

used the cold wire snare in the further treatment of the case and also employed chromic acid, with no results out of the ordinary. Of course the transient blindness can only be considered as a reflex amaurosis, the result of the intranasal operation.

In connection with the report of this case, I reviewed in my article the literature of the subject, and in doing so called attention to the many curious phenomena that have manifested themselves after operations within the nasal cavities.

In 1885 Ziem<sup>12</sup> wrote a lengthy article on evil results of reflex origin following intranasal operations, in which he reported a number of cases of visual disturbances under such circumstances and also several of delirium.

Dr. Thorner<sup>13</sup> reported a case almost identical with that reported by me of reflex amaurosis. Although it resembled in some respects the case which Dr. Holmes saw with Dr. Thorner, which I have already referred to, it differs so essentially in its nature that I think it must have been a distinct case. The patient, following the cauterization of a small polypus in the middle meatus of the nose, suffered from a temporary amaurosis of the same side. He could distinguish between light and dark, could see objects held closely before the eye, but could not count the fingers at five feet. His vision was gradually restored in four or five weeks. In the same article Chappell is quoted as reporting two other cases, one a boy aged 16 years in whom the removal of a piece of the middle turbinate the size of a pea was followed four hours later by total loss of memory. The boy's family physician reported in Thorner's case that the boy's temperature was elevated, his conjunctivæ hyperemic and his pupils dilated. He complained of headache and was absolutely unconscious of everything that had happened since he left home to go to Dr. Thorner's office. There was absolute loss of memory for six weeks, after which the memory gradually returned until it was completely restored, three months after the operation. The other case was that of a woman, aged 24, who had a severe subacute cough accompanied by neuralgia of the left side of the face following the removal of the anterior portion of the left middle turbinate.

W. F. Chappell<sup>14</sup> reports the case of a woman, aged 58, in whom he injected one drop of monochloracetic acid into the mucous membrane of the right middle turbinate. The same evening the patient was attacked with severe pain in the right side of her face, extending over the top of the head to the occiput; she also had pain down the right side of her neck and along the course of the nerves to the tips of her fingers. The pain was neuralgic in character and began to subside after one week, but six weeks had elapsed before she was restored to her normal condition.

Another patient of Chappell's, after the removal of a portion of the left middle turbinate, had a good deal of hemorrhage, but only slight pain. Two hours after operation she began to suffer with pain and tenderness over the left frontal region, extending to the occiput and down the back of the neck to the left shoulder. She felt dizzy and at times feared that she would fall. Three months after the operation, although much better, she still had some numbness of the left side of the face and neck. Dr. Chappell also refers to another case in which

a portion of the left middle turbinate was removed with forceps and the galvanocautery was used on the left inferior turbinate. Following the operation the patient vomited and complained of pain in the back of the neck. A month later the galvano-cautery and chromic acid were used to cauterize the right inferior and middle turbinates. Shortly after this last procedure the patient complained of pain in the head and aching of the neck and shoulders. Another cauterization was followed by similar symptoms, in addition to which she had pain in all the large joints of her body. The following day she had great pain over the bridge of the nose, vertex and back of the neck and suffered from aphasia. A few days later she fell into a cataleptic state, pupils contracted, respirations shallow, and heart action normal. This condition continued for about an hour and recurred daily for ten days. The patient, at the time Dr. Chappell reported the case, was still far from well.

One can not help thinking that in this case there must have been a large hysterical element, as her complaints of pain did not always seem to have been backed up by the physical lesions which would have caused it.

Sir Felix Semon<sup>15</sup> reports a case in which the removal with a galvanocautery loop of multiple recurrent mucous polypi of the nose was followed by sudden exophthalmos of the right eye, accompanied by Graefe's sign (lagging behind of upper lid when patient looks down) and Stellwag's symptom (retraction of the upper eyelid). There was no enlargement of the thyroid gland.

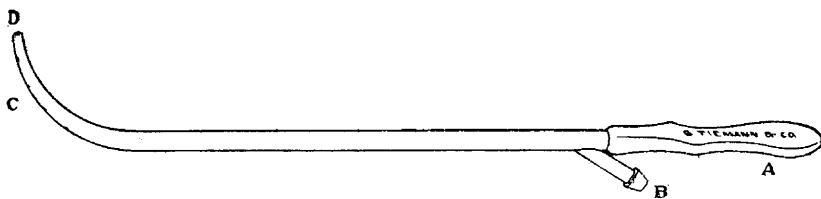
## Clinical Notes

### COMBINATION CATHETER AND SOUND.

J. W. MEEK, M.D.

CAMDEN, ARK.

I have had made a combination catheter and sound. So far as I know there is no other instrument of exactly this type. The advantages claimed are as follows:



Combination catheter and sound: A, head of sound, solid, (steel); B, outlet for escape of urine, or point of attachment of fountain syringe to wash out the bladder; C, small perforations communicating with central canal; D, perforation at point.

1. When a metallic instrument is to be used, this is more readily introduced than a silver catheter, as the weight of a solid, or almost solid, sound, after reaching the deep urethra, readily carries the instrument into the bladder—at least when raised perpendicular—unless there be serious mechanical obstruction to the introduction of any instrument.

2. This instrument not only dilates the urinary canal, but its entrance into the bladder will be made known by the slow discharge of the urine. I say slow, because the canal or channel in this instrument is purposely made small in order to preserve the weight of the sound.

3. If this instrument meets with serious obstruction, a little warm sterile oil or glycerin may be injected

12. *Monatschr. f. Augenheilk.*, Berlin, 1895, xix, 257.

13. *THE JOURNAL A. M. A.*, Sept. 26, 1896.

14. *N. Y. Med. Record*, May 10, 1890.

15. *British Med. Jour.*, April 20, 1889.

through this canal with a small hand syringe, thus facilitating its introduction.

I was led to feel the need of such an instrument by having to attend a man over 70 years old, who, after months of catheter life from enlarged prostate, was operated on by Dr. J. B. Murphy. After some months the patient again had trouble in fully evacuating the bladder. Dr. Murphy advised me to introduce a sound once a week, or two weeks as required. This maintained the patency of the canal, but did not drain off the residual urine. This necessitated the use of a catheter afterward. The sound would frequently pass into the bladder when neither a soft nor metallic catheter would do so, unless the sound preceded it.

The bladder can also be readily washed out by attaching a fountain syringe to the hollow projecting point B in the engraving.

### MARKED MALPOSITION OF THE SIGMOID SINUS.

RICHARD H. JOHNSTON, M.D.  
BALTIMORE.

On March 16 of the present year I was called on to open the mastoid of Fulton M., aged 5, who had suffered from acute suppurative otitis media for two weeks. There was decided swelling of the skin over the bone. After making the usual incision through the skin, a small fistula was found in the mastoid fossa which passed down through the cortex. After removing the bone, granulation tissue was encountered, but the peculiar doughy sensation imparted to the probe warned against the use of the curette. The soft tissue was carefully uncovered from the mastoid fossa to the tip, and everywhere presented the same granular appearance. Its position was directly back of the posterior wall of the canal. There was no pulsation of the mass. In trying to make a positive diagnosis a portion of the canal wall was removed and even then it was impossible to tell whether I was dealing with granulation tissue alone or with the sinus covered by it.

At one point the granulations were accidentally scraped off and a bluish shimmer convinced me that I was dealing with the sinus. To make assurance doubly sure a sterile, hypodermic needle was pushed through the blue spot and the withdrawal of dark blood made the diagnosis positive. The position of the sinus was directly back of the posterior wall of the canal, hugging it as closely as possible, and extending from the mastoid fossa just below the dura above to the uncovered tip below. Its direction was perfectly straight instead of the usual S shape. The position of the vessel changed an apparently simple operation into a complicated one. Since there was no evidence of thrombosis, the granulation tissue was not disturbed. The skin wound was sutured a short distance above and left open below.

The patient made an uneventful recovery. I had never seen such a marked displacement of the sinus.

919 North Charles Street.

### TETANUS TREATED WITH MAGNESIUM SULPHATE BY HYPODERMOCLYSIS.

MORTON LYON, M.D.  
DE WITT, IOWA.

I wish to report a case of tetanus treated with magnesium sulphate by hypodermoclysis, with recovery:

The patient, J. K., male, 7 years old, stepped on a nail, which punctured the sole of his shoe and entered the left foot, barely through the skin, making a wound scarcely noticeable.

Eight days later he complained of stiffness in his foot and leg. On the ninth day a spasm of the leg caused him to fall, and rigidity of muscles was increased. On the tenth day trismus was noticed and there were occasional convulsions. On the eleventh day I was called to see him and found his jaws

set and almost all his muscles rigid. He could move his arms and hands to a limited extent. The wound was laid open and thoroughly treated with hydrogen dioxid and tincture of iodine.

The convulsions were partially controlled by morphine, chloral and bromids. On the twelfth day, at 3 p. m., I gave two drams magnesium sulphate in four ounces of distilled water under the skin of abdomen. At the end of two hours the boy could separate teeth 2 cm., and his other muscles were relaxed to a marked degree. On the thirteenth, fourteenth, seventeenth and nineteenth days the magnesium sulphate injection was repeated, and, although the muscles were not relaxed to the same extent as after the first injection, the convulsions were infrequent and not so severe. Only twice was there any bronchorrhoea, and then of slight consequence. About the fourteenth day a vesicular eruption appeared all over his body. The vesicles were of pin-head size and filled with a clear fluid. These dried up and disappeared with an exfoliation of epidermis in about one week.

From the last injection of magnesium sulphate on the nineteenth day the stiffness in muscles slowly disappeared, the last to disappear being in the foot which was injured. It was necessary to give digitalis to improve heart action after the first week of illness, and tonics for anemia during convalescence. About the thirtieth day he was able to sit up, and in ten days more to walk again as usual.

### CASE OF MULTIPLE SACCULATED THORACIC ANEURISM SUCCESSFULLY TREATED BY WIRING.

JAMES M. ANDERS, M.D., LL.D.

AND

JAMES P. MANN, M.S., M.D.

PHILADELPHIA.

*Patient.*—M. W., a colored man, aged 36 years, was admitted to the Medico-Chirurgical Hospital, Jan. 18, 1907, complaining of a painful, throbbing lump in the sternal region, a troublesome cough, marked dyspnea, and general weakness.

*History.*—The family history was negative. The patient as a child had measles and mumps. When about ten years of age he fell and sustained an injury to the chest, to which accident he attributed his present condition, though the first local symptoms appeared twenty years later. He had always been more or less subject to colds and had suffered from several slight attacks of acute rheumatism. For the past twelve years he had been a barber and had previously been employed for a number of years on a farm. He had used tea and coffee in moderation, but tobacco, beer and whisky freely until entering the hospital. He had been married eight years. The patient admitted a specific infection, the primary lesion appearing, however, only four months previous to the time of his admission.

The present illness began about four years ago, when he noticed a dull boring pain under the sternum. Soon, a small, painful, throbbing protuberance appeared to the right of the mid-sternal region, but this swelling largely disappeared under absolute rest and medicinal measures. During the four years intervening between that date and his admission to the hospital, he had an occasional pain in the same region, and a cough at intervals, which, however, was not characteristic of thoracic aneurism.

Since Christmas, 1906, he had a severe cough, which caused considerable pain in the area of the original swelling. On January 14, four days prior to date of admission, he indulged in a "spree," during which he suddenly felt a sharp pain accompanied by a sense of "something giving way" in the chest. This was attended with a smothering sensation, and at the same time he noticed a return of the swelling. The tumor now rapidly enlarged and four days later it was about the size of a small orange. Neither dysphagia nor aphonia was present.

*Examination.*—On admission to the hospital, the most striking feature of the physical examination was a conical tumor-