Original Articles.

A CASE OF ADDISON'S DISEASE WITH
AUTOPSY.¹

REPORTED BY HALL CURTIS, M. D.

THE following notes were given me by the patient's son, a medical student: —

Mr. J. B., fifty-four years old, had an attack of pleurisy about ten years ago and recovered well; with this exception he has been well and strong; weight about one hundred and eighty pounds. First began to complain about May 1, 1881, of exhaustion after rising in the morning and of difficulty in dressing himself, requiring frequent rests. For some little time previously he had not had much appetite and was probably losing flesh, though not marked at the time.

From May 1st till July 1st, he lost flesh rapidly, the greater part being lost during three or four weeks in May. During May had little or no appetite, and remained at home part of the time, although able to go down town occasionally (during March and April he had been very busy and frequently drove down town at 6.30 A. M., not getting back until dinner at six).

• Was somewhat nervous and restless at night. The only prominent symptoms, loss of flesh and strength, and peculiar color, once or twice looked very yellow.

May 6th. Urine carefully examined. No albumen. Color normal; specific gravity 1015; sediment slight; reaction acid; uph. + u. n. cl. n. e. p.; ind — a. p. n.: albumen absent; bile pigments absent; sugar absent; sediment, nothing abnormal; amount about 425 centimetres; no casts, bile, or sugar detected, amount in twenty-four hours about normal. Sometime in May Dr. Ellis saw him; after examination could discover nothing behind the anæmia, and prescribed quinia and gentian. About June 1st came to the shore, and there remained at home most of the time, going in town occasionally. Took milk and all the nourishing food possible, and appetite improved somewhat, and also color. About July 5th, saw Dr. C. D. Homans at his office in town. Nothing new outwardly since Dr. Ellis saw him, no pain anywhere, no gastric symptoms, bowels regular, sleeps better than in May. July 25th. Urine examined again with negative result. Color normal; specific gravity 1011; odor normal; sediment slight; reaction acid; albumen very slight trace; bile pigments absent; sugar absent; sediment — very few hyaline casts, considerable number of spermatozoa, and in twenty-four hours 1650 centimetres (a little above normal); total amount of urea 29.37 grains. "Thought by Professor Wood of little moment." No cough, but no better, and able to make less exertion without fatigue. On slight exertion liable to a feeling of "faintness," but never lost consciousness. Dr. Homans prescribed iron, quinia, etc., as much food as possible, and some other suggestions were made.

On July 29th, as Dr. Homans considered him very sick, Dr. Edes saw him in consultation with Dr. Homans at the latter's office.

Thorough examination was made with no result as to diagnosis, though Dr. Edes suggested the possible existence of Addison's disease from the discoloration of the face.

¹ Read before the Section for Clinical Medicine and Pathology of the Suffolk District Medical Society, April 8, 1882.

Dr. Edes examined the blood and found, he said, not "an excessive degree of anæmia." "I think the number of red globules was about four million to the cubic millimetre. (Normal five million.) There was not any deformity observed in their shape nor was there an excess of the white."

Since then he has not been away from home except a short distance to drive, and on the water. Taken Wyeth's vinum cibi et ferri cum cinchona and Fowler's solution. The latter proved too irritating and was omitted a week ago. Slight looseness of bowels occasionally. Saturday, August 20th, had diarrhœa for first time, without pain; taking during day milk and lime water, and a little brandy.

During last two weeks has had less appetite and has again become restless at night, for which has taken bromide of potassium with some apparent relief.

Dr. Graham, at the suggestion of Dr. Homans, had treated him four times with massage. By his kindness I am able to read you extracts from his notes on the case.

August 13th. J. B. since May has lost twenty-five pounds in weight. His face has a grayish, tanned, sallow appearance, and but for the normal redness of his lips and tongue, one would also think he was anæmic.

On awaking in the morning there is some stiffness of the legs in the usual easy semi-flexed position, so that it is with difficulty and discomfort that he extends them in bed before getting up, but after walking across the floor a few times this entirely disappears, and does not return during day.

He gets up regularly every morning in spite of the feeling of weakness, which is his most troublesome symptom, and which obliges him to lie down and rest once or twice while dressing himself. This feeling of weakness continues all the forenoon, growing less until he has his lunch about twelve or one o'clock, after which he is at his best, but still greatly below par. There has been no perspiration on his skin since last May.

There is at times slight thickness of speech and difficulty of articulation, but this is scarcely perceptible. . . . At the first application, on the 13th of August, the patient had forty minutes of massage, consisting of upward and circular friction, deep manipulation, and passive motion of the joints, the deep manipulation occupying about half the time of the whole procedure. The friction and passive motion about one fourth of the time. This was between eight and nine A. M. before his usual time of rising.

On the 15th, Dr. Graham learned that when he arose on the morning of the 13th, he had no feeling of stiffness in his legs, and that during the following days he had several times perspired naturally. On the 15th and 17th the patient again had massage applied in a similar manner, with a like result to the first application. Two days intervened before the fourth and last massage on the 20th. The patient quietly remarked that he thought an omission of the massage for two days was rather long, as he had missed the tonic and sedative effect of it.

The influence of massage in this case was marked in improving the capillary circulation and restoring the perspiratory function of the skin, and also in reawakening the muscles, nerves, and spinal cord to their normal function.

The diarrhœa continued through Saturday, and on

Sunday, August 21st, he was seen by me for the first time. During the past thirty-six hours he had been troubled with frequent dejections, thin and yellowish, no blood or mucus, and without much pain (at this time there had been many cases of nausea, vomiting, and diarrhoea along the shore). He complained especially of flatulence and distention of stomach and abdomen, particularly in the course of the colon; the abdomen was retracted, but resonant over large intestine, and not tender. The hands and feet were quite cold. The face was quite dark, almost a copper color, with many purpuric spots and points. On the forehead were large, irregular patches of color of a deeper brown. The eyes were sunken, conjunctivæ slightly congested, and with a tinge of yellow; under the eyes the pigment was nearly black. The deep color of face extended half way down the neck, gradually fading in depth of shade. The hands were quite dark, with spots and flecks of a deep chocolate color, ceasing abruptly just above wrists; the inside of the elbows showed a deposit of pigment, which was also very marked on the outer aspect of the joint.

Treatment consisted in a hot rectal douche three times a day, followed by starch and laudanum enema (fifteen drops to half an ounce), Hoffman's anodyne, one drachm three times a day, hot fomentations to abdomen, hot bottle to feet, claret, glass of milk with two teaspoons of lime-water every two hours.

Monday. Pulse 120; patient has had three dejections in past twenty-four hours; slept pretty well; abdominal flatulence relieved; now complains of distress and pain in left side from nipple to edge of ribs, which becomes worse towards morning, caused by the dilated stomach; frequent yawning; hands still cold; tongue clean, except at posterior part, and marked with deep, transverse furrows; nervous at times during night; hyperæsthesia of back, followed by flatulency. Before the flatulence became troublesome was much annoyed by severe itching over shoulders and back; this has not been spoken of since the distention.

Tuesday. Last night was very much disturbed by pain in left side of chest; relieved by Dover's powder and mustard paste; past twenty-four hours one dejection with scybala. *R* Zinci valerianatis, one grain, every four hours at night; chloroform, one ounce, aqua, four ounces; teaspoonful when flatulence is troublesome. The teeth were prominent; the gums were retracted, unhealthy, with abundant dirty gray deposit of tartar. *A few lines from the junction of the mucous membrane and skin of each lip was a waving line of black pigment following the lip curves*; pulse 120; temperature 100° F.; has dyspnoea at times in morning after exertion; no palpitation or cardiac distress; no headache; sight at times troublesome, with "black specks floating," always myopic; no cough; chest resonant, and respiration clear throughout; hyper-resonance begins two inches below left nipple, and extends half way to navel (stomachal distention); heart sounds feeble, distant, without soufflé, apex beat just below nipple; liver dullness in mammary line normal; spleen not enlarged; abdominal aorta pulsating strongly along left side of umbilicus.

Wednesday, August 24th. Quiet day and night, three dejections after brandy and Apollinaris; one dejection this A. M. more natural; was very restless at three A. M.; was relieved by zinc; the flatulence, distention, and consequent nervousness were relieved by the zinc and chloroform; took food well; was on couch part of day,

also this morning; temperature yesterday evening and to-day 97° F.; pulse 120; hiccough at visit, accompanied by marked succussion in stomach; still complains of pain one inch below nipple; colon much less distended.

Thursday August 25th. Temperature 97.2° F. last night and this morning; pulse very rapid and feeble; patient dull, constantly yawning; mind quite clear; passed urine freely this morning; wandered a little early this morning, possibly from Dover's powder given at two A. M. (?).

Friday, August 26th. Yesterday quite restless, going often from bed to couch; took more milk and broth; no dejection yesterday, one this morning; no distress from abdominal or stomach distention; slight delirium; yesterday and last night not so strong; restlessness relieved by zinci valerianate, one grain, at six and eleven o'clock P. M.; last night temperature 98.3° F., to-day, A. M., 98.2° F.; pulse 112; yesterday erythema on nose and right ear, none to-day; now rational, but torpid; eyes often closed; tongue more coated; voice at times inaudible; extremities cold; pulse very feeble and compressible; abdomen generally tympanitic except at left of navel; stomach resonance begins at seventh rib; epigastrium depressed; left hypochondrium full.

Saturday, August 27th. Yesterday was very restless, picking at bedclothes; low, quiet delirium; took food freely; during night was especially restless, constantly sitting up, and wishing to leave bed; no relief from zinc; became quiet at one A. M., after bromide of potassium, twenty grains; one dejection past twenty-four hours; abdomen generally tympanitic and full; this morning the joints of legs were stiff, and he was unable to flex them; pulse feeble; voice weaker; arms cold nearly to elbows; feet and ankles cold; complexion darker; no albumen in urine.

Sunday, August 28th. Yesterday he passed a quiet day, taking nourishment freely, requiring no sedative; now decidedly weaker; pulse 128; respiration 32 to 36; intellect duller; voice very faint; one dejection since yesterday A. M.; mouth half open; tip of tongue dry and glazed; passed urine freely this morning; temperature in axilla last evening 98.3° F. Seven P. M. Has been quiet without complaint; delirium constant but quiet; temperature 99.3° F.; hands and arms abnormally warm; legs cold; pulse 130; respiration 40; eyes closed; pupils respond to light; does not reply to questions; has passed urine twice; unable to drink or unwilling; fed with a spoon.

Monday, August 29th. Had tranquil night; refused food; died this A. M. at 9.40 without a struggle.

An autopsy was made twenty-four hours after death by Dr. Cutler.

Lungs. Right entirely adherent from old inflammation. Left adherent at apex. Dependent parts of both lungs posteriorly congested. Bronchi healthy. Right lung more injected than left. A gland softened from old inflammation was found just outside of bronchus.

Heart atrophied; color good; consistence normal. Valves healthy with exception of a vegetation, not large enough to give rise to symptoms, on one of the curtains of the aortic.

Spleen four by three and one half inches; capsule moderately tense; color good; consistence normal.

Peritonitis old and limited on right and left sides of abdomen, also in pelvis.

Kidneys not abnormal.

Liver simply atrophied.

Intestines not abnormal.

Aorta slightly atheromatous.

Left supra-renal body was not disorganized; altered in shape from the well-known cocked hat to an irregular, lobulated appearance, the largest lobule size of a Lima bean. On section yellowish gray, homogeneous surface, with caseation, here and there softening; the size of organ but slightly increased.

Right supra-renal body presented the same appearances, only more marked; the largest lobule at top of gland size of end of thumb.

PSEUDO-MEMBRANOUS LARYNGITIS COMPLICATING TYPHOID FEVER AND CAUSING DEATH.¹

BY E. W. CUSHING, M. D.

WITH PRELIMINARY HISTORY OF THE CASE BY W. B. C. FIFIELD, M. D.

On February 12, 1880, I was called in consultation by Dr. W. C. B. Fifield, to see a case of œdema of the larynx, as was supposed, of the previous history of which he has kindly written the following account.

"The patient, aged eighteen years, was seen for the first time on February 2, 1880. She had been complaining of fatigue and lassitude, accompanied with obscure abdominal pains for a week previous. The following points were then noticed, namely, tenderness on pressure over abdominal region, moderate distention, gurgling in the right iliac fossa; pulse 110; morning temperature 103° F.; evening 104° F.; slight diarrhœa; February 3d, two or three loose stools during the night; pulse 112; morning temperature 103° F.; evening 104° F. Still some tenderness of abdomen; tendency to diarrhœa. February 4th, pulse 112; temperature, morning 104° F.; evening 102° F.; diarrhœa. February 5th, morning temperature 103° F.; evening 104° F.; pulse 120; diarrhœa. February 6th, morning temperature 103° F.; evening 104° F.; diarrhœa; pulse 120. February 7th, temperature, morning 104° F.; evening 104° F.; pulse 120 per minute. This day rose spots were first noticed on chest and abdomen; diarrhœa. February 8th, Sunday, morning temperature 104° F.; pulse 130. Same condition of bowels, for which lead and opium pills were ordered. Evening, Dr. Stedman saw the case on account of my being too ill to visit her. Temperature 105° F.; pulse 130. Diagnosis of typhoid fever confirmed. February 9th, morning temperature 103.4° F.; pulse 120; less diarrhœa. February 10th, seen again with Dr. Stedman; pulse 120; morning temperature 105° F.; evening temperature 102° F.; pulse 110. Rose spots abundant; no diarrhœa. Complaints of roof of mouth being sore. Nothing to be seen either by Dr. Stedman or self. February 11th, morning temperature 104° F.; at one o'clock had fallen to 102° F. Still complains of roof of mouth. Nothing to be seen. Snoring respiration as if from nasal obstruction. Expectoration of purulent fluid. February 12th, morning temperature 104° F.; pulse 140. Difficult snoring respiration; cheeks purple; labored breathing. Seeing the impending suffocation I thrust my finger into the pharynx and immediately felt the

epiglottis, erect, stiff, and much swollen on the right; the swelling very hard: the whole rim of the glottis also seemed invaded by hard œdema. No membrane or deposit had ever been seen in the pharynx or upon the tonsils. A profuse discharge of muco-purulent matter followed the withdrawal of the finger with partial relief to the patient. Believing that I was in the presence of that very rare complication of typhoid fever, œdema laryngea, I telegraphed Dr. Cushing to come at his earliest convenience and to act independently, as my presence was required at the hospital for a tracheotomy there. At noon, Dr. Cushing not having arrived, I declined to do tracheotomy, on the ground that the young lady would probably not survive the operation, the pulse having risen to 160 per minute, and the labor of respiration not being sufficiently severe to momentarily threaten life. That I did not attempt it I deem fortunate, for at the post mortem the thyroid gland was found to so completely cover the trachea that one must either have cut directly through its substance or have levered it up with the handle of the knife; in either way I think there would have been bleeding enough to have put out the flickering life long before the operation had been completed. Alexander Tweedie, in his Lectures on Fevers, when speaking of œdema laryngea as a complication of typhoid says: "I have proposed tracheotomy in these cases, but never found any surgeon bold enough to perform it under so hazardous circumstances." Yet I imagine that Dr. Tweedie's cases were not parallel with mine. Somebody has spoken of laryngotomy as applicable. I cannot think that it would have advantaged in my case. Dr. Cushing will relate the appearances as he saw them, both in the living and in the dead body. I will only add that death took place very quietly at 9.30 o'clock the evening of February 12th, and that after the funeral on Sunday, the 15th, an older sister, who had been in the house during the last few days, came to me with well marked diphtheritic membranes on both tonsils. (Query. Does the thyroid gland become enlarged in typhoid?)"

On arrival I found the patient very weak, but perfectly sensible, and able to bear a laryngoscopic examination, which was made as she lay in bed by reflecting a clear north light which was increased by a field of snow. No spots were visible in the fauces or on the palate; the epiglottis was distorted to the right, much swollen, very red, and in such a position as to cover the glottis and obstruct the view.

The upper part of the larynx was also red and swollen, looking hard and firm, and clearly it was not a case of simple œdema. There was no membrane anywhere visible, and no record of the expulsion of any. The sputa when examined seemed simply muco-purulent, and although there was an account of paroxysms of dyspnœa succeeded by the expulsion of a large amount of secretion, I had no suspicion of the real nature of the case. There was some dyspnœa, but no sign of laryngeal obstruction, and therefore no indication for operative interference, even if it had not been contraindicated by the great prostration.

I expressed the opinion that the case might probably be one of perichondritis of the larynx, although a certain diagnosis was impossible. The young lady died the same evening of exhaustion, not of suffocation from any laryngeal obstruction.

At the autopsy there were unmistakable evidences of typhoid fever. The small intestine was studded

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