

STREPTOCOCCAL PERICARDITIS AND COLITIS FOLLOWING TONSILLITIS.

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THE two cases recorded below are, I think, of some interest on account of their similar and unusual symptoms and as warning of the possible dangers from an apparently slight attack of follicular tonsillitis. I do not think that the colitis was a mere incidental complication. In neither case did it give rise to any symptom until the hæmorrhage occurred.

CASE 1.—The patient, a well developed, healthy-looking girl, aged 20 years, was treated on April 26th, 1907, at St. Mary's Hospital, Plaistow, for follicular tonsillitis. On the 28th she had pain in her limbs but no trouble in any of her joints. The tonsillar condition was well by the 30th, but the pains had not yielded to salicylates. On May 3rd her temperature was found to be 105.6° F. and she was admitted into the hospital under the care of Mr. S. J. Wareham. The only points in the history were that her mother, who was in the country, "suffered with her heart." The patient had always had trouble with her bowels and had been treated two years previously for chlorosis.

On admission she did not appear to be very ill. The temperature was 105° F., but she was quite conscious and took a great interest in her own condition. Examination revealed pain on pinching the muscles, especially the thighs. There was no pain in the joints. There were a few small pustules on the buttocks. The heart sounds were well heard and there was no increase of cardiac dulness. She was put on a mixture containing sod. salicyl. gr. xv. every two hours, and shortly the temperature fell to 102° . On the evening of May 5th it rose again to 105° , but the patient seemed no worse. Typhoid fever was suspected, but there was no evidence, and Widal's reaction was negative throughout her illness. On May 6th the temperature was 106.8° , but there was no sign of delirium. Cardiac dulness had increased up to the second left space, and later in the day pericardial friction was detected for the first time. On the 8th the patient became drowsy and later delirious. On the 9th there was incontinence of loose fæces. On this day the urine, which had contained albumin throughout, was found to have a trace of blood in it and the next day was quite dark red. Pustules appeared on the outer aspects of the soles of the feet. There was no œdema or desquamation. On the 10th I heard from Dr. J. W. H. Eyre of Guy's Hospital that he had obtained a pure culture of streptococcus longus from the blood. Antitoxin was given on the following day, but her condition remained the same. On the evening of the 12th the patient suddenly passed about two pints of dark red blood per rectum and died shortly afterwards. The stools, which had been watery, had not shown a sign of blood previously. A post-mortem examination revealed intense inflammation of the pericardium, which contained about two ounces of thin pus. The layers were rough, shaggy, and thickened. There was no endocarditis, the valves being healthy and competent. The whole length of the large intestine was studded with shallow, irregular ulcers varying in size from a threepenny-bit to half a crown. One large and deeper one was seen in the descending colon.

CASE 2.—The patient, a girl, aged seven years, was admitted on July 23rd complaining of pain in the knees, which, however, were neither red nor swollen. Five days previously she had had an acute tonsillitis, of which there was still slight evidence. No history of rash was obtained. The cardiac sounds were normal. The apex beat was in the fifth space nipple line. The temperature was 102.6° F., the pulse was 144, and the respirations were 42. She was put on sod. salicyl. gr. xv. every four hours. The temperature fell in a few hours, but pains persisted. The temperature was as high as ever on the next day, and on the following rose to 105.4° . Pericardial friction was now heard, and there was increased cardiac dulness. On the evening of the 29th I discovered an unusual phenomenon. The temperature in the

right axilla was 102° , compared to 106.4° in the left, whilst the rectal temperature was 104° . I confirmed this by two thermometers, placing them in different positions, but always with the same result. The child became very apathetic, and later delirious. The streptococcus longus was grown from the blood and 10 cubic centimetres of anti-streptococcic serum were injected daily. On August 7th and 9th the child passed about two ounces of bright red blood per rectum and after this the stools were often blood-stained. Pustules appeared on the buttocks on the 12th. On the 14th the child began to improve. The heart sounds became more audible and the dulness less. She left the hospital on Sept. 14th for a convalescent home and returned a month later quite well. She was on various drugs, including five grains of sodium sulphocarbonate, which seemed to improve her, but I should not like to lay any stress on this.

These two cases were so much alike that I was prepared for the late developments in the second case. The hemipyrexia was discovered by a nurse, and since this case I have frequently observed that in acute pericardial effusions the temperature in the left axilla is often a degree higher than in the right; in fact, I look upon this sign when present as very suggestive of pericarditis and one which may be useful when the auscultatory signs are doubtful.

I am indebted to Dr. E. B. Randall and Mr. Wareham for permission to publish their cases.

New Cavendish-street, W.

A SIMPLE METHOD FOR THE STERILE COLLECTION OF BLOOD.

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WHEN collecting numerous samples of bloods by venipuncture the use of a syringe necessitates a considerable waste of time as the syringe cannot, after use, be plunged into boiling water without great danger of cracking, neither can it be safely removed from boiling water. If the temperature is gradually raised to boiling point and then lowered about ten minutes will be required for each case. If an all-metal syringe is used it is impossible to see whether the blood is flowing into the barrel properly. Also, if a metal plunger is used and pure uncitrated blood is required (as is the case when the blood is required for the serum diagnosis of syphilis), the thin film of blood between the plunger and the barrel is liable to clot, when the plunger becomes immovably fixed in the barrel. This is obviated by lubricating the plunger with oil or vaseline, but as this must be done after sterilisation there is an added opportunity for contamination. If a rubber plunger is used it is not always smooth and satisfactory in working in a dry barrel.

I have, with Dr. Charles Slater's kind help, devised the following simple little apparatus which I find quite satisfactory, and which permits of the collection of 18 samples

FIG. 1.

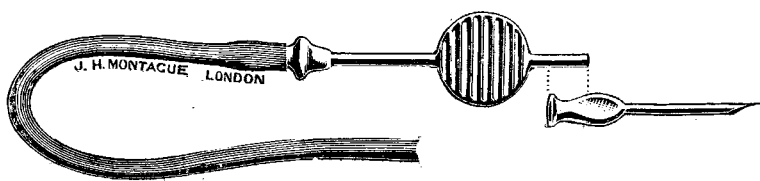


FIG. 2.



in an hour of whatever quantity may be required. Instead of a syringe I use a hollow metal needle holder two and three-quarter inches long, having a finger-grip half an inch from the nozzle end. The bulbous distal end is connected by about four inches of rubber tubing with a sterile test-tube, into which the blood flows directly (see Fig. 1). I use needles one inch long and with the calibre of a large exploring needle. J. H. Montague, of 69, New Bond-street London, W., has made me a small case containing 18 needles

and two holders, and while I am using one holder, the other, with tubing attached, is being sterilised.

I use a fresh needle for each case, and the needle will slip into the vein with ease if lubricated with a little sterile vaseline, and for this purpose I use a five cubic centimetre serum flask, filled to the shoulder with vaseline, which is autoclaved at 120, and after the vaseline has solidified a few drops of izal are introduced into the neck of the flask, which is then covered with a sterilised rubber teat. The needle, immediately after removal from the steriliser, is dipped into the vaseline before use. After use the holder and tubing should be washed through with a small glass urethral syringe to remove the blood before placing in steriliser.

If the patient objects to venipuncture, which is seldom the case, I use the glass tube depicted in Fig. 2 with which I can easily collect one cubic centimetre from the finger. The tube is made from No. 4 glass-tubing with one end drawn out into a capillary tube and the other end sealed and a bulb blown near the drawn-out end with a small hole blown in its side (see Fig. 2). The tube is held with the hole in the bulb uppermost and the blood will flow into the bulb by capillary attraction and then collect in the sealed end, the displaced air escaping through the hole in the bulb. After filling, the drawn-out end is sealed in the flame and the hole in the bulb is sealed with wax.

Brook-street, W.

Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A NOTE ON SOME NON-TUBERCULOUS THROAT COMPLICATIONS OF PHTHISIS.

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TUBERCULOUS laryngitis is by far the most important of those complications of phthisis which affect the upper respiratory tract, so much so, indeed, that it is apt to overshadow all the others and to receive the exclusive attention of the laryngologist as well as of the physician. Nevertheless, other complications are very frequently encountered and are of sufficient importance to claim some consideration. A "pre-tuberculous" condition of the larynx has often been described, and this expression seems to mean an abnormal condition, consisting of anaemia, congestion, or swelling of the larynx of a phthisical patient but without as yet any true tuberculous deposit, and it is implied that this is a precursor of tuberculous infiltration. The use of this expression appears highly unscientific, for there are no grounds for the view that there is any distinctive state of the larynx which is always, or frequently, followed by tuberculosis. There is also a very general opinion that pallor of the larynx is a characteristic feature of tuberculous laryngitis, but this opinion requires qualification. Many consumptives are anæmic, and in such cases the larynx, as well as the fauces and other mucous membranes, are, of course, pale; in other cases the colour is quite normal, and very frequently the tuberculous larynx is in a state of hyperæmia as the result of coughing and irritation; in fact, it may be stated that tuberculous larynges are reddened quite as frequently as unduly pale. It is true that the swollen infiltrated arytenoids are often pallid, and that the margins of tuberculous ulcers are characteristically anæmic, and this may have given rise to some misconception; but very often tuberculous infiltration is decidedly red and congested, especially on the cords, ventricular bands, and epiglottis.

Simple chronic pharyngitis and laryngitis are extremely common among consumptive patients and not infrequently give rise to mistakes in diagnosis, for there is naturally a tendency to diagnose tuberculous laryngitis in a phthisical patient who complains of hoarseness and discomfort in the throat. The frequency of simple inflammation of the larynx may be explained by the strain of constant coughing and by the contact with irritating

sputum which contains numerous micro-organisms and their products in addition to the tubercle bacillus. In the absence of other distinctive signs a uniform redness of both vocal cords should not be diagnosed as tuberculous, but if one cord be affected markedly in excess of the other tuberculosis may be strongly suspected. The subjects of active phthisis often complain of much dryness and discomfort in the throat, especially at night, even when there is no obvious nasal obstruction. This appears to be the result of the nocturnal pyrexia and the consequent rapid respiration which makes nasal breathing insufficient. A drink of hot milk or a demulcent lozenge diminishes the sense of discomfort. Patients in quite an early stage of phthisis sometimes complain of painful sensations about the throat which on examination appears perfectly normal. The cause of this is obscure; it may, perhaps, be that the pain is referred from the pulmonary disease to the most sensitive part of the respiratory system. Be that as it may, the symptom is not very uncommon, and I would suggest that the patient who complains of pain about the larynx for which no cause can be found should be submitted to a careful examination of the chest.

Pachydermia laryngis is also disproportionately common among the subjects of pulmonary phthisis; indeed, Gougenheim¹ considered the majority of cases of pachydermia to be tuberculous. I personally consider the affection as an extreme form of chronic laryngitis and due to the same causes; it is therefore natural that it should be frequent in the larynges of consumptives exposed to the mechanical irritation of coughing and the chemical irritation of the sputum without, of necessity, any entrance of the bacillus tuberculosis into the tissues. The firm white, almost cornified, appearance of a typical case is very different from the soft semi-translucent granulations of tuberculous laryngitis. On several occasions I have removed the pachydermatous thickening from the posterior commissure of consumptive patients and have failed to find any sign of tuberculosis on microscopical examination.

It is well known that in cases of tuberculous laryngitis the voice is readily lost and is generally much weaker than it would be with a similar extent of lesion due to another cause, such as syphilis. But apart from any laryngeal affection, functional aphonia is very common among consumptive patients. The feeble respiration, the general weakness, and the tendency to catarrh and discomfort of the throat all conduce to this affection, which is found in male as well as female consumptives, though more frequently in the latter. It is so frequent that an examination of the chest is advisable in every case of intractable functional aphonia. True paralysis of a vocal cord is also a recognised complication of pulmonary phthisis. It is due to pressure on the recurrent laryngeal nerve, and is therefore of the abductor type. Paralysis of the left cord is the result of pressure on the left recurrent laryngeal nerve by enlarged bronchial or tracheal glands, but the right nerve passes very close to the apex of the right pleura and is thus sometimes directly involved in an infiltration of the lung on this side. This is, perhaps, the commonest cause of paralysis of the right vocal cord, therefore the possibility of pulmonary phthisis should always occur to the mind of the observer who discovers this lesion on laryngoscopic examination.

Thus, other complications of pulmonary phthisis occur in the throat besides tuberculous laryngitis, and deserve recognition; and in a few cases where the first complaint is of the throat a correct estimate of their significance may direct the attention to the pulmonary disease.

Wimpole-street, W.

NOTE ON A CASE OF JACKSONIAN EPILEPSY TREATED BY TREPHINING.

BY W. BERNARD SECRETAN, M.B. LOND., F.R.C.S. ENG.

THE following are notes of a somewhat unusual case of Jacksonian epilepsy, in which cessation of the fits was brought about by operation.

The patient was an anæmic woman, aged 24 years. Her occupation was that of a clerk. About 16 years ago she fell down a flight of steps on to her head. She was not stunned at the time and was apparently able to get up by herself and

¹ Atlas de Laryngologie et de Rhinologie, p. 16.