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. THOMAS'S HOSPITAL.

A CASE OF ŒSOPHAGOTOMY FOR AN IMPACTED ARTIFICIAL PLATE; RECOVERY; REMARKS.

(Under the care of Mr. H. H. CLUTTON.)

THE following case presents several points of interest, and is an example of an operation and the after-treatment required which from its rarity is seldom recorded. The shape and size of the plate made its detection with the Œsophageal forceps difficult; it was probably flattened against the posterior wall whilst they from their curve passed in front of it. It will also be noticed that the length of incision required was unusually short.

A woman, aged thirty-nine, was admitted on April 28th, 1888, with the following history. She was in the habit of wearing a vulcanite plate, which carried one central incisor tooth, and was kept in position by two hooks. It had latterly been reduced in size by several small pieces having been broken off, and was consequently very easily displaced. Two days before her admission, whilst eating a hard crust of bread, she accidentally swallowed the artificial plate. She was unable to take any solid food afterwards, and could only swallow fluids, such as tea, with great difficulty and pain. On the advice of her neighbours she took castor-oil, but she did not consult a doctor before she came to the hospital two days after the accident. Mr. Bidwell, the house-surgeon on duty, found on examination with forceps and coin-catcher, that the foreign body was fixed to the walls of the Œsophagus opposite the cricoid cartilage, and that any attempts at drawing it towards the mouth caused such intense dyspnoea as to make it impossible to proceed, even if he had otherwise thought it safe to make any prolonged effort at extraction. The patient was therefore admitted into the hospital.

After the administration of an anæsthetic, Mr. Clutton introduced a pair of Œsophageal forceps in order that he might be quite sure of the exact position of the foreign body. Again and again the forceps passed beyond the artificial plate without giving any indication of its presence. This was easily explained afterwards by the small size of the artificial plate, but at the time it gave the impression to the operator that the foreign body had passed onwards down the Œsophagus. By external manipulation there was an abnormal swelling to be felt opposite the cricoid cartilage, and after several further attempts the foreign body was eventually caught by the forceps, but it was so firmly fixed that it was obviously hopeless to attempt its extraction through the mouth. The operation of Œsophagotomy was therefore commenced by an incision two inches in length opposite the cricoid cartilage on the left side of the neck. After drawing the sternomastoid and omo-hyoid muscles to the outer side, the carotid sheath came into view and was similarly displaced outwards by a retractor. The Œsophagus was then seen at the bottom of the wound, and on introducing the finger one of the hooks belonging to the artificial plate could be felt protruding through the Œsophageal wall. After an incision had been made upon the foreign body, there was still some difficulty in extraction on account of the hooks. This was eventually overcome by turning the plate round and disentangling one hook at a time. The superficial incision was not enlarged, as the difficulty in extraction was not due to the size of the plate. The wound in the Œsophagus was then carefully closed with three catgut sutures, and a drainage tube being placed in the lower angle of the wound, the superficial parts were brought together with silk, and an antiseptic dressing applied.

From April 20th to May 8th she was fed entirely by nutrient enemata, and, as her chief complaint was then found to be that of thirst, from six to ten ounces of tepid water

were injected into the rectum in the intervals between the administrations of the nutrient enemata. She was forbidden to have anything by the mouth, and after the water had been given by the bowel she made much less complaint of thirst. But by May 8th she began to get so discontented at being (as she called) starved that it was found desirable to change the method of giving her nourishment. She was therefore fed by an Œsophageal tube from the 8th to the 15th, when, the wound being healed, she resumed the ordinary mode of taking food by the mouth.

On the day after the operation (April 29th) the dressing had to be changed on account of the quantity of the discharge. On the 30th the discharge was almost as copious and offensive, and left no doubt as to the fluid having come from the Œsophagus. The dressing was therefore changed to warm boracic lotion every four hours. The discharge continued to be very copious and offensive till May 10th, when two large sloughs were removed from the wound. The skin also became much excoriated. As soon as the sloughs were removed the wound quickly began to close, and was soundly healed by the 15th. The temperature rose to 101.4° on April 29th, but after May 2nd did not reach beyond 99.2°, except on one occasion (the 7th), when it rose again to 100.2°.

The patient left the hospital perfectly well in every respect on May 16th.

Remarks by Mr. CLUTTON.—First let me thank Mr. Stabb, the house surgeon to the case, for the attention and trouble which he took in carrying out the details of the treatment. Although the vulcanite plate was a small one, it was difficult to extract, the hooks being firmly embedded in the Œsophageal walls. There is one other feature in the case deserving of notice. An attempt was made to close the wound in the Œsophagus with sutures, in the hope that the whole wound might close by first intention; but from the nature of the discharge it is clear that this entirely failed, and the sloughs which were eventually removed must have come from the walls of the Œsophagus. No suppuration, however, extended from the wound, which was soundly healed in a little over a fortnight. The method adopted in feeding the patient was of material assistance, in my opinion, in promoting this desirable result; for, had any particles of food escaped from the Œsophagus, some suppuration beyond the limited area of the wound might naturally have been expected.

HOSPITAL FOR SICK CHILDREN, BRIGHTON.

A CASE OF INTUSSUSCEPTION OF THE CÆCUM AND VERMIFORM APPENDIX; DEATH; NECROPSY; REMARKS.

(Under the care of Dr. CHAFFEY.)

FOR the following report we are indebted to Dr. Bird, who was acting as house-surgeon.

A. B—, aged three years, was admitted on April 26th, 1888, complaining of pain in the abdomen. The patient was a pale, thin boy, with a somewhat pinched cast of countenance. His mother stated that he had been in about the same condition for six weeks, but had never been a strong child. There was an uncertain history of his having swallowed some kind of button a long time previously. During the ten days previously to admission he had vomited several times. The bowels had acted regularly except for the previous three days, during which time he had only passed a little slime and blood.

On examining the abdomen, an elongated sausage-shaped hardness could be observed, somewhat uneven in outline, situate in the region of the transverse colon, not pitting on pressure, and apparently not tender to the touch. It descended with each inspiration. The abdomen was not preternaturally distended at any part, and was quite symmetrical. A simple enema, consisting of fifteen ounces of soap-and-water, was administered, and belladonna fomentations were applied externally.

April 27th.—Child in a semi-collapsed, drowsy condition; has vomited twice this morning; complains frequently of pains in the abdomen, in the region of the tumour. On examination under chloroform the tumour became less evident in its first position, but there was a distinct swelling in the right hypochondrium, beneath the margin of the liver. The patient was ordered a mixture of ether with three minims of tincture of opium every four hours, together with brandy by the mouth, whilst small enemata of

concentrated beef-tea and peptonised milk were administered every three hours.

28th.—Tumour again evident. Patient not quite so collapsed. Chloroform being administered, a pint and a half of warm milk-and-water was slowly injected, whilst the abdomen was gently manipulated in the region of the tumour. The latter disappeared, with the exception of a body in the right ilio-hypogastric region, feeling very like a movable kidney, though not so defined. The greater part of this injection was retained from 11 A.M. to 2.30 P.M. The child seemed much better; no vomiting. The quantity of stimulants and opium were increased.

29th.—Small quantities of beef-tea and peptonised milk given every hour; brandy increased to three ounces in the twenty-four hours, the patient appearing more collapsed; pupils contracted; motions very offensive, containing undigested milk. Opium diminished, and a little castor oil mixture ordered.

30th.—Blood appeared in the motions for the first time, along with some mucus and undigested milk. Temperature 98.2° to 99.4°

May 1st.—The tumour has reappeared at its old site; patient very restless and in evident pain. Castor oil mixture discontinued, and opium fomentations substituted for belladonna, as more tenderness and less movement of the abdominal wall created a suspicion of peritonitis supervening. Temperature 98.5° to 102°. At 4.30 P.M. an anæsthetic was again administered, and two pints of warm water were injected, the abdomen being manipulated the while. The tumour disappeared.

5th.—The patient has now continued free from any appearance of the tumour for four days. Lies in a drowsy condition, his pupils being contracted by the repeated small doses of opium. Respiration 8 per minute. Thinner and weaker. The effects of the opium on the respiratory centre quickly subsided under small doses of belladonna tincture, and the patient was able to take small quantities of strong beef-tea with brandy by the mouth, whilst the enemata of peptonised milk and of beef-tea were administered as before every two hours.

6th.—Respiration 18; pulse 120; temperature 98° to 98.8°. Patient still much collapsed.

7th.—The tumour reappeared, but was apparently reduced after the injection of two pints of warm water under ether and chloroform, aided by external manipulation. Small and repeated doses of tincture of opium were recommended. At 7 P.M. the tumour, having again returned, was reduced as before. At 9 P.M. the patient was sleeping; respiration 20; pulse 120. At 11.15 P.M. he was much exhausted, but sleeping quietly. He was taking a fair amount of food and stimulants by enemata.

8th.—The patient became gradually weaker, and died at 2.45 P.M.

Necropsy, made twenty-four hours after death.—Some rigor mortis in the extremities. Toes and finger-tips much discoloured; no post-mortem congestion elsewhere. Small intestines semi-distended with flatus; in some places collapsed, and contracted in others; no general peritonitis. Great omentum drawn over to the right side and fixed down to the parts in the vicinity of the cæcum by firm old adhesions. Here there was also a little flaky, recent lymph; no pus. The place of the cæcum was occupied by a rounded tumour (about three inches by two), composed of the cæcum partly invaginated into itself along with the ileo-cæcal valve, the parts being held in this relationship by tough, rounded, cord-like bands of old adhesions stretching across the fissure between the small gut and the caput cæcum coli. No tail of the vermiform appendix could be discovered, though diligently sought for, but the proximal end of that structure had become inverted, so as to form a little polypoid projection (about one inch in length) into the cavity of the cæcum close to the ileo-cæcal valve; this, moreover, appeared surmounted on a boss-like protuberance of the adjacent part of the caput coli, which was likewise partially inverted by the contraction of the adventitious bands applied to it externally. The mucous membrane covering these projections had become almost gangrenous, being deep purple in colour and softened, and there was a line of demarcation in one direction. The apex of the polypoid protuberance presented a well-marked ostium leading into a tubular cavity, about half an inch in length. A little gritty yellow concretion adhered to its summit, and something of the kind existed in the cavity of the polypoid projection. The cæcum was more roomy than natural; its

walls were much hypertrophied. The ascending colon commenced rather abruptly from the cæcum. The coats of this and of the rest of the large bowel were considerably hypertrophied, the rugæ being very marked. There was no ulceration anywhere, and no localised patch of congestion, nor any recent peritonitis along its course. It occupied the usual position. There was no accumulation of faeces anywhere within the large bowel. Some yellow feculent material with mucus existed in the small bowel just above the ileo-cæcal valve. The margins of the valve were of a slate colour, not ulcerated or thickened to any extent, if at all. The orifice was not contracted, being about normal in dimensions. There was no sign of blood having been extravasated into the tissues in its vicinity. The mucous membrane of the Peyer's patch immediately above the valve was swollen, not ulcerated. The cæcum was not very movable, but the adventitious bands were perhaps sufficiently long to allow of the change in its position to be observable apparently during life. The liver was enlarged and fatty. The spleen was also enlarged and congested.

Remarks by Dr. CHAFFEY.—The special points of interest are—1. The unusual condition of parts. The old adventitious bands originated probably in some inflammatory mischief about the vermiform appendix; but I have thought it possible that they may have resulted from an old intussusception. Their subsequent contraction would account for the inversion of the vermiform appendix and adjacent portion of cæcum. One can easily understand how the polypoid projections thus occasioned would act in exciting the intussusception reduced during life. I can find no similar case recorded, notwithstanding the many and excellent papers on the subject. 2. Abdominal section would probably not have afforded any material relief. The obstruction to the passage of faeces was by no means complete at any time, and, moreover, the extreme state of collapse, from which the patient died, almost precluded the idea of further surgical procedure. 3. External manipulation very materially aided the action of the injections per rectum. This was particularly insisted on by Dr. Cheadle in a former paper on the subject. It seems to me a point that should always be remembered, as until this was performed the tumour remained fairly fixed, notwithstanding the bowel was forcibly distended from below.

LIVERPOOL NORTHERN HOSPITAL.

A CASE OF ACUTE GLOSSITIS.

(Under the care of Mr. DAMER HARRISON.)

FOR the following report we are indebted to Mr. William Permewan, house-surgeon:—

Joseph C—, a lad of fourteen, apprentice to a currier, was admitted on April 20th, 1888. He stated that on April 17th he got wet through and felt chilled, but went home and went to bed shortly afterwards. He remained apparently in good health till the 19th. On that day, while eating his dinner, about 12 noon, he bit his tongue severely on the right side about the middle. He went to his work as usual, but in the afternoon he suddenly felt a pain in his right ear, and to relieve it he put his ear under a tap and let cold water run into it. Most of the water returned, but a small quantity, he says, did not come back for half an hour; none ran into his mouth. The pain was not relieved by this treatment, and in the evening he felt his throat sore and had difficulty in swallowing. However, he seems to have been fairly comfortable when he went to bed. On awakening the next morning (April 20th) at 6 A.M., he had great pain in his tongue, and found that his tongue was very much swollen. He felt weak and ill. At 12 noon he was admitted into the Northern Hospital.

On admission the patient, a rather delicate-looking lad, was evidently very ill. The tongue was much swollen, was protruded about three-quarters of an inch in front of the teeth, and the frænum was pressed forcibly down on the lower incisors and canines. The upper and lower teeth were separated about an inch. The tongue almost completely filled the cavity of the mouth, and was immovable, and no view could be had of the fauces. There was considerable swelling below the jaw, extending to the hyoid bone. The patient was quite unable to speak or swallow, and salivation was profuse. Breathing was carried on almost entirely through the nose, but there was no marked dyspnoea, and apparently no very acute pain. There was a