Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF GUNSHOT WOUND

IN WHICH THE BULLET WAS REMOVED BY MEANS OF
THE ŒSOPHAGOSCOPE.

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THE following case is of interest and worthy of record in order to demonstrate for future use the advantages of the method adopted for the removal of a bullet in the neck. The only alternative was a deep dissection.

The patient, a private in the Irish Guards, was under the care of Colonel A. Fullerton, C.B., C.M.G., at that time senior consulting surgeon to the Boulogne Base. He first came under my notice as the result of a gunshot wound; the bullet had entered the right side of his face, penetrated the right antrum, fractured the septum, passed through the hard palate, missed the soft palate, and having entered the posterior wall of the pharynx about 1 inch above the cricoid cartilage had tracked down into the soft tissues, and was shown by X rays to be lying embedded in the muscles about 1½ inches below the cricoid cartilage exactly in the middle line.

Removal of the bullet would have had to be by an extensive dissection in the neck unless another method was found; it was desirable to avoid dissection, for the operation was bound to be followed by infection of the wound, since the bullet was lying in an abscess cavity. The latter fact was proved by the presence of a discharging sinus in the deep pharynx; the opening of this sinus closed from time to time, with the result that a swelling developed in that region and ruptured after a few days, with the free discharge of pus.

I was asked to see the case, and found, on examination with the laryngeal mirror, that there was a small sinus on the posterior wall of the deep pharynx in the middle line, from which protruded some small granulations. At Colonel Fullerton's suggestion I decided to make an attempt to remove the bullet with the Œsophagoscope, and had the patient removed to No. 54 London General Hospital.

A general anæsthetic was administered and an Œsophageal tube passed down until the opening of the sinus was reached; with great difficulty this sinus was enlarged and the tube passed down it until the bullet could be easily seen. This operation was a long and tedious one owing to the free oozing of blood from the granulations lining the wall of the sinus. The bullet was seized with forceps, and the tube, forceps and bullet slowly withdrawn; unfortunately, just as I was removing the instrument and the bullet the patient coughed violently, the smooth bullet slipped out of the forceps and was swallowed by the patient, but was passed per rectum four days later. The nasal opening of the antrum was enlarged under the same anæsthetic to allow of free drainage and portions of necrotic septal cartilage were also removed.

The patient made an uninterrupted recovery and was evacuated to England about three weeks later; in addition to the condition described he had also a gunshot wound in the right forearm, with a bad compound fracture of the radius and ulna.

I should like to express my thanks to Colonel Fullerton for referring the case to me, and to Captain A. T. Swan for the excellent way he administered the anæsthetic in what proved to be a long and difficult case.

A NOTE ON

PERIARTICULAR ABSCESS AFTER SCARLET FEVER.

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THE following case was observed at the Royal Waterloo Hospital, and is of sufficient interest to be recorded.

P.R., a female, aged 5 years, was admitted to hospital on Jan. 11th last suffering from a distinctly swollen right ankle, which was very tender and painful. The swelling extended to the knee; pain was felt all over this region and in the right hip. The child was pale and looked extremely ill; temperature on admission 99°6 F., pulse 130, and respirations 27; the urine showed a slight trace of albumin, but was otherwise normal.

The history showed that seven weeks previously she had been taken ill with scarlet fever and admitted to a special hospital for treatment. Nothing of importance was noted except a slight albuminuria, and also four weeks after admission a rash developed which was alleged to be chicken-pox. Shortly after this occurred the patient manifested pain in the right ankle, which became steadily more swollen and painful. She had suffered from whooping-cough a year previously and had continued to cough, more or less, since then.

Upon examination of the child, who looked distinctly toxic, the condition of the ankle and leg was as described above, the former being very swollen, red, and exquisitely tender and painful. Pitting was observed over the leg, and fluctuation was felt over the lower part of the fibula. A few râles were heard in the lungs. The albumin noted upon admission soon disappeared and did not return.

It was decided to open up the area of fluctuation and this was done by Mr. J. R. M. Whigham within two hours of admission. From 2 to 3 ounces of pus and blood were evacuated from around the anterior and external surfaces of the joint capsules. It was noted by the surgeon that the subjacent bone and ankle-joint were red and appeared to be involved. It was decided, however, to await developments for from 24 to 48 hours before opening into the joint cavity. The temperature falling at once and the swelling, pain, and tenderness greatly subsiding it was deemed inadvisable to do anything further. In short, the patient made an uninterrupted recovery and left the hospital on Feb. 7th looking really well and able to walk without pain. The pus grew *Streptococcus longus*. The chicken-pox (?) rash, which was still present on admission, had the appearance of a streptococcal rash, and was not chicken-pox.

The interest in this case is the peri-arthritis and septic rash occurring about five weeks after the onset of scarlet fever and the evident non-involvement of the ankle-joint in the septic process. The question occurs, Was the scarlet fever responsible for the above-mentioned condition? It would be of great interest to hear of others who have had experience of similar cases.

A CASE OF

DOUBLE DORSAL TRAUMATIC DISLOCATION OF THE HIP.

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ALTHOUGH the mention of a double traumatic dislocation of the hip conjures up visions of patients very seriously mangled and shocked, yet the record of the following case will show that, given the most favourable causative factors, such injury may be productive of little pain or shock and may necessitate only a short absence from a wage-earning existence.

William A —, aged 44, was admitted to Bermondsey Hospital on Nov. 8th, 1920, with a history of accident. He was working near a concreted pit about 22 feet deep, used for storage of coal at a gas works. The pit was practically empty and there was only a little loose slack coal lying at the bottom. A truck being pushed along hit him in the back and he fell into the pit, turning a complete somersault and landing in a stooping position on both feet with his legs slightly apart; after which he pitched forward on to hands and forehead. Hence the heads of the femora were subjected to a force consisting of the weight of the trunk, increasing with every yard fallen, and to my mind also increased by the somersault turned in mid-air, which would give an action like swinging a hammer. The loose coal acted as a shock absorber, and the stooping position favoured a dislocation. The man was raised from the pit on a stretcher with ropes tied to the four corners—a matter evidently requiring very careful supervision—and was brought straight to the hospital.

The patient was suffering very little from shock; there was a small cut on the forehead and considerable bruising of the right foot. I shall not forget the appearance of his lower limbs when the bedclothes were turned up. The inner borders of the patellæ were touching, and the feet were rotated inwards strongly. The thighs would flex slightly, but in an inwards as much as a forward direction. On the dorsum of the ilium each side could be felt a hard rounded tender lump. X-ray screening showed double dorsal dislocation of the hip, and with considerable difficulty I managed to get a photograph of the two hip-joints on the one plate. In view of the extreme rarity of the injury I was determined to obtain lasting evidence, and the plate¹ is now in the possession of the Museum of the Royal College of Surgeons of England. The os calcis was found to be fractured also, a piece having apparently been torn off by a sudden strain on the long plantar ligament. Under ether anæsthesia reduction of the dislocations was very easily effected by flexion, slight internal rotation, circumduction and external rotation, and finally extension. At the end of the circumduction and external rotation on each side reduction was felt to take place, and neither took longer than half a minute. Slight traction was made by hooking the right arm of the operator under the flexed knee of the patient, and counter extension was provided by an assistant pressing with the hands on the anterior parts of the crests of the ilia. The joints were rested for three days after reduction, and then massage and passive movements were commenced. The right foot was put up in plaster and the patient was allowed to take his discharge on crutches three weeks after admission.

On referring to the literature on the subject I find that the injury has been recorded about 30 times, the nearest description to the accident above recorded being a case of the late Mr. A. E. Barker's. The dislocation is practically always of a mixed type, and this is the only instance I can find of the double dorsal variety.

I am obliged to the chief medical officer, Mr. R. C. Harkness, for permission to publish the case.

¹ We have seen a print which bears out the author's contentions, but which cannot be effectively reproduced.—ED. L.