CHLOROBROM IN SEA-SICKNESS.

By R. C. ROBERTSON, M.B., C.M. GLAS.,
SURGEON, SS. "FURNESSIA."

IN THE LANCET of June 24th Dr. Ledingham contributes an interesting note on the use of chlorobrom in sea-sickness. My experience of this solution, derived from its systematic use during six trips across the Atlantic, has led me to entertain a similarly high opinion of its efficacy in this malady. There can be no doubt that, administered in the right way and assisted by a careful regulation of diet and exercise, it quickly restores the patient to health after the first outburst of retching and vomiting is over, and there is a probability that it will prove to be an absolute preventive of the onset of sea-sickness in a very large proportion of cases provided that due attention is paid to the stomach and bowels for a few days previously to sailing. The voyage across the Atlantic occupies so short a time nowadays that few even of those who know themselves to be bad sailors think it worth while to consult a physician, and as a result an opportunity of testing the prophylactic value of any drug rarely presents itself; but in one case of which I have notes the result could hardly have been more satisfactory.

A young married lady, who when voyaging had invariably suffered from utter prostration and sea-sickness, dreading the eight days' ordeal which she confidently anticipated, consulted her medical adviser in the hope of obtaining some measure of relief. The result was that she went on board in a condition of health, so far as concerned her bowels and stomach, to admit of chlorobrom having a fair chance of showing what value it possessed as a prophylactic. She continued to take it night and morning for the first three days in half-ounce doses, and during this time she felt in perfect health. On the fourth day she ceased even to be nervous and no longer regarded herself as a patient. She gave up her medicine and freely indulged an excellent appetite. Unfortunately for her, but fortunately for the value of the case as a test one, the sea became rougher during the fifth night of the voyage. In the morning when called to see her I found her vomiting and retching violently. After her stomach was thoroughly emptied a mustard leaf was placed on the epigastrium to allow chlorobrom to be retained, and half an ounce was given. She fell asleep and remained so for four hours. On awakening she felt well and wished for something to eat. She was given some beef-tea, which her stomach rejected after she went on deck; but immediately after this took place the feeling of sickness entirely left her, and she remained, with the aid of chlorobrom in the evenings, perfectly well till the end of the trip.

It is rare indeed to find passengers so carefully prepared as this lady was. The condition of most of them, owing to pleasant meetings with their friends before sailing, is one in which the first acute attack of sea-sickness acts as a very wholesome and beneficial emetic; but it is the secondary stage—the stage of headache, retching and prostration—which is most undesirable for the weak and fraught with most discomfort to all because it is often prolonged, and it is just in this stage that chlorobrom is most useful. The testimony of an intelligent patient is most valuable in a case of this kind, and if my memory serves me right I have never given this solution to a saloon passenger without his speaking well of it to me afterwards. One gentleman, an Anglo-Indian in delicate health and a martyr to sea-sickness, told me that he would never travel by sea again without taking chlorobrom with him.

MEDICO-PSYCHOLOGICAL ASSOCIATION.—The next examination for certificates in Psychological Medicine will be held in England at Bethlem Hospital, London, on July 18th, at 11 A.M.; in Scotland at the Edinburgh, Glasgow and Aberdeen Royal Asylums, on July 20th, at 10 A.M. The examination for the Gaskell Prize will take place at Bethlem Hospital at 11 A.M. on July 19th. Candidates should give notice to the general secretary, Dr. Fletcher Beach, 11, Chandos-street, Cavendish-square, if they wish to be examined in England; and to the honorary secretary for Scotland, Dr. Urquhart, Murray's Asylum, Perth, if they desire to be examined in Scotland.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL AND THERAPEUTICAL.

A CASE OF PENILE FISTULA IN A CHILD.

By HERBERT W. PAGE, M.C. CANTAB.

THAT the treatment of penile fistula presents many difficulties, which are not likely to be lessened when the subject of it is a child, will doubtless be readily conceded by all surgeons. In the particular instance which here seems worthy of record the fistula had been caused by destructive sloughing of the floor of the penile urethra from the tight ligature of a piece of thread round the penis by the child himself. The treatment adopted, both that which failed and that which in the end succeeded in curing the fistula, shows how very essential it is to divert the stream of urine by a perineal opening, and how well it would be in all such cases to proceed forthwith to carry this out rather than to waste time over other methods which are pretty sure to fail. The case, moreover, illustrates with what advantage the urethra may be sutured, in that stricture is surely less prone to follow the careful apposition and union of the freshened edges of a urethral gap than when the opening is allowed to close, if, indeed, it ever would close, by the slow contraction of cicatricial tissue. This has been clearly demonstrated by Dr. Manley of New York and other recent writers in the treatment both of organic stricture and of ruptured urethra.¹ A similar case was published some years ago by Mr. Clutton,² and there also the benefit resulting from a perineal opening was unquestionable, for, the stream of urine having been thus diverted, he closed the penile fistula by a plastic operation with almost entire success, a pinhole orifice alone remaining and causing so little inconvenience that his patient declined further treatment. His case was probably a very much worse one than mine, but in my case likewise some temporary trouble arose from a minute orifice. This at length was fortunately closed, and when the child left the hospital he was able to micturate in the natural way.

A boy aged five came into St. Mary's Hospital on September 14th last with his penis enormously swollen and oedematous and having a ring-like ulcer near the root. Incisions were made to relieve the tension, but it was not until the 16th that there was found tied tightly round the penis a piece of cotton thread buried and hidden in a deep sulcus. The discovery of the piece of thread was a matter of no small difficulty because of the depth of the sulcus, overlapped by the oedematous tissues in which it lay, and only the conviction that, in spite of the child's denials, there must be a ligature there, determined the continuance of the search. The child then acknowledged that he had himself tied the thread round his penis fifteen days previously, and it was therefore not surprising that after so prolonged a strangulation there should be deep ulceration round the penis and into the urethra, that the organ presented an unusual condition of solid oedema and that it was greatly swollen and enlarged. There was no material diminution in the oedema after the removal of the thread and accordingly Mr. R. M. Smyth, the house surgeon, circumcised the child on the 28th. This, then, was the state of the child when I returned to the hospital in October, and, moreover, all his urine was being passed through an ulcerated gap in the urethra immediately in front of the scrotum. Examination revealed distinct stricture at the site of, and slightly anterior to, the fistula. Stricture and fistula both, therefore, called for treatment, and the following were the stages of it. In the first place, it was hoped that dilatation of the stricture might lead to closure of the fistula, and to effect this a soft catheter was passed every day until the urethra bore with ease a No. 7. Nevertheless this treatment was without influence on the fistula. Next we tried tying in a No. 5 soft catheter, in the hope that no urine might escape by the fistula and that the wound might heal. The child resented the treatment and evidently suffered much pain, and it was necessary to confine his legs in a box splint. But the

¹ Annals of Surgery, vol. xvii., p. 181.

² THE LANCET, Dec. 8th, 1883.

treatment was without avail, save that by Nov. 3rd all indications of stricture had gone. Accordingly on Nov. 6th, the fistula being as bad as ever, I made a perineal opening and inserted thereby into the bladder a rubber tube, so that for the next few days at any rate the urine should have no other route for escape. At the same time I pared the edges of the fistula, urethral as well as cutaneous, and with fine catgut sutures in the axis of the tube succeeded in closing the orifice in the skin and urethra alike. By reason of hæmorrhage this part of the small operation was most troublesome. The body of the penis was now encircled with a strip of iodoform gauze, and when this dressing was removed on the 21st, the child meanwhile having been kept from undue movement by splints and bandages, the penile orifice was happily found to be closed and, the tube also having been taken from the bladder, the greater part of his urine was passed per viam naturalem. The perineal wound rapidly healed, but on Dec. 10th it was seen that the fistula could not be as perfectly closed as had been previously noted and believed, for urinous moisture occasionally exuded from a very minute pinhole orifice. This was touched from time to time with nitrate of silver, whilst the passage of a sound enabled me to feel sure that there was no recurrence of stricture: and that the child might be sent home without even the suspicion of urethral narrowing he was kept in hospital until Jan. 11th of this year in order to pass the sound for a fortnight after the pinhole orifice had finally closed. The penis had by this time regained its natural size, and here it may further be said that the œdema and induration had subsided with greater rapidity after the fistula had been closed.

LATERAL LIGATURE OF THE INTERNAL JUGULAR VEIN.

By J. ERNEST FRAZER, M.R.C.S., L.R.C.P. LOND.,
SENIOR HOUSE SURGEON TO THE METROPOLITAN HOSPITAL, KINGSLAND-ROAD, N.E.

AN anæmic girl aged twenty-seven came to the Metropolitan Hospital on March 27th. There was a mass of glands, apparently about the size of a small hen's egg, behind and rather above the centre of the sterno-mastoid muscle, to which it seemed adherent. No fluctuation or discolouration of skin was observed. There were many strumous scars on both sides of the neck. As it was evident that the glands would soon break down, if they had not already begun to do so, I determined to remove them. Under ether, and subsequently chloroform, an incision about one inch and three-quarters long was made downwards and backwards over the swelling. A few drops of dark-coloured pus were found in one of the superficial glands, the rest were solid. On the outer aspect the mass was fairly easily separated from the surrounding structures, but it was firmly adherent in front and internally; the external jugular vein, being involved, was clamped and divided. The mass was found to extend behind the muscle, from which it was with difficulty separated. Whilst removing the tumour from the deeper structures behind the muscle there was an alarming rush of blood from the situation of the internal jugular vein. The vein wall was immediately drawn forward with pressure-forceps and the hæmorrhage controlled. Pressure was now placed over the vein above and below and the wound examined, when a cut about half an inch long was seen in the vein in a transverse direction. Clamps were placed on either side of this cut and a lateral ligature of stout silk was tightly applied. The wound was then cleared of all glandular structure, washed out with a solution of perchloride of mercury (1 in 500) and closed entirely, the patient being put to bed with the neck bandaged as firmly as possible, flexed, and fixed between sandbags. The wound healed by first intention, the stitches being removed in a week. The day after the operation the right pupil was noticed to be smaller than the left and had remained in that condition. In connexion with this pupil affection an interesting point was noticed after a few days—namely, the development of slight ptosis on the right side, which was apparently functional and secondary to the contracted pupil. I have thought this case worth recording on account of the size of the wound in the vein, which was almost half an inch long. The application of the ligature included so much of the vein wall that the vessel became tense and dragging so marked that the head was flexed as soon as possible, a proceeding

which immediately relieved the tension. This tension seemed to be the only source of danger provided the wound remained septic, as Mr. Walsham showed, in a paper read before the Medical and Chirurgical Society in 1888, in which he had tabulated sixteen cases of lateral ligature of veins. One of the patients referred to by him died from causes unconnected with the wound of the vein and three from secondary hæmorrhage on separation of the ligature—conditions that should not exist now under ordinary circumstances. During my patient's stay in the hospital there was at no time any reason to suppose that the lumen of the vein was blocked.

Croxted-road, West Dulwich, S.E.

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.

CHARING-CROSS HOSPITAL.

PERIGASTRIC ABSCESS PERFORATING THE DIAPHRAGM AND CAUSING EMPYEMA; OPERATION; DEATH; NECROPSY.

(Under the care of Dr. MITCHELL BRUCE and Mr. JOHN H. MORGAN.)

OUR readers are aware of the rapidly fatal results which usually follow perforation of a gastric ulcer into the peritoneal cavity, death taking place within a few hours or days after the commencement of symptoms. The following illustrates the course of a rarer class of these cases, in which the inflammatory changes consequent on the giving way of the ulcer are subacute and localised, and in which the subsequent suppuration is shut off by the adhesions thus formed from the general peritoneal cavity. Looking at the case from the light of subsequent events it would appear that the perforation of the diaphragm began to take place about five days after the patient's admission, the slight area of dulness at the lower part of the left thorax, accompanied by a sudden rise of the thermometer to 104° F., being probably coincident with the commencement of the empyema. The liver had possibly already been implicated, as was shown by the enlargement and tenderness. It was not until five days later that the abdominal swelling was observed to diminish, and in the course of the next three days it became almost imperceptible and the tenderness had entirely disappeared from the region occupied by the tumour. As the swelling disappeared from the abdomen the area of dulness in the posterior thoracic region gradually spread upward, with other evidence that the lung was receding from that part of the chest. On March 20th the consultation was held and the operation was performed immediately afterwards.

A female domestic servant aged twenty-five, with good family history, had suffered from symptoms of gastric ulcer at intervals since 1885. On Feb. 13th, 1891, she was suddenly seized with violent pain in the epigastrium whilst kneeling, causing her to feel faint and to lie with the thighs flexed for about thirty minutes. She was attended by a medical man and a few days after was able to get about. Shortly before admission to hospital she was attacked with faintness whilst riding in an omnibus, but managed to reach home, when she suffered from violent pains in the back. The bowels were not relieved for three days and on Feb. 16th the motion was quite black and was followed by loose and watery evacuations. During this period she suffered greatly from thirst and frequent night sweats, which were accompanied on two occasions by shivering fits lasting for ten minutes or more.

When admitted to Charing-cross Hospital on March 2nd she was thin and anæmic; the tongue was furred, the temperature was 101° and she complained of pain in the epigastrium, which at intervals extended across the abdomen. On inspection a rounded, tense swelling the size of a small orange was found on a level with, and to the left of, the umbilicus. During the next ten days this swelling became less distinct and the general condition improved. No pus was seen in the motions