Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

GENERAL RESTRICTION OF DIET IN DIABETES.

BY G. S. KEITH, M.D., F.R.C.P. EDIN.

THIS brief outline of a case of diabetes which has recently been under my care may be of interest to the readers of THE LANCET inasmuch as it bears out the beneficial results of a method of treatment which I have advocated for many years. In its results, however, it is no whit more satisfactory than I have found to be the case in innumerable instances of divers diseases which have been described in my "Plea for a Simpler Life" and "Fads of an Old Physician."

The patient, a man, aged 38 years, had resided for several years in a tropical but not unhealthy climate. He came home early last year as the heat did not seem to suit his health and since then he has been living in North Berwick where he could enjoy his favourite game of golf. He there consulted a medical man and was told that the immoderate thirst from which he was suffering was due to diabetes. The specific gravity of his urine was then found to be 1037. Subsequently he was advised to consult a London specialist who put him on the usual anti-diabetic diet. He was ordered to abstain from everything which contained starch or sugar and was given a long list of animal and albuminous foods in which he could indulge. No restriction whatever was put on the quantity of these and, further, he was recommended to take fatty substances *ad libitum*, with the view of restricting the waste of tissue which was going on very rapidly. He soon found that the fats which he consumed in large quantity did not agree with him and his medical adviser in Edinburgh advised him to discontinue their use; this he did with marked benefit.

I first saw the patient about the middle of October, 1901. He had then lost about two stones in weight, but his muscular strength was only slightly impaired, and he was still able to enjoy a game of golf. He had, however, an intense craving for food, suffered from severe thirst, and was likewise passing a very large quantity of urine. I recommended him, therefore, to reduce as rapidly as possible the total nitrogenous intake, and at the same time to introduce a small quantity of bread into his dietary. I saw him again three weeks later and during the interval he had reduced his total food to a very moderate allowance, while for the last week he had taken for breakfast a couple of ounces of bread which he enjoyed amazingly. The craving for food and water had practically disappeared, while the amount of urine was now reduced to two and a half pints. An analysis of a sample gave the following results: specific gravity, 1019; albumin, *nil*; and sugar, 0.32 per cent. His weight had increased in three weeks by six pounds—a fact which, as I pointed out to him, was no doubt owing to the retention in the system of water which had previously served as the vehicle for the discharge of waste products and in this way had been lost to the tissues. He now resolved to return to the tropics in order to resume the duties which he thought he had finally relinquished. I saw him again two months later (Jan. 6th, 1902) and found that he had made arrangements to leave the country in the middle of the month. In the meantime he had a slight return of his former symptoms, owing probably to the fact that while still reducing his animal food he had indulged somewhat too freely in farinaceous and sweet articles of diet. On the adoption of the dietetic restrictions previously ordered the symptoms once again rapidly disappeared, and at the present moment he is on the point of carrying out his original intention of resuming work.

The interest of this case centres in the remarkable amelioration of the diabetic symptoms which followed a general restriction of diet without reference to particular elements of food. This is nothing new in face of my past experience and I attribute it, as I have endeavoured to show in my published works, to the curative influence of a

restricted diet, more especially with regard to nitrogenous foodstuffs.

Currie, Midlothian.

A CASE OF INFECTIVE PERIOSTITIS.

BY JOHN R. GRIFFITH, M.R.C.S. ENG., L.R.C.P. LOND.

A SHORT time ago I attended a child suffering from the above disease and as the case presented, to my mind, one or two interesting features I think it is worth recording.

The patient, a female child, aged 11 years, who had always enjoyed robust health, had been "out of sorts" for two or three days. The morning on which I first saw her she had a rigor, and on examination her condition indicated a severe constitutional disturbance. The temperature was 103° F., the pulse was 120, the tongue was furred, and the breathing was quick. On inquiry the mother gave the information that the child did not complain of pain in any particular region and for a short time I was non-plussed to account for the constitutional disturbance. On further examination it was discovered that the child had a double talipes—i.e., right talipes equino-varus and left talipes equinus. Further, a puffiness located over the internal malleolus of the right leg was noticed. The veins were swollen, but the child did not cry out when the afflicted leg was being manipulated. I noticed that the vulva was inflamed and a purulent discharge was seen about the vulval orifice. The next morning (the second day) the general condition of the child was worse; the temperature was 104°, the breathing was rapid, and the usual symptoms which accompany pyrexia were present. On examining the afflicted leg it was noticed that the swelling had much increased, the whole of the shaft of the tibia being implicated up to the tubercle. The skin was becoming dusky red in colour, pitting on pressure, and the child now was in evident agony on the least handling. The nature of the case was fully explained to the parents and the necessity of an immediate operation having been fully laid before them they consented to its being carried out. Later in the morning my principal, the late Mr. D. E. Edwards of Llwynypia, and myself went to the house fully prepared to lay bare the whole shaft and to gouge parts of it away if thought necessary. The parents by this time had changed their minds and they absolutely refused treatment; therefore nothing was done. The condition of the patient went from bad to worse; on the third morning septic pleurisy supervened, and on the fourth pericarditis, and she died at 11 o'clock the same night.

The child, at any time of her existence, had not been treated for the talipes. I ascertained from the mother that the child was in the habit of falling about in walking and especially on trying to run. This undoubtedly accounts for the injury constituting one cause of the periostitis.

The point of interest of the case which appeals to me is whether one is justified in thinking that the entry of the virulent streptococci and staphylococci was through the vagina from this purulent discharge. The child had never had typhoid fever.

Blackwood, Mon.

A METHOD BY WHICH DEPOSITION OF MOISTURE ON THE LARYNGEAL MIRROR MAY BE PREVENTED WITHOUT THE AID OF HEAT.

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WHEN about to make a laryngoscopic examination by means of reflected light the laryngeal mirror is warmed before being passed into the mouth with the object of preventing condensation of moisture from the breath on its reflecting surface. When gas or oil is used as the illuminant the warming of the mirror by holding it over the flame is simple, very convenient, and eminently satisfactory for routine examination, and is quite devoid of risk so long as the examiner is careful to test the temperature of the mirror before passing it into the buccal cavity.

But if the mirror so warmed be retained for some time in the pharynx, as is frequently necessary during delicate intra-laryngeal operations, it becomes cool, if not cold, and its

surface becomes dulled by deposition of moisture upon it and the image is blurred. And this is apt to occur when the operator requires to have the part which is being operated upon most clearly in sight. Again, when electric light is used as the source of illumination the mirror must be warmed by holding it before a fire, over a spirit-lamp, or placed in hot water. The first two methods are inconvenient and not always within reach and the last is deleterious to the mirror. All laryngologists are painfully aware of the rapid destruction of mirrors regularly heated by immersion in hot water. To overcome this difficulty several methods, such as smearing the mirror with glycerine, &c., have been tried, but all of them so interfered with the reflecting quality of the mirror that they proved useless in practice.

Lately, and somewhat by accident, I fell upon the following plan, and it has been so eminently successful that I desire to call the attention of laryngologists particularly to it. An ordinary laryngeal mirror is taken and after polishing it with a soft cloth the surface of the mirror is rubbed or pencilled over with "le crayon anti-buée." This dulls the surface. The mirror is again wiped or polished with a soft cloth and the surface will again be clear and bright. It may then be breathed upon without its brightness being affected. After being so prepared the mirror may be used for laryngoscopic examination, and it may be retained in contact with the palate or in any part of the buccal or pharyngeal cavities as long as may be desired, or, as is ever necessary, without the reflecting surface being affected in the slightest degree by the breath-borne moisture. The crayon causes no scratching of the glass nor does its use interfere with the cleansing and sterilising of the mirror. I do not employ this method to the exclusion of heat, as the latter is much too convenient to be lightly discarded, but this method of preserving a clear, bright, reflecting surface will be found of great service under the following circumstances—namely, (1) in an examination to be made with electric light; (2) where a prolonged use of the mirror is necessary; (3) in examinations made away from home; and (4) in the examination of children whose timidity is so often increased by seeing the mirror held over the flame of the lamp before being used. Dentists may also find the "crayon" to be useful, and the eye-piece of a microscope may be kept perfectly clear and bright, even during a prolonged examination in warm weather. The crayon may be obtained in Glasgow from Messrs. W. B. Hilliard, 63, Renfield-street.

Glasgow.

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.

ST. GEORGE'S HOSPITAL.

TWO CASES OF GASTRIC SURGERY.

(Under the care of Mr. HERBERT W. ALLINGHAM.)

THE modern treatment of gastric ulcer is in striking contrast to that which was employed only a few years ago. A chronic ulcer of the stomach may reasonably be submitted to operation if it has materially interfered with digestion and nutrition, even though no hæmatemesis may be present. The first of the following two cases is an excellent example of this recent surgical advance. In the second case pyloroplasty was employed for a fibrous stenosis of the pylorus. This operation has been somewhat discredited lately, chiefly because it has been performed in unsuitable cases. Koëppelin's "submucous pyloroplasty,"¹ though perhaps safer than the ordinary operation, must be of more limited applicability.

CASE 1. Excision of a gastric ulcer.—A woman, aged 34 years, was admitted into St. George's Hospital on Oct. 29th with a history that for about eight years she had suffered from pain in the stomach after food. The pain, which was

severe and prevented her from following her occupation, came on immediately after food, as a rule, but at times was not felt until from half to one hour had elapsed. She was unable to take solid food without vomiting, but hæmatemesis had only occurred once about seven years previously. She had never passed blood by the bowel, but was always very constipated. She was not emaciated. On examining the abdomen nothing abnormal was found except slight tenderness which was always present at one particular spot in the epigastrium. Seeing that the condition had existed for so long and had persisted in spite of medical treatment operation was advised. On Nov. 7th Mr. Allingham made an incision in the middle line above the umbilicus and opened the abdomen. The stomach was drawn out and on the anterior wall a puckered mass of thickened tissue of about the size of a shilling was found. It was covered with lymph and was slightly adherent to the surrounding parts. The peritoneum having been protected by means of sponges the ulcer and the tissues immediately around were excised and the wound in the stomach was sewn up by means of two rows of sutures, the mucous membrane being first brought together and then the muscular coats and the peritoneum. In the latter Lembert's method was employed and in both rows silk alone was used. The abdomen was then closed without drainage. Recovery was uneventful, the wound healing by first intention and the patient left the hospital on Nov. 30th, having taken solid food without pain or discomfort for 14 days before her discharge.

CASE 2. Pyloroplasty for pyloric stenosis caused by nitric acid.—A man, aged 37 years, was admitted into St. George's Hospital on August 28th, under the care of Dr. Latham, complaining of constant vomiting and pain after food, which had existed for seven weeks, during which time he had been unable to retain any solids. Whilst under observation the vomiting only occurred about once every two days and after a few days, during which time he was fed on peptonised food, it ceased altogether. He stated that he had vomited blood on one occasion on August 10th, but never since. On examination of the abdomen the stomach was found to be much dilated, and the abdominal muscles were rigid and moved but slightly on respiration and he complained of some tenderness in the epigastrium. After some days he volunteered the statement that he had swallowed a quantity of nitric acid on July 16th in mistake for ginger beer and had never been well since. He looked ill and was a good deal wasted, but improved somewhat under treatment—i.e., stomach lavage and careful feeding; the dilatation of the stomach, however, did not diminish, so on Sept. 24th Mr. Allingham operated. The stomach was washed out immediately before the operation and 70 ounces were drawn off. By the phloroglucin-vanillin test no free hydrochloric acid was found in the vomited material. The abdomen having been opened in the middle line above the umbilicus the stomach was drawn out of the wound. It was much dilated and the pylorus was thick and hard. There were no adhesions. A longitudinal incision was made over the pylorus and the lumen was only found by means of a probe. The tissues of the stomach at the pyloric end were exceedingly tough and fibrous. Pyloroplasty was performed in the ordinary way, and the wound was sutured in two layers over one of Allingham's bone-bobbins. The patient made an uninterrupted recovery and was discharged from the hospital on Oct. 22nd, having been able to take solid food without pain, discomfort, or sickness for some days previously.

Remarks by Mr. C. R. KEYSER.—Case 1 serves to illustrate several points which are gradually becoming recognised. In the first place, in cases of gastric ulcer which have resisted medical treatment and in which the patient is rendered a chronic invalid, or vomiting and hæmatemesis are constant, operation should be undertaken much earlier than has hitherto been the custom. The complications of gastric ulcer are so numerous and dangerous that, according to recent statistics,² 25 per cent. of all cases treated medically terminate fatally, whereas the mortality of those surgically treated is only 5 per cent., and it is practically certain that if, instead of waiting until the patients are emaciated and worn out with suffering, operation was resorted to at a comparatively early date, the mortality would be reduced still further. The operation which will be necessary depends entirely on the condition found after opening the abdomen and examining the stomach, and may be either excision of

¹ Lyon Médical, Sept. 24th, 1899.

² Robson and Moynihan: Diseases of the Stomach, p. 110.