm of the uterus, but as the patient became deeply anaesthetised this passed away, and a knee, the left, was seized and brought down. Version was easily effected. The patient was then allowed to come to, good strong pains came on at once, and the body of the foetus passed slowly through aided by traction during the pains. The cord was pulled down a little and placed to the left side of the promontory; it pulsated freely and regularly until the head entered the brim and became arrested, when it at once stopped. Traction by the feet, and later by the feet and neck and lower jaw, was tried for some minutes, and just as perforation of the after-coming head was decided upon the head commenced to move and was extracted as quickly as possible. The child was completely asphyxiated and could not be made to respond to any of the means of resuscitation employed. As the uterus failed to contract upon the placenta, it was firmly grasped in the left hand, and one drachm of liquid extract of ergot was given. The placenta came away by expression in twenty minutes. A carbolic douche (1 in 40) was at once administered; this was ordered to be repeated twice a day. At 6 P.M. the temperature was 99.4° F. and the pulse was 96; at 10 A.M. the temperature was 98.8° and the pulse was 90. The temperature was never above 100° during the whole puerperium, which was indeed most uneventful.

The chief points of interest in the case are: 1. The ease with which the tonic contraction, or rather the tetanic condition of the uterus, was overcome by chloroform and turning accomplished twenty-seven hours after the escape of the amniotic fluid. 2. The child being alive (as proved by auscultation and pulsation of the cord) towards the end of such a prolonged second stage. 3. The possibility that the life of the child might have been saved if the cord had been placed to the right side of the promontory—i.e., the side unoccupied by the large occipital portion of the head of the foetus, as the stoppage of the pulsation took place just as the base of the head was engaging the brim.¹ 4. The amount of pressure and manipulative interference that the soft parts of the mother tolerated without injury—viz., digital dilatation of the os followed by three distinct applications of the forceps, with strong prolonged traction on each occasion, and finally the great traction required to bring the head through the

brim after the passage of the body. 5. Forceps were not applied to the after-coming head, as the pulsation of the cord had ceased and any pressure applied to the head antero-posteriorly would tend to increase the bi-temporal diameter and hence retard delivery. 6. The child was a large full-term male. Extensive bruising was seen on the right temple, evidently caused by the promontory of the sacrum, and a good deal of head moulding had taken place during the first stage before turning, as seen by the following diameters: mento-occipital diameter, 6½ in.; fronto-occipital diameter, 6½ in.; bi-temporal diameter, 3½ in. The scalp was oedematous, with a well-marked caput succedaneum over the left frontal bone.

Highbury-place, N.

A CASE OF ASCITES; RECOVERY.

By J. M. WALKER, M.B., C.M. EDIN.

EXTENSIVE accumulations of fluid within the peritoneal cavity so frequently resist the best directed efforts to promote their absorption and necessitate a recourse to paracentesis that a short account of the following case, in which complete recovery—as far as the dropsy was concerned—resulted from purely medical treatment, may prove to be interesting to the readers of THE LANCET.

A man aged forty-eight consulted me on Aug. 1st last in consequence of his abdomen having recently become enormously distended, and a very slight examination sufficed to prove that he was suffering from ascites, a history of many years' excessive indulgence in alcohol leaving little room for doubt that cirrhosis of the liver was the cause. There was no oedema of the legs or other part of the body. The urine, of which only three or four ounces were passed in the twenty-four hours, was loaded with lithates and contained some bile, but was free from albumen. The heart and lungs were healthy, and the abdominal girth measured forty-five inches. I prescribed a mixture containing acetate of potassium, spirit of nitrous ether, tincture of squills, tincture of digitalis, and decoction of scopolarius, a considerable increase in the flow of urine (from which the lithates and bile disappeared by degrees) taking place in the course of a day or two. In addition to this the abdomen gradually became softer, and its girth was reduced to forty-three inches. The improvement, however, did not continue, notwithstanding that other diuretics and an electuary of compound jalap powder and confection of senna were subsequently tried. The patient strongly objected to paracentesis being performed, and I saw him on Aug. 29th in consultation with Sir James Sawyer, who prescribed the following: iodide of potassium, one scruple; muriated ammonia, four scruples; carbonate of ammonia, one scruple; bicarbonate of soda, one drachm; liquid extract of taraxacum, half an ounce; dill water to eight ounces. One ounce with half an ounce of lime-juice to be taken three times a day. The electuary to be continued. Within a week of commencing the above the amount of fluid had sensibly diminished, and by Sept. 27th it had completely disappeared, the abdominal girth measuring thirty-five inches. The patient, who had become greatly emaciated during the course of his illness, rapidly gained flesh and strength, and in a little more than two months from the date of my first seeing him was actively engaged in the pursuit of his business, and was able to walk several miles daily. The case is an instructive one as showing what may be accomplished by persevering with suitable remedies and the advantage to be gained by varying the latter should one class fail to bring about the desired result. Attention also may be drawn to the value of chloride of ammonium in such cases, which drug Dr. Murchison¹ speaks of as holding a "pre-eminent place" in the treatment of hepatic derangements and as "exercising a powerful influence in relieving the portal circulation."

Belgrave-road, Birmingham.

LEAD POISONING FROM TEA.

By J. P. WILLIAMS-FREEMAN, M.D. DURH., D.P.H.

BETWEEN the months of October and March last winter five cases of undoubted lead poisoning amongst cottagers came under my notice, besides about half a dozen cases in

¹ Dr. Matthews Duncan held that this was due to asphyxia of the child and infarction of the air passages from detachment of placenta. Transactions of the Obstetrical Society, vol. xx., p. 63.

¹ Lectures on Diseases of the Liver.

which there were obscure abdominal pains and constipation where no lead line was detected, either because the teeth were absent or because it was not looked for. I was quite unable to find the source of the intoxication in the three instances in which I carefully looked for it. In one case I had the tea examined, but with a negative result. During this autumn I have seen nine cases in which the patients had a well-marked blue line, as well as several others in which there were abdominal pains and constipation. Having practically excluded every other probable source, I again submitted samples of tea to Mr. Arthur Angell, Ph.D., F.I.C., of the County Laboratory, Southampton, and he reports as follows:—

No. 1.—Loose tea as supplied to four of my patients. (This, the village shopman assured me, he received from London in large paper bags, with no lead paper.) “In this sample lead was distinctly present.”

No. 2.—A quarter of a pound packet in thick lead paper. “In this sample distinct traces of lead were found.”

No. 3.—A quarter of a pound packet not in a lead package. “Here the faintest possible reaction for lead was found.”

No. 4.—A quarter of a pound packet in lead paper. “In this sample a larger quantity of lead was found than in any of the other samples.”

Nos. 1, 2, and 3 were bought by me at a village shop. No. 4 was taken from a patient's house.

The symptoms have in all the cases been abdominal, with marked pallor, and the addition of severe facial neuralgia in one case, pains in the limbs in another, and gout in a third. There has been vomiting in two or three cases and diarrhoea (possibly, however, due to pills, of which the cottagers partake so freely) in one or two. One patient had a serious relapse after about a fortnight, but he may, of course, have re-intoxicated himself. I have seen no wrist-drop or eye symptoms. In three instances both parents have been affected at the same time, and in no case have there been any symptoms in children. They, however, usually have weak tea in small quantities. I have full notes of the quantities drunk in two or three cases, which may be of interest when I receive the quantitative analysis from Mr. Angell, who is fully investigating this matter; but I hasten to send his preliminary report.

Weyhill, Andover.

BENZOLE IN INFLUENZA.

BY WILLIAM ROBERTSON, M.D. GLASG.,
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THE majority of the cases of influenza I have met with lately I have treated with benzole, and with the best results. I have already in the columns of THE LANCET referred to the several ways in which the drug can be administered. In every case the drug has been well tolerated. The cases treated have all shown the usual symptoms met with in influenza—viz., rapid onset of attack, temperature ranging from 101° to 103° F., quick pulse, shivering, pain in the head and down the back, dull-red injection of fauces, &c. The drug was administered in the form of an emulsion in lemonade, five minims to be taken every two hours and a half. As a rule, in about two hours after the first dose the general discomfort had disappeared, and within the first twenty-four hours the temperature was observed to be normal. Rarely, indeed, was any further pyrexia to be noticed. Convalescence was usually rapid, with very little of the debility so noticeable when routine treatment was employed. As a check experiment, and when two patients were observed in one house, one would be placed upon benzole and the other on, for example, liquor ammoniæ acetatis, &c. As a rule the next morning the patient taking benzole would be found to be free from fever, with the pulse normal, &c.; while the other would still be feverish and in general discomfort. The patients usually showed no very severe pulmonary symptoms, but a few had a temperature of between 103° and 104°, and in each case within twenty-four hours the temperature was normal. This result was met with in influenza, and the equally good results of its action in whooping-cough determine the value of benzole as a pulmonary antiseptic.

Osborne-road, Newcastle-on-Tyne.

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.

GUY'S HOSPITAL.

A CASE OF CARDIAC FAILURE DURING THE ADMINISTRATION OF ETHER.

(Under the care of Mr. DAVIES-COLLEY.)

THE following account of the occurrence of serious syncope during the administration of ether will be read with considerable attention, for the profession is not accustomed to regard such a complication as at all likely to occur during inhalation of this drug; in fact, many surgeons prefer ether to chloroform for anæsthetic purposes, because of the absence of liability to accidents of this kind. We shall be pleased to receive communications on this subject from those who may have had similar experiences. For the following report we are indebted to Mr. T. D. Lister, house surgeon, and for the remarks to Dr. Silk, assistant anæsthetist.

A labourer forty-eight years of age, not bronchitic and with no signs of organic disease or alcoholic degeneration, was admitted to the accident ward of Guy's Hospital on the morning of Oct. 14th suffering from a severe compound fracture of the left leg. There were two wounds, the larger, on the front of the leg, having the upper fragment of the tibia projecting over the skin at the lower end of the wound. As this was irreducible by extension without an anæsthetic it was resolved to administer ether, and the anæsthesia was maintained during an incision of the skin to enable reduction to take place, cleansing, and final setting of the limb in a Croft's splint. Clover's apparatus was used, two ounces of ether being put into the previously empty container. The patient took the anæsthetic well, and the stage of excitement was very brief. The container was gradually moved round until the indicator pointed to “3” and full anæsthesia was induced in rather less than four minutes. The head was then turned to the right to facilitate the removal, from time to time, of the small quantity of mucus that formed. This was, if anything, less than usual. The indicator was gradually brought back nearly to “1,” and, to ensure a further diminution in the strength of the vapour, two or three aerial respirations were alternated with every eight or nine taken through the inhaler. At the end of half an hour slight signs of returning consciousness, of which the patient afterwards had no knowledge, made it necessary to replenish the inhaler. The small quantity of aqueous ethereal fluid in the container was poured out, and two ounces of fresh ether were added. Full anæsthesia was again induced, during which process the breathing became noisy for a few minutes, and the indicator was again gradually brought back to the “1” mark. The anæsthetic condition then appeared to be quite normal. At the end of a second half hour, when the process of setting the limb was nearly completed, suddenly and without warning or apparent cause, and while in a condition of complete anæsthesia, the patient became intensely pale, his lips blue, and his respirations rapidly failed. The pupils remained contracted; there was no retching. The fauces and upper aperture of the larynx were clear. The cardiac apex beat could not be felt, and no arterial pulse could be detected anywhere. The foot of the bed was raised about two feet, and artificial respiration slowly and deeply performed, air entering quietly and without difficulty. After twelve or thirteen movements, occupying nearly a minute, one small, very short inspiratory gasp occurred automatically. Soon afterwards the apex beat became again feebly palpable, and artificial respiration being continued for a further nine or ten movements, another short inspiration took place, and was followed by very small but gradually increasing respirations, expiration being then assisted by pressure on the thoracic wall. There was no vomiting at any time. The