Clinical Notes

CANCERUM ORIS.

STEWART L. McCURDY, M.D.

Professor of Orthopedic and Clinical Surgery and Anatomy and
Oral Surgery in Western University, Pennsylvania; Orthopedic
Surgeon to Presbyterian and Columbia Hospitals.
PITTSBURG, PA.

Patient.—A child, aged 5, had fever beginning June 8, 1905.

History.—On June 22, when the fever had about run its course, the attending physician noticed a swelling of the left cheek. On June 24 the skin over the cheek became glossy.

Treatment.—On June 26 the physician decided that an abscess had formed and made an incision through the mucous membrane over the maxilla of the superior sulcus of the mouth, and to his great surprise the knife passed directly into the bone, which was denuded. With a probe he found that almost the entire external surface of this bone was denuded of periosteum.

On June 30 the epidermis of the cheek, about $1\frac{1}{2} \times 2\frac{1}{2}$ inches, came off, leaving a glossy discolored derma vera, which was evidence to him that gangrenous process had begun.

Course of Disease.—At this time I was called and made a

diagnosis of cancerum oris and removed the patient to the hospital, July 1. The history of this case from this time on was that of progression, the gangrenous process rapidly extended into new fields in every direction, so that at the time of the patient's death, July 10, the outer angle of the mouth and the left anterior naris were included; the entire maxilla was destroyed and had the patient lived this would have come away in one sequestrum, since the entire surface was bare as well as the roof of the mouth on the left side.

My idea was to operate by removing the gangrenous tissue just as soon as a distinct line of demarcation was formed and a healthy margin presented itself, but the virulency of the gangrenous process was so great and the extension into new tissue so rapid that this was not possible.

The patient remained in semicoma during the entire course of the disease and died from exhaustion. The odor from the slough was so offensive that the room had to be isolated with antiseptic sheets over the door. A number of physicians examined the case with me and took a number of photographs at different stages, but the one shown is typical.

CASE OF CEREBRAL HERNIA.

E. F. TALBOTT, M.D.

GRINNELL, IOWA.

The infrequency of cerebral hernia justifies me in giving the following report:

History.—Boy, aged 16, was brought to my office Dec. 28, 1906, suffering from gunshot wound of the head. He was semi-conscious, had vomited freely and was in a condition of shock.

Examination.—Two small holes were found in the scalp a little to the left of the crown of the head and about one and a half inches apart. Between the openings was a well-defined depression. The arm and leg of the right side were paralyzed as were also the bladder and rectum.

Treatment.—The head was shaved and a temporary dressing put on to allow him to recover from the shock. The following morning the boy was anesthetized, the scalp opened and a small opening in the skull about $\frac{1}{2}$ inch in diameter was found. A portion of the inner table, which was depressed, was removed, together with several small spicules of bone, and the wound closed with drainage. In a few days pressure symptoms necessitated the reopening of the scalp when a hernia protruded which relieved the pressure symptoms. A sinus leading into the brain was discharging pus. The boy's condition remained about the same for nearly a month when in the bottom of the sinus I found about $\frac{1}{3}$ of a 22 caliber bullet; the bullet had evidently been cut by the bone of the skull, two-thirds of it being deflected and one-third going into the brain. The discharge of pus now lessened and the hernia became larger; the boy could retain no nourishment

and the paralysis still continued. Pressure symptoms, due to organization of the hernia, again demanded attention and the hernia was removed. The pressure symptoms disappeared and the patient began to improve, but the hernia again appeared and grew larger. Ten days later it was again as large as an orange at which time the accompanying illustration was taken. The boy's condition improved until April 6, when he had a chill, developed a high fever, became cyanosed and dissolution seemed imminent. On probing I located an abscess and drained it after which he again improved until May 25, when he began to fail rapidly. I again removed the hernia entire at the same time evacuating another abscess that extended well into the brain. The opening in the skull which was originally but $\frac{1}{2}$ inch in diameter had, due to pressure absorption, become $1\frac{1}{2}$ inches in width. The hernia was covered with a firm, well-organized tissue about $\frac{1}{8}$ or $\frac{1}{4}$ inch thick. The scalp extended on one side of the hernia for at least one inch.

The wound is now entirely healed and the boy enjoys good health and is perfectly well mentally. The paralysis of the bladder and bowels has disappeared but the fore-arm and leg are still paralyzed, and he is unable to walk without assistance.

Tonsillitis.—Holt, in *Northwest Medicine*, states that rheumatic and gouty disease of the tonsils differs from other forms of these conditions principally in the cause, and are to be treated like other cases of rheumatic and gouty inflammation in addition to local treatment. Syphilis, primary, secondary or tertiary, may attack these glands, and like the disease elsewhere must be treated specifically.