

rise of temperature a few days before death must be noted as a symptom of infrequent occurrence. With this may perhaps be associated as a possible cause the advancing tuberculous affection of the prostate, epididymis, and testicle. The tubercles in the lungs were probably the earliest change of all those revealed at the necropsy.

### CLAYTON HOSPITAL AND WAKEFIELD GENERAL DISPENSARY.

AN UNUSUAL CASE OF ADDISON'S DISEASE; SUDDEN DEATH; REMARKS.

(Under the care of Mr. PAUL STAR, senior house surgeon.)

TUBERCULOUS disease of the suprarenal bodies is an affection more common in men than in women, but the following case presents some other more important points of difference from the usual type, which mark it as especially interesting. The most characteristic symptom of Addison's disease is the gradual development of debility without appreciable loss of flesh, and a sudden cardiac failure ending fatally without previous complaint of weakness is fortunately very rare. "It is probably not possible in any case to ascertain the exact date of the commencement of the disease; there are good reasons, indeed, for believing that the process of suprarenal degeneration is always far advanced before the clinical signs of the affection reveal themselves. Counting then from this latter date, the malady is sometimes remarkably rapid in its progress—proving fatal in the course of two or three weeks,—while sometimes it is prolonged for several years."<sup>1</sup> Dr. Leva<sup>2</sup> has described a case the duration of which was supposed to have been eight years. This case exemplifies the advantages and advisability of holding a post-mortem examination in cases of sudden death.

A girl seventeen years of age was admitted to the Clayton Hospital on Jan. 27th, 1894. She had fallen in the street while on an errand, close to the hospital, and was brought to the institution on an ambulance. At the time of admission she was unconscious, motionless, and very pale; she was perspiring slightly about the face and neck, and the surface of the body was cold. There was no rigidity, and the sphincters were unrelaxed. The pupils were somewhat dilated, equal, and reacted to light. The conjunctival reflexes were present, but feeble. The tendon reflexes were normal, and there was no ankle-clonus. Respiration was shallow and the pulse was imperceptible. The cardiac impulse could just be felt and the sounds very indistinctly heard. The heart-beat was 65 to the minute. No injury to the head was apparent, and there was no distinct odour of the breath. Half a drachm of sulphuric ether was injected over the cardiac region, and a few minutes later the pulse could be distinctly felt at the wrist. The patient was put to bed and hot-water bottles applied to the legs and sides. She completely recovered consciousness in about half an hour. The pulse and respiration rapidly improved. She answered questions as to her name, previous health, &c., and said she felt quite well enough to go home. The heart and lungs were found to be quite healthy. The urine was normal. The patient was kept in bed and given some warm milk and about half an ounce of brandy. In about three hours the pulse again began to fail rapidly and became irregular in force and rhythm, the respiration at the same time becoming short and shallow. Sal volatile and brandy were exhibited, but there being no improvement in the pulse a drachm of ether was again injected over the heart. This had no effect, and the patient died a few minutes after the injection, the time between the commencement of the second attack and death being about ten minutes. The patient's mother said that her daughter had always been a healthy girl until about three months before the present attack, when she had to leave her situation owing to continued attacks of abdominal pain and vomiting. These symptoms were considered to be due to derangement of the digestive functions and had quite ceased about two months after their first onset, and she had again gone to work. Her family had always been healthy, and there was no history of any hereditary disease.

*Necropsy.*—A post-mortem examination was made fifteen

hours after death, when the body was found to be that of a well-nourished and finely developed girl. Rigor mortis was present in the lower limbs, but was passing off in the arms. There was no post-mortem staining, or pigmentation of skin, or mucous membrane, except below the umbilicus, where the skin of the abdomen was distinctly bronzed, forming a marked narrow line leading from the umbilicus to the pubes. The skin over the iliac regions was pigmented in a less marked degree. On opening the thorax the heart and lungs were found to be quite normal. The thymus gland was persistent and as large as that of a child twelve months old. It was normal in situation and weighed six drachms. The lobes were well marked. The abdominal viscera were normal. The stomach contained about half a pint of semi-digested food. The pelvic organs were normal. The adrenals were very large and tuberculated, hard to the touch, and on section showed no distinction between cortical and medullary substance. They cut like hard cheese and contained many cretaceous nodules, but no pus. Both the organs were surrounded by dense and tough connective tissue, and were bound down to the kidneys. The retro-peritoneal and mesenteric glands in their vicinity were enlarged and hard, but were normal in appearance on section. The semilunar ganglia and solar plexus were surrounded and compressed by fibrous tissue. The brain was normal. Microscopic examination of the adrenals showed the usual changes found in Addison's disease. Tuberculous growth was present in various stages; caseous centres were surrounded by small-celled infiltration with giant cells. A good deal of altered tissue was undergoing fibroid change. Sections of all other organs showed nothing abnormal. Unfortunately, the solar plexus and semilunar ganglia were not removed at the necropsy, so that a microscopic examination of their condition could not be made.

*Remarks by Mr. PAUL STAR.*—The chief points of interest about the case are—(1) the cessation of all symptoms for a month before death, the patient enjoying good health and following her occupation during that time; (2) the sudden death, this occurring about three hours from the time the patient fell in the street; (3) the presence of a large thymus; (4) the limited extent of the bronzing; and (5) there being no disease of other organs than the suprarenal capsules.

### ROYAL INFIRMARY, NEWCASTLE-ON-TYNE.

A CASE OF CUT-THROAT INVOLVING THE LARYNX TREATED BY SUTURING; COMPLETE PRIMARY UNION; REMARKS.

(Under the care of Dr. ARNISON.)

THE ordinary rules of surgery as recently understood and expressed in our text-books left very little room for the exercising of the individual skill and discretion of the surgeon in charge of a case of cut-throat. If there was one thing about which there was unanimity it was the harm done by the insertion of sutures in such cases, and the great responsibility resting on the surgeon who ventured to use them. Dr. Arnison's treatment of his patient shows the excellent result which may be obtained by judicious suturing. The condition of these cases is often most unfavourable for the primary union of wounds: miserable, depressed, the subjects of chronic alcoholism, melancholia, renal disease, heart disease, or chronic phthisis—every injury, even the slightest, becomes of moment. Then, again the wounds vary very much in extent, depth, irregularity of surface and number of structures divided, and if there is any septic accumulation in a closed wound cellulitis of a spreading kind, only too frequently fatal, may ensue within a day or two. It is therefore necessary to exercise a careful selection before attempting primary union. For the notes of this case we are indebted to Dr. W. E. Harker, house surgeon.

A man aged forty years was admitted into the Royal Infirmary, Newcastle-on-Tyne, having cut his throat one hour previously. The skin incision began at the anterior edge of the left sterno-mastoid and tailed off a little beyond a corresponding point on the right side of his neck. Parts of the following muscles were cut: platysma, omo-hyoid (anterior belly), sterno-thyroid and thyro-hyoid, exposing on the left side the trunk of the vagus, which was lying internal to and on the same level as the vessels, which were uninjured. The thyroid cartilage was completely severed just below the pomum Adami, giving a good view of the interior of the larynx. The cut edges of the cartilage came accurately

<sup>1</sup> Pristowe: The Theory and Practice of Medicine.

<sup>2</sup> Virchow's Archiv für Pathologische Anatomie und Physiologie und für Klinische Medizin, Berlin, Band cxxv., 1891.

together, and were firmly retained in position by six catgut sutures. The divided muscles in turn were sutured over the cartilage. Deeply buried sutures were now inserted through the cellular tissue on either side of the larynx, so as to completely obliterate all spaces in which discharges might accumulate, after which the skin and subcutaneous tissue were united by silkworm gut sutures, entirely closing the wound, no drainage being employed. Careful asepsis was observed in dressing the wound. For three days after admission to hospital the patient was violently delirious (alcoholic), but was able to take liquid nourishment by the mouth from the first. At the end of seven days the wound was dressed for the first time, and the silkworm gut sutures were removed, primary union having taken place. Four days afterwards the patient was discharged.

*Remarks by Dr. ARNISON.*—The treatment in this case is quite opposed to the ordinary rules of surgery, but, given perfect asepsis, there is no reason why a wound in the throat should not heal as readily and completely as wounds in other parts. The difficulty in the case of wounds involving the air passage is that, however carefully the external wound may be treated, it becomes infected from the windpipe, with the resultant dangers of emphysema, cellulitis, &c. In this case I happened to enter the ward just as my house surgeon had finished suturing a somewhat jagged wound through the larynx, and I found he had closed it so carefully and effectually that I felt very confident that, with the same care in applying deep and superficial sutures to the external wound, and obliterating all dead spaces, it would heal throughout without drainage. My confidence was fortunately justified by the result.

## Medical Societies.

### MEDICAL SOCIETY OF LONDON.

#### *A Successful Case of Paracentesis Pericardii. — The Treatment of Empyema in Children, based on an Analysis of Eighty-six Cases.*

An ordinary meeting of this society was held on Jan. 28th, Sir WM. DALBY, President, being in the chair.

Dr. PERCY KIDD described a successful case of Paracentesis Pericardii, which is reported in full in another part of this issue.—Dr. SANSOM, in discussing the case, dwelt upon the presence of lead poisoning and of contracted granular kidney, and said that two years ago he had stated that he had never seen a satisfactory recovery from pericarditis under those circumstances. Since that time, however, he had come across two cases of the kind, both of which presented traces of old retinal hæmorrhages, a sign which added greatly to the gravity of the prognosis. The present case, he thought, was partly a true pericarditis and partly a hydropericardii judging from the quantity of fluid withdrawn. In some other forms of pericarditis such a mode of interference would hardly be justifiable, and in many there would be great difficulties in the way, as in what Dr. Sturges called pancarditis, an inflammation of the whole heart, with swelling of its substance, followed by pronounced pericardial adhesions, where the presence of fluid was only a small part of the problem.—Mr. MARMADUKE SHEILD fully agreed that paracentesis pericardii should be restricted to very special cases, and dissented from Dr. West's statement that it was an easy and satisfactory operation. There was great difficulty in diagnosing with certainty pericardial effusion, and especially in distinguishing between that and enlarged heart with adherent pericardium, while an injury to the heart wall or a rim on its surface might easily occur. It was an important point first to make a small incision in the skin and then to pass the trocar obliquely. Anæsthesia was generally necessary, especially in young children.—Dr. CARR recalled a case seen post mortem. During life there had been great extension of the pericardial dulness, and the advisability of tapping was discussed and decided in the negative. The pericardium was greatly enlarged in all directions, containing pus and lymph, the pus being packed away, as is often the case, at the back of the pericardium. The heart itself was anchored by firm adhesions to the front of the pericardial sac, so that practically if any attempt had been made at paracentesis the needle must necessarily have gone into the

ventricular wall wherever and however inserted.—Dr. EWART fully agreed with what Dr. Kidd had stated and with the conclusions he had quoted from Dr. West's paper. He had had several cases with very similar results. The most satisfactory was one in which twenty ounces of very bloody fluid were removed from the pericardium of a man aged about forty who was suffering from valvular disease with extreme dropsy and was in imminent peril. The relief was complete, though recovery was slow, the œdema lingering for a time; but the man was subsequently enabled to resume his occupation. The speaker had had the operation performed in cases of rheumatic pericarditis of severe degree, and with complications which made the safety of the patient depend on the immediate relief of intra-thoracic pressure. In one case, for instance, there was effusion into the three cavities of the chest, and all these were laid open, two of them at one *séance*, the patient recovering completely. He insisted strongly on the necessity of laying the pericardium freely open and cited cases illustrating the inefficiency of merely inserting a trocar.

Dr. CAUTLEY read a paper on the Treatment of Empyema in Children. Solis Cohen mentioned that absorption of pus from the pleural cavity was practically a myth, and said the late Dr. Sturges was of opinion that resection of rib was necessary and that the small mortality of empyema in children was due to improved treatment in this respect. Sutherland went even further and insisted on the necessity of washing out the cavity. Dr. Cautley had analysed a series of eighty-four cases with a mortality of 16.6 per cent. In respect of the cases in which no surgical treatment was adopted the fluid might of course be absorbed, but it might also rupture externally through the chest wall or internally through the lung. There was a considerable element of danger in leaving these cases to themselves, though in a certain proportion of such cases, either when left alone or treated by aspiration, absorption did take place. Of twelve cases treated by aspiration only one died, one ruptured externally, and one discharged through the lung. Of thirty-five treated by incision and drainage seven died, while of thirty-three treated by resection and drainage six died. A comparison of the two latter tables showed that the average age was practically the same, the mortality almost the same, and the duration of the after-treatment only differed in the matter of one or two weeks in favour of resection. It was a remarkable fact that five out of six cases under two years of age treated by resection died. An analysis of the fatal cases showed that in a large proportion death was not due to anything connected with the wound. The object of treatment was to remove the pus, to prevent reaccumulation, to procure complete re-expansion of the lung, and to leave behind no deformity. Although it was possible for small effusions to be absorbed, Dr. Cautley asserted most emphatically that in every case in which pus was present the only sound treatment was its evacuation. It might be conceded that aspiration was sometimes useful and might cure cases in which the pneumococcus was the primary cause. The disadvantage of aspiration was that thick effusions would not pass through the cannula, that it was impossible to remove all the contents of the cavity, thus leaving behind a focus of irritation, and, lastly, that pus rapidly reaccumulated afterwards. Moreover, there were certain dangers if the operation was performed too rapidly. On the other hand, it was useful in cases of urgency, in cases with thin sero-purulent fluid, and in cases of double empyema. The advantages claimed for resection were better drainage, facility for exploring the boundaries of the cavity, and for breaking down loose adhesions; also that there was less danger of hæmorrhage, that the chances of recovery were better, and that recovery was more rapid. Dr. Cautley pointed out that none of these advantages were proved by the experience of this series of cases, and that it was sometimes a distinct disadvantage to break down adhesions. The disadvantages of resection were that it was more severe, and, judging by the mortality, ought never to be employed in children under two years of age; and that there was greater liability to pyæmia and deformity of the chest. It ought, he thought, only to be had recourse to in cases in which the tube could not be inserted without and when drainage was imperfect, or for the cure of an old sinus. The tube should be short and only left in for a short time. Empyemata did not heal by granulation from the bottom, but by expansion of the lung, ascent of the diaphragm, and contraction of the chest wall. The tube should always be removed as soon as the discharge