NOTES OF A CASE OF
FOREIGN BODY IN THE ŒSOPHAGUS,
CAUSING DYSPNŒA.

RELIEF GIVEN BY THE SUCUTANEOUS INJECTION OF
TARTAR EMETIC.

BY WALTER H. DODD, L.R.C.P., L.S.A. LOND.

M. W—, a lady aged about thirty-two, whilst enjoying "giblet-pie," was suddenly seized with a choking sensation, together with a difficulty of breathing. I was summoned to attend her, whilst undertaking the practice of Mr. Hammersley, about 2 P.M.; it was then half an hour after the symptoms had come on. The patient was sitting on a sofa with a basin in front of her, into which she had spat up a quantity of mucus with here and there a trace of blood. There was no history of hysteria. Her face was much flushed and anxious-looking, and she complained of feeling hot and faint. The patient indicated as the seat of pain a point somewhere opposite the cricoid cartilage. On examining that region with my index finger and thumb, I was unable to detect any prominence behind. In order to ascertain whether she could swallow, and at the same time with the object of producing vomiting, I gave her warm mustard-and-water, but she apparently failed to get any past the obstruction, and the fluid was almost immediately rejected. Warm water, pure and simple, was then tried with the same object in view, but only to be returned with no better result. I now introduced the index finger of my right hand as far as I could reach down the pharynx, but was unable to feel the obstruction. I then tried the œsophageal probang, but that refused to pass beyond five or six inches from the mouth; it was clearly arrested by something of a softish nature, and the patient began to feel that the probang only seemed to lodge the body firmer. Not knowing exactly from her account whether it was bone or meat that caused the obstruction, I introduced a coin bougie, which, being much smaller in calibre than the probang, I hoped to be successful in passing, but this also refused to pass beyond the same distance. I next attempted to promote vomiting by means of tickling the fauces with a feather; but here, again, no effect was produced. After this, there being no very urgent symptoms, I left the house, with the intention, if possible, to procure some apomorphia to use *pro injectione*, but this drug I was unable to obtain unless I sent up to London for it. I then thought of trying some tartrate of antimony, so I had a solution made up with distilled water (1 in 20).

I again visited the house about 6.30 P.M., and found the patient sitting propped up in bed, still expectorating mucus. Her face was now even more congested. She said the pain was greater, and she decidedly had more difficulty in breathing. She constantly affirmed that she was "going to die," and implored me to do something for her. I tried once more to get fluid past the obstruction, but in vain. Having now obtained her permission, having previously explained the risk of an abscess, I injected into the subcutaneous tissue of the left forearm ten minims of the tartrate of antimony solution (equal to half a grain). In less than two minutes a sensation of sickness was produced, and almost immediately afterwards a sudden fit of vomiting came on, which had the effect of expelling a perfect specimen of the heart of a bird. The patient felt at once relieved. After this she began to complain of intense pain at the seat of injection, which extended up her arm, and which at length became so excessive that I had to inject a quarter of a grain of morphia into the right forearm. I also had cold-water dressings applied to the seat of the first injection, and ordered it to be kept wet with the water. A small quantity of cold brandy-and-water was given after the vomiting had lulled, and she was ordered milk and beef-tea. I left the house about 7.15 P.M., but before doing so I informed the friends that the vomiting was likely to continue for a time.

I visited the house the following morning. The patient was then in bed, looked altogether more cheerful, and bore an expression of thankfulness. She complained of slight soreness about the throat, and the region behind the thyroid cartilage was tender on manipulation. She had taken nothing solid. The skin around the injection wound of the left forearm was slightly red and swollen, but there was

scarcely any tenderness to the touch. The vomiting had now entirely ceased, and she stated that it had only occurred once or twice since I last saw her. She got up during the day.

I called again two days after, and found the patient up and downstairs. Her throat was still sore; the fauces and tonsils were slightly inflamed, and were treated accordingly with chlorate of potash and acidulated rose-water, &c. Her arm was painful and much more angry-looking, but there was very little swelling. The temperature was 98.8°, and the pulse 84. Poppy-head fomentations were ordered. Three days after my last visit the patient was well, only a trace remaining of the injection wound.

Remarks.—The above case, so far as I am aware, is unique; no other of a similar kind to my knowledge being on record, although some of the text-books hint at such a remedy being tried. The chief interest in this case lies in the fact that the symptoms of impending death from asphyxia were quickly relieved. I think it plainly illustrates the value of tartar emetic, given by injection, for producing almost instantaneous vomiting. Although it is well known that tartar emetic, when applied locally, produces great irritation—often, in fact, giving rise to a pustular eruption,—yet in this case it was remarkable how slight was the irritation, and how easily combated by the above simple treatment. Moreover, its usefulness was proved by the readiness in which the drug is obtainable, as well as the quickness of its action; and I have no doubt, from these facts, that it might be employed in a like manner with advantage in certain cases of poisoning, where the shortness of time for removing the poison from the stomach is all-important, thus allowing the antidotes at the same time to be administered by the mouth. The increased pain that the patient complained of during the passage of the bougie was due, I believe, to the bird's heart, which, having its apex downwards at the narrowest part of the alimentary canal, excepting the sphincters, caused the obstruction by acting the part of a wedge.

Sirhowy, Monmouthshire.

TRACHEOTOMY IN CHILDREN OF AN
EARLY AGE.

By W. F. HEARNDEN, M.R.C.S.

As the results of tracheotomy in children under two years of age are not very successful as a rule, the following two cases which occurred under my care may be of interest. The third case which I append failed. According to statistics collected by Dr. Arnold Hirst Watkins, and published by him in the *Edinburgh Clinical and Pathological Journal* of Dec. 22nd and 29th, 1883, the percentage of recoveries in children aged one year and under is 0 per cent. Of those aged two and between one and two, the recoveries are 8½ per cent., as out of seventy-two operated on six recovered. This percentage is arrived at by adding published and unpublished cases together, and are collected from 702 cases. Out of four cases occurring at Chalmers' Hospital, Edinburgh, one, aged a year and two months, recovered. Out of 141 cases occurring in Great Ormond-street Hospital in the year 1864, only three cases of the age of two and under two years recovered—one of thirteen months, one of seventeen months, and one of two years; two were cases of diphtheria and one of laryngitis. Amongst the recoveries and deaths of older children, mention is made of acute laryngeal obstruction. Of course I am aware that a foreign body in the larynx is not the same as disease of that organ, but still I think it might fairly be called acute laryngeal obstruction. In diphtheria, under two years of age, tracheotomy is so seldom successful that my second case seems worth publishing. Dr. Peter Michiel, as quoted by Trousseau, says that in both boys and girls tracheotomy was always unsuccessful when performed on very young subjects. Thus, in fifty-six girls and fifty-one boys on whom tracheotomy was performed at the Children's Hospital (Paris, 1858), it was done fifteen times on girls between two and three years, and eleven times on boys of the same age, and it failed in all. Trousseau, in 1834, operated on and cured a child aged thirteen months, and relates the case in his lectures on Clinical Medicine; also another, a case in which the child was two years old all but six days, on the

very confines of that age in which he said the operation was attended with very little hope of success. Dr. Muslieurat also reported a successful result in a child aged twenty-three months. Dr. Ball, in 1862, operated successfully on a child aged seven months, and Dr. Barthez on a female infant aged thirteen months.

CASE 1.—Francis W. I. P.—, aged eleven months and two weeks. On January 7th, 1884, I was asked to go at once to see a child who was choking. As I was starting the child was brought into the surgery, and I was told he had an orange pip in his throat. He was quite insensible, of a deadly pallid colour, and breathing with the very greatest difficulty. Inversion was tried without success. The throat was examined by the finger, but no foreign body could be felt. I then tried to pass a catheter through the rima glottidis, but failed. As the child was just dying, I, as a last resource, performed tracheotomy. He was so insensible that no chloroform was required, although, being fat and the trachea rather deep, the operation took some time. On the windpipe being opened coughing took place, and after the tube was introduced the child soon regained consciousness. The pip was afterwards found on the floor, having been coughed out after the first inspiration. The tube was removed eighteen hours after. Whisky was freely given at first, and the child made a good recovery.

CASE 2.—Eva M. H.—, aged one year and ten months. The child had been suffering from croupy symptoms for three or four days, and, in spite of ipecacuanha and sulphate of copper (the latter as recommended by Niemeyer) having been given, she got rapidly worse, and on the evening of Oct. 1st, 1884, it was determined to perform tracheotomy, as both the epigastric and episternal regions were greatly depressed on inspiration, and dyspnoea was extreme. No patch could be seen on the throat, nor were any other persons in the house suffering from sore-throat, although the premises were in a very insanitary condition. Chloroform was given and the trachea opened, with great relief to the little patient. The tube was removed on the fourth day, but had to be replaced on the fifth day, as the breathing was much obstructed. The tube was removed and cleaned three times a day on account of the membrane that collected in it. My friend, Mr. J. Poland, of Guy's Hospital, kindly saw the case a few days afterwards, and gave it as his opinion that it was an undoubted case of diphtheria. Towards the beginning of the fourth week the tube was taken out night and morning, for half an hour at a time, and at the end of the fifth week was taken out for six hours, but it had afterwards to be replaced, and it was not till thirty-eight days after the operation that the instrument could be entirely dispensed with.

CASE 3.—George H.—, aged one year and nine months. This was a case of croup. No patch could be seen on the throat. As dyspnoea was extreme, tracheotomy was performed on the evening of March 25th, 1882, with so much relief to the little patient that he was soon sleeping calmly. On the next day he seemed to be doing well, but the tube ultimately became blocked, and he died about forty-eight hours after the operation.

Sutton, Surrey.

FOREIGN BODY IN THE LARYNX; REMOVAL THROUGH TRACHEOTOMY WOUND; RECOVERY.

By SOLOMON C. SMITH, M.D.

On July 17th, while I was seeing my out-patients at the Halifax Infirmary, a girl five years of age was brought in suffering from extreme dyspnoea. This had commenced the day before, soon after accidentally swallowing a button. An emetic had been given, but without relief to the breathing, which was becoming more laboured, and for some time she had been unable to swallow. There was extreme obstruction to the respiration which led to great muscular effort, stridor, and working of the nostrils; the skin was moist and somewhat cyanotic; the pulse very quick. Vocal tone was not entirely lost, but the cough was croupy. The laryngoscope showed the vocal cords acting freely, and a dark apparently metallic mass below them. In addition to the danger arising from the already existing dyspnoea, there was the imminent risk of sudden dislodgment and suffoca-

tion from spasm of the glottis. I therefore immediately performed tracheotomy. I hoped that after this the foreign body might loosen and discharge itself without further interference. But this not having occurred on the second day after the operation, and the laryngeal mucous membrane having become red and swollen, I took further steps for her relief. Having removed the tube, I passed a probe up the trachea towards the larynx, when I came upon a metallic substance about a quarter of an inch above the upper end of the wound; it was firmly impacted, and the forceps at first failed to dislodge it, but by slightly enlarging the opening it was removed without much difficulty. The substance proved to be a flat metal button, which the child had chewed into a "cocked hat" form with many sharp angles; and these had no doubt caused it to catch and become firmly impacted in the situation where it was found. The healing of the wound was somewhat slow, but she made a good recovery, and was discharged on August 5th.

Halifax.

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.

MIDDLESEX HOSPITAL.

TWO CASES OF STRANGULATED FEMORAL HERNIA; OPERATION; CURE.

(Under the care of Mr. HULKE.)

CASES of strangulated hernia, of whatever variety, are always of great interest to the practical surgeon. The questions as to the best treatment to be pursued in the particular case under consideration, and, when operation has been decided upon, the best course to be followed in dealing with the condition of bowel or omentum found in the sac, and lastly the treatment of the sac itself, demand the greatest skill and judgment. In one case which we publish there was a considerable flow of fluid from the peritoneum after the return of the gut, but this appears to have been of inflammatory character, and the presence of this fluid did not influence the after-progress of the case. That the fluid did not come from a wounded diverticulum of the bladder was proved by the passage of a catheter into the normal bladder. In neither case does the sac appear to have been removed. For the following notes we are indebted to Mr. Ernest E. King, house-surgeon.

CASE 1.—M. H.—, a female aged fifty, was admitted at noon on January 9th, 1885, complaining of severe pain in the right groin, and vomiting. She stated that whilst carrying a heavy parcel the previous evening she had experienced sudden pain in the region already referred to, and on reaching home noticed a swelling there, and shortly after commenced vomiting.

On admission the pulse was 96, temperature 99°. In the right femoral region was a small hard swelling, about the size of a walnut, situated at the outer side and below the pubic spine. No redness apparent; no impulse on coughing; very tender and irreducible. The patient vomited every now and again, but the mucus brought up had no fœcal odour.

At 2 P.M. on the day of admission, the patient having been placed under ether, taxis was tried very gently, but failed. An incision was then made over the inner border of the swelling, and all structures carefully divided until the sac was exposed; this was seen to be remarkably thin, and on opening it no fluid escaped, but a small knuckle of deeply-congested shining intestine was exposed. The constriction was felt for, but so tight was it that it was found impossible to pass either director or knife beneath it. The incision was therefore enlarged to expose thoroughly the lower end of Poupart's and Gimbernat's ligaments, and then it was found possible to pass the knife beneath and notch it, the bowel being easily returned. As this was done, a large quantity (many ounces) of thin yellow-looking fluid escaped, and for a moment it was thought that a diverticulum of bladder