A COMBINED BED AND EMERGENCY COT

GUSTAVUS M. BLECH, M.D., CHICAGO

The accompanying illustration shows a separable cot-bed, primarily constructed for the humane transportation of sick and disabled on railroads, improvised ambulances, etc. Experiments with this bed have shown it to have a distinct value in hospital practice as well.

In the institution under my control we maintain such a bed for the reception of patients who have met some injury on the street or in the workshop. Usually these patients have soiled clothing and in spite of rubber sheeting, the linen and bedding are apt to become soiled. Should this happen on one of these beds, washing of the iron stand and laundering of the duck material is all that is necessary.

With this in mind we have used the bed also in a small number of cases of suppurating extremities, empyema of the chest, etc., and especially for patients who have lost sphincteric control. As already said, soiling of the entire bed would not ruin it.

The material on which the patient is to rest is put on very taut; at the same time it has sufficient resiliency to make it comfortable. The springs serve in this respect as an additional aid. We have noted that the tendency to decubitus is considerably lessened by this bed, which is probably explained by the ability to prevent wrinkling of the linen.

Adjustable spring cot with attachment for holding a canopy or a netting.

Convalescents, or patients suffering from medical and surgical diseases requiring open-air treatment, have been placed in good weather in the hospital yard on one of these cots. When not needed the bed is folded in a few seconds and put in some corner until needed again. The bed is made by the Comfort Spring Cot Co., Chicago, and costs less than the average hospital bed and a trifle more than the old-fashioned folding cots. The illustration shows an attachment for holding a canopy or a netting. This is not a part of the cot proper.

7 West Madison Street.

EARLY OPERATION FOR PERFORATION IN
TYPHOID FEVERCLARENCE L. COLE, A.B., M.D., WASHINGTON, D. C.
Captain, Medical Corps, U. S. Army

The patient who forms the subject of this communication was treated for typhoid fever at the Post Hospital, Fort Logan, Colo., in May and June, 1911, a positive Widal reaction being obtained on the tenth day. The course of the fever was mild and the patient was returned to duty, June 27, no typhoid bacilli being found in the urine or stools at that time. He was apparently well during the month following his discharge from the hospital.

The patient was readmitted to the hospital, July 26, with a fairly high temperature and pulse, but without abdominal symptoms. He was restless and uncomfortable during the entire day of August 1, and at about 6 p. m. of this day he

complained of a sudden, very sharp pain in the right lower abdomen. He was suffering severely when seen by a medical officer a few minutes later. The features were drawn and anxious, the abdomen was retracted, very rigid, extremely tender throughout, and dull on percussion over the epigastrium. The leukocyte counts showed a rapidly progressing leukocytosis. A diagnosis of intestinal perforation was made and the abdomen was opened at midnight, six hours after the perforation. With but little difficulty a perforation of a diverticulum of the small intestine was found.

This diverticulum was about 1 inch in diameter and $1\frac{1}{4}$ inches in height, arising from the side of the free margin between the free margin and the mesenteric attachment. It was united to the bowel by a short pedicle, slightly

Fig. 1.—Diverticulum; a, pin inserted in perforation; b, pearly white area immediately surrounding perforation; c, dirty gray exudate surrounding base of follicle; d, one of the smaller nodules; e, one of the smaller nodules. From a photograph made from the preserved specimen; less than one-half actual size.

Fig. 2.—Section of lymphoid follicle showing perforation; a, perforation; b, infiltrated tissue; c, c, rugae in which the normal lining of the intestinal tract is intact; d, a recess beneath the infiltrated tissue which protrudes into the lumen of the diverticulum. From a drawing; twice actual size.

Fig. 3.—The adherent intestine with the enterotomy wound opening on the abdominal wall; a, wound in intestine resulting from enterotomy; b, loop of intestine adherent in lower angle of original laparotomy wound; c, abdominal parietes; d, unhealed wound in abdominal parietes at center of a median incision, 4 inches in length below umbilicus (from a drawing). No obstruction closing either limb of the adherent loop of intestine was found to exist, yet removal of the occlusive dressings in the wound was followed by profuse discharge of intestinal contents.

constricted. Its dome was irregular in outline, studded with a number of irregular, indurated masses or bosses. From the center of the largest of these gas was escaping, and here an opening about one-sixteenth inch in diameter was found.

The diverticulum was removed *en masse* and the wound in the bowel closed by a continuous suture with Lembert sutures. Ordinary peritoneal toilet. Three large wicks of gauze were introduced, one overlying the sutured intestine, one in the left flank, and one to the pelvis. The immediate course was good.

Thirty hours after operation there was a voluntary bowel movement. Forty hours after operation definite evidences of acute intestinal obstruction came on, for the relief of which the small intestine, lying at the bottom of the original wound, was opened. Immediate relief followed this enterotomy. On December 12 a persistent fecal fistula at the site of the enterotomy opening was closed in the usual way. This procedure was followed by recovery.

Pathologic examination of the diverticulum leads to the conclusion that it was of the false or pulsion variety. Acute perforation of such a diverticulum is sufficiently uncommon to warrant a report of the case. If it serves no other purpose it will at least call attention again to the supreme importance of an early resort to operative interference.

LONGITUDINAL FRACTURE OF THE LOWER EXTREMITY OF THE RADIUS

ROBERT C. PARRISH, M.D., PHILADELPHIA

Clinical Assistant in Surgery, Philadelphia Polyclinic; Assistant Demonstrator of Anatomy and Professor to the Chair of Anatomy, Medico-Chirurgical College

While transverse fracture of the lower end of the radius is the most frequent of all fractures, longitudinal fracture is an uncommon injury.

In 1858 at a meeting of the Boston Society for Medical Improvement, Bigelow¹ showed the lower extremity of a radius which presented on its articular surface a stellate crack, with longitudinal fissures running up the shaft for a distance of more than an inch. The patient had sustained other injuries which ultimately proved fatal. At first he complained only of lameness of the wrist, but after several days the wrist was swollen, and persistent tenderness led to a diagnosis of fracture.

Skiagram showing longitudinal fissures in fracture of the radius.

Dr. Bigelow also reported having seen a similar case two years previously, in which the cracks were not so extended.

Cotton² says of this type of fracture, "So far as we know they are the result of direct violence by crushing. They are very rare; three specimens constitute the total of the evidence. The writer has not seen such a fracture shown in the *x*-ray." Two of the cases referred to are the Bigelow cases. No reference is given for the third.

Stimson³ refers to the Bigelow cases and states that he has seen one shown by skiagram.

Carl Beck⁴ and Thompson and Miles⁵ mention longitudinal fracture of the lower extremity of the radius, but do not quote any cases.

The case that I have to report occurred in the service of Dr. Morris Booth Miller at the Philadelphia Polyclinic, and had the following history:

T. G., aged 33, machinist, June 12, 1912, while engaged in repairing a compressed air apparatus, was struck on the wrist by a heavy piece of machinery, known as an accumulator, which fell from a height of about nine feet. The wrist was found to be slightly swollen and discolored, painful and decidedly tender over the lower extremity of the radius. There was no deformity, but the extreme localized tenderness suggested the probability of fracture, which was confirmed by the *x*-ray. The patient was treated on a Bond splint for three weeks, at the end of which time the wrist was in a normal condition, without stiffness or limitation of motion.

The lines of fracture are fairly well shown in the accompanying skiagram.

Dr. Miller has seen another case of this type of fracture in which there was a single longitudinal fissure. This fracture was caused by a window-sash falling on the wrist.

5301 Chester Avenue.

OTHYGROMA NEPHRITICUM

A HITHERTO UNDESCRIBED DISEASE OF THE EAR-LOBE *

OTTO GLOGAU, M.D., NEW YORK

Consulting Otolaryngologist, German Odd Fellows' Orphanage; Adjunct Otolaryngologist, Bronx Hospital; Chief, Nose, Throat and Ear Department, St. Mark's Hospital, Bronx Hospital and the Northwestern Dispensary; Otolaryngologist, H. H. School and Clinic for Atypical Children, Plainfield, N. J.

While the auricle consists of elastic fibrocartilage covered with perichondrium and skin, the lobule is made up of skin only. The subcutaneous tissue of the lobule, although highly developed, contains within its meshes only a few vessels and nerves and many fat cells. Thus, on account of its poor vitalization, the restorative power of the lobule is rather weak.

Hypertrophy of the lobule may be congenital or acquired. If acquired, it may be caused by certain diseases or brought about artificially. Congenital hypertrophy of the lobule is frequently encountered among the negro races. This portion of the auricle is artificially elongated by some savage tribes; for instance, the Botokudes introduce into the perforated lobule wooden disks of increasing size, until the lobule almost touches the shoulder. In civilized countries too an elongation of the lobule is sometimes produced in women of the poorest and richest classes by wearing large and heavy earrings.

Among pathologic conditions causing elongation of the lobule, othematoma has to be considered first. Othematoma may develop spontaneously, but is usually due to trauma. In spontaneous othematoma blood extravasates between perichondrium and cartilage of the auricle, oozing down, in some instances, into the lobule. Elongation of the lobule may also be due to elephantiasis of the entire auricle,¹ or to tumor, sebaceous cyst and horny growth at this locality. Davis² published a report of a case of bilateral edema of the entire auricle of unknown cause. The disfigurement was similar to that of perichondritis of the auricle. Only a slight elongation of the lobules was present. A relatively frequent disease of the ear-lobule that causes its elongation is the so-called tuberculosis of the ear-lobule, first described by Haug.³ In these cases no ulceration is present. Their histologic structure is that of an epithelioid tubercle. The ear-lobules are elongated to the size of a walnut and show in most instances a livid discoloration. This disfigurement occurs mostly in young persons; it may be bilateral. In the center of an angioma of the lobule of twenty-two years' duration, Haug⁴ found a caseous nodule the size of a walnut.

* Read at the Seventeenth Annual Meeting of the American Academy of Otolaryngology, held at Niagara Falls, Ontario, Aug. 20-22, 1912.

1. Haug: Arch. f. Ohrenh., xliii, 15.

2. Davis: Tr. Roy. Soc. Med., otol. section, 1911.

3. Haug: Arch. f. Ohrenh., xxxii and xxxvi, 176.

4. Haug: Arch. f. Ohrenh., xxxii, 158.

1. Bigelow, H. J.: Boston Med. and Surg. Jour., 1858, lviii, 99.

2. Cotton: Dislocation and Joint Fractures, p. 337.

3. Stimson: Fractures and Dislocations, Ed. 5, p. 290.

4. Beck, Carl: Fractures, p. 142.

5. Thompson and Miles: Manual of Surgery, 1, 499.