

17, a little over five and one-half days after the accident. At death the tongue was nearly double its normal size, and of a brownish color. It looked like cooked beef, and during the night before death the bowels were moving constantly.

Remarks.—The application used was what is commonly known as "dead-shot;" the wood alcohol and the bichlorid of mercury had been purchased separately, and the mercury had been added by the purchaser, hence the label on the bottle was simply wood alcohol, although it also had a skull and cross bones, and a "poison" label on it. The preparation was in a little medicine case in the toilet room and was supposed to have been locked up, but evidently was not. The young woman saw it, thought it would be good for her rheumatism, and had a friend apply it.

Some years ago I had a case of poisoning by arsenic, which presented almost the same symptoms. It was taken by the mouth by a very dissipated middle-aged woman, with suicidal intent. She survived the first shock, but died five or six days later from exhaustion caused by inflammation of the alimentary canal.

I know of no physiologic antidote for poisoning by corrosive sublimate. I relied wholly on giving the patient all the albumin she could take, hoping each day that the poison would become neutralized, and that the patient would recover. In that, however, I was doomed to disappointment. There was not the slightest indication that the poison was losing its power.

[EDITOR'S NOTE.—There are numerous cases¹ of poisoning from the external application of mercurial compounds. Generally the poison has been corrosive sublimate and has been applied in the form of ointment or as an alcoholic solution. Watery solutions, however, may be absorbed. Even black wash externally applied has produced salivation. The symptoms of mercurial poisoning after absorption through the skin are almost identical with those produced by the poison when swallowed. The irritation, inflammation and ulceration of the stomach and intestines are very prominent. There is good reason to believe that the stomach and intestines act as eliminating organs in these cases as in poisoning by other substances. No clear plan of treatment has been laid down by authors on toxicology for cases of poisoning by external application. The usual antidote for corrosive sublimate is albumin in some form which unites with the mercury to produce an insoluble albuminate. This albuminate, however, is soluble in an excess of albumin and hence the administration of albumin as an antidote should be followed by an emetic or by lavage of the stomach to get rid of the mercury which has been rendered insoluble before it can be re-absorbed in consequence of becoming soluble in an excess of the antidote. In case of absorption from an external surface, it is possible that the mercury escapes from the system in the gastric and intestinal mucus, in which case probably the use of albumin would be superfluous, if not contraindicated. Whether or not another antidote might be used is uncertain; it would seem as if a trial of some sulphid might be desirable. In regard to the external wound, probably nothing better could have been one than was done by Dr. Craig, as the bicarbonate of sodium tends to produce an insoluble basic carbonate of mercury which would not so readily penetrate the skin. But it is probable that in this case the poison had been absorbed before any application was made. Aside from the attempt to produce an insoluble compound of mercury in the intestinal canal, there is no special treat-

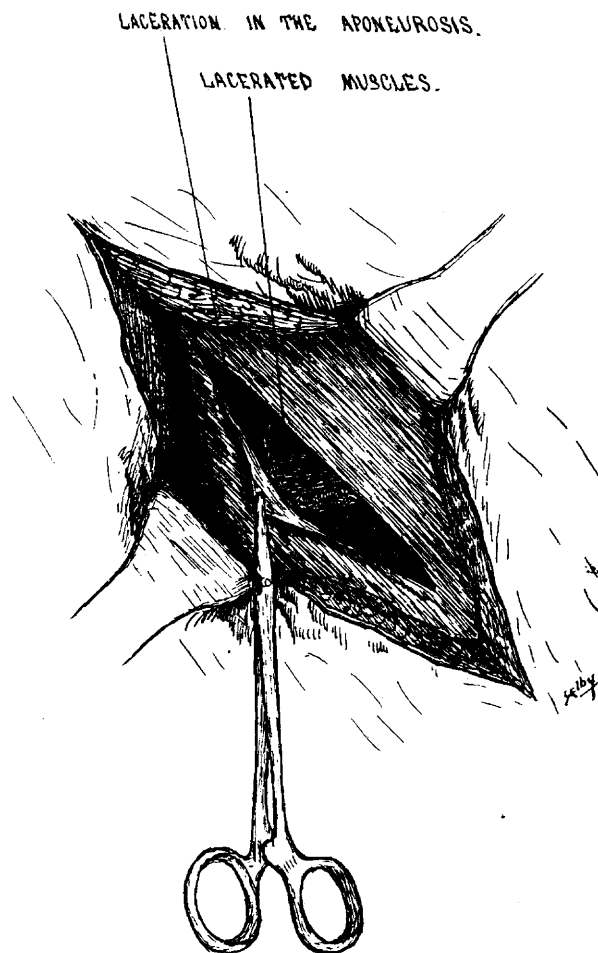
ment for poisoning by mercury. Elimination should be encouraged by copious introduction of liquids, possibly better by enteroclysis or hypodermic injection of saline solutions; proper stimulants should be given, and the particular symptoms treated as they arise.]

DIRECT ABDOMINAL HERNIA OF TRAUMATIC ORIGIN.

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This case is interesting, perhaps more in its origin than in the lesion produced, though none the less instructive.



Patient.—A man, aged 32, laborer, was employed with a wheelbarrow on a scaffolding six feet from the ground, when a misstep caused him to fall, the wheelbarrow following and the handle striking him in the right iliac region.

Examination.—When first seen, a short time later, there was a soft hemispherical mass, 6 cm. in elevation and 8 cm. in diameter, in the region of the injury, with but slight abrasion and no discoloration of the overlying skin. Extreme pain prohibited manipulation, but as the diagnosis was apparent the man was sent to the hospital. There, when placed in a recumbent posture, the mass receded, and a hiatus could be felt in the supporting structures of the abdominal wall. In fact, the margin of the lacerated aponeurosis was plainly palpable.

Operation.—Under ether anesthesia an incision was made parallel to Poupart's ligament over the break in the wall, which was 4 cm. above the ligament. The ruptured aponeurosis was evident. The break was clean cut as though produced by a knife, following, of course, the fiber of the tissue. The internal oblique and the transversalis beneath were torn away

1. See Taylor's Medical Jurisprudence"; also Blyth, A. W.: "Poisons, Effects and Detection"; Sachur: Berlin. Wochchr., 1892; and Meeres: Lancet, Sept. 16, 1871.

from their points of origin on the iliac crest and crural arch, producing a triangular laceration with the apex toward the anterior superior spinous process. The peritoneum was intact. Thus, in the words of the text-book, the coverings of this hernia were integument and peritoneum.

Recovery was perfectly satisfactory and the man returned to work in three weeks.

This man at first refused operation. Of course it is apparent what the result would have been had he not consented.

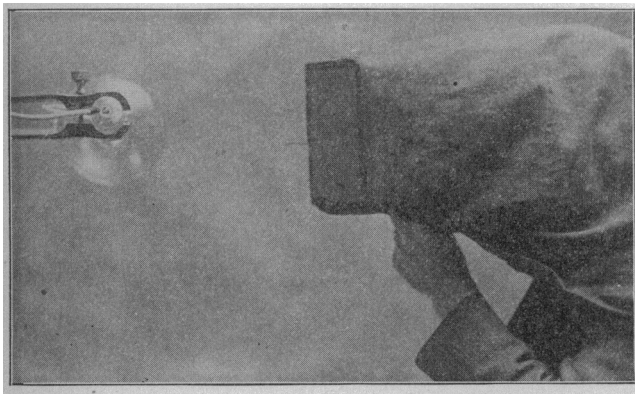
Perhaps the most instructive feature of this case is the fact that the muscles and fascia, the most rigid structures in the wall, gave way, while the integument and peritoneum, the elastic tissues, were unharmed.

502 Main Street.

SUBSTITUTE FOR DARK ROOM DURING FLUOROSCOPIC EXAMINATIONS.

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Physicians who use the fluoroscope only occasionally do not find it convenient to equip a dark room for the purpose and are consequently at a disadvantage when working by daylight. To obviate the necessity of heavily screening windows and



other avenues of light, a hood can be easily improvised which serves the purpose admirably. A sheet of rubber lead composition is chosen by preference, for it serves also as a protection to the operator. If the latter is not at hand, several layers of newspapers enfolded in a suitable piece of black muslin and fastened to the fluoroscope will effectually shut out the light. So arranged, the observer is in absolute darkness and can see only the image reflected on the fluoroscopic screen.

DIPHTHERIA ANTITOXIN IN THE TREAT- MENT OF EXOPHTHALMIC GOITER.

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OMAHA.

The symposium on "Exophthalmic Goiter"¹ reminds me of a short report² under the same heading as my note, written by Dr. Robert T. Legge, of McCloud, Cal. The doctor reported several cases of the above disease, in which he had used diphtheria antitoxin with curative results.

Prompted by his report, I lately used the same antitoxin for the same disease, and also with very satisfactory results. For, though only about five weeks have elapsed since the injection (of 3,000 units), already the

tumor has almost disappeared, the circumference of the neck having diminished almost one and one-half inches. The pulse rate has fallen from 135 to 80; the tremor, before injection very marked, is now almost imperceptible; the exophthalmos can no longer be detected; the nervousness and weakness have almost disappeared. There have been no untoward effects whatever. No other treatment has been used except local inunction with ointment of red oxid of mercury, which before injection had no effect. When I reported this case to our local medical society lately four other cases of the same treatment were reported. In three of these the results were good or excellent; in one no marked results were reported after several injections.

Of course, one case, or a dozen cases, are of very little value. But I make this report principally in the hope that other physicians, who may have used the same treatment, may be prompted to report. Thus the collective testimony of many may be of value. Or probably Dr. Legge may have used the antitoxin since, in which case a word from him would surely be of interest.

1902 South Seventeenth Street.

STRIKING IDIOSYNCRASY TO THE USE OF COCAIN IN THE EYE.

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The patient here referred to has an idiosyncrasy for two drugs, quinin and cocain. Such susceptibility to quinin has been frequently reported, and I have seen several cases so afflicted, but I am not aware of any one being affected by cocain in this manner, and a cursory examination of the literature fails to reveal a similar case.

During January, in testing the refraction of L. L., a bank clerk, aged 25, I had a nurse in the office instil a solution of homatropin, gr. $\frac{1}{2}$, in $\frac{1}{2}$ dram of 4 per cent. solution of cocain, one drop in each eye, repeated every five minutes until six drops were used. Just before using the last drop the nurse called my attention to the fact that the patient's eyes had become very much swollen. To my astonishment I found the lids so swollen that it was only after the greatest effort that the patient could separate them at all. There was considerable chemosis and redness, the cornea appearing sunken. Hot fomentations, continued for half an hour, reduced the swelling enough for the patient to go home on a car, but it had not disappeared sufficiently for him to resume his duties the next morning, fifteen hours after the first instillation.

I was extremely puzzled as to the cause of this until about six months afterward when this patient came to me with a foreign body in one eye. I used one drop of 4 per cent. solution of cocain and the patient exclaimed immediately: "That is the medicine that swelled my eyes," and in five minutes the swelling of lids and conjunctiva was very apparent and in half an hour (nothing being used to counteract the action of the cocain), the palpebral fissure had become a narrow slit. This subsided almost entirely before morning, the patient having applied hot fomentations for half an hour that evening.

This young man has considerable nasal obstruction, both the inferior and middle turbinates being almost in contact with the septum when he is free from a cold (which he rarely is) and when suffering from an acute exacerbation of his rhinitis his eyes are red. He tells me that he is very susceptible to the influence of quinin, his body becoming nearly covered in a very short time with giant hives with great swelling, from so small a dose as 2 grains.

1. THE JOURNAL A. M. A., Sept. 1, 1906.
2. THE JOURNAL A. M. A., April 22, 1905.