

# A Mirror

## HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum, tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

### KING'S COLLEGE HOSPITAL.

THE TREATMENT OF PNEUMONIA, ILLUSTRATED BY  
SOME RECENT CASES.

(Under the care of Dr. JOHNSON.)

THE subjoined cases, for the notes of which we are indebted to Mr. Barrow, medical registrar, present many aspects of clinical interest. Both patients seem to have contracted their illness on the same day, and both from the same cause—exposure to wet. In both instances the symptoms began abruptly on the morning following the exposure, but from the very beginning the male patient was evidently more profoundly affected than the female. In the former, sharp stabbing pain in the left side, rapidly followed by shortness of breath and cough, was one of the first indications of disease; in the latter, pain in the (right) side, shortness of breath and cough, did not occur until the second day. From this time the two cases had very little in common. In the man the respirations were very rapid (64), the dyspnoea extreme, the cough was troublesome, and accompanied with copious rusty-coloured sputa; in the woman, on the other hand, the respirations, although rapid (50), were 14 per minute less than those of the man, the cough was occasional only, and unaccompanied by visible expectoration; doubtless the patient swallowed the sputa. The physical signs, too, were in many respects different. In the former there was tubular breathing in the supra-mammary region, and bronchial breathing and bronchophony at the back, but no moist sounds could be detected, and the vocal fremitus was markedly diminished; in the latter, neither bronchial breathing nor bronchophony could be heard, but numerous loose crepitant râles were audible all over both the back and front, and the vocal fremitus was scarcely perceptible. But the greatest difference between the two cases was manifested in their subsequent course and progress. The man's condition soon became alarming, and rendered the indications for speedy relief most pressing; the woman in a short time began steadily to improve on a mild expectant plan of treatment. Venesection seemed to be imperatively demanded to relieve the embarrassed respiration, and to diminish the venous engorgement of the lungs and the bronchial veins, the marked benefit which at once accrued affording the best possible confirmation of the propriety of the procedure.

In addition to some clinical remarks by Dr. Johnson, we hope next week to publish the notes of a case of double pleuro-pneumonia, attended by excessive pleuritic pains which were greatly relieved by the application of leeches.

**CASE 1. Acute pneumonia; great dyspnoea; venesection; immediate relief; recovery.**—Henry M—, aged thirty-five, a strongly built and previously healthy man, was admitted Nov. 22nd, 1876, with pneumonia. He gave the following account of his illness. On Nov. 18th he got his feet very wet, and during the afternoon of the next day he was suddenly seized with a sharp stabbing pain in the left side, and became very faint and dizzy, so that he was obliged to go to bed. Soon after he noticed that his breath was getting very short, and he began to cough. On the 20th the shortness of breath and cough had greatly increased, and were now accompanied with a brown-coloured frothy expectoration; the patient also complained of feeling very hot and feverish. This state continued, preventing sleep almost entirely, until his admission, when he was found to be very prostrate and suffering from dyspnoea, the breathing being 64 per minute; his face was dusky, and the lips were livid; cough was very troublesome, and accompanied by a rusty-

coloured liquid expectoration. There was diminished expansion of the left side, with dulness on percussion all over back and front, a tubular note being obtained in the supra-mammary region. Loud bronchial breathing and bronchophony were heard at the back, but no moist sounds could be detected. In front the breath-sounds were very indistinct. Vocal fremitus was markedly diminished. On the right side the breathing was puerile. The heart-sounds were feeble; pulse 106, and rather tense; temp. 103.4°; skin hot and dry; urine high-coloured and scanty, chlorides not diminished. He was ordered a mixture of acetate of ammonia, six ounces of brandy in twenty-four hours, and a diet of milk and beef-tea. Linseed-meal poultices were applied to the left side.

Nov. 23rd.—Condition unimproved. Did not sleep at all during the night. Respiration 64. Twelve ounces of blood taken from his right arm, with the effect of reducing the respiration to 44 per minute, and of relieving the sense of dyspnoea to a considerable degree.

24th.—He appeared much more comfortable than yesterday morning. Respiration 54; pulse 108; temperature 102.4°.

From this time he gradually improved, and on the 26th the temperature had fallen to 99.4°, and all the other symptoms had much improved. Dry crepitant sounds also were heard over the left lung, but the physical signs were otherwise unchanged.

Dec. 2nd.—Vesicular breathing heard over the left lung, except at the base, where it is still bronchial. Sputum thick and muco-purulent, not rusty.

His convalescence was uninterrupted except by a rise of temperature to 103° on Dec. 6th; the temperature returned to the normal on the following day, and did not again exceed the healthy standard.

**CASE 2. Acute pneumonia; recovery.**—Harriet P—, aged seventeen, a well-nourished girl, was admitted Nov. 22nd, 1876, with pneumonia. She was much exposed to wet on the 18th, and on the morning of Nov. 19th she was taken suddenly ill with shivering, headache, and sickness. Next day (Nov. 20th) she felt a pain in the right side, became very short of breath, and began to cough; she was very thirsty, lost her appetite almost completely, and felt burning hot. A rather profuse diarrhoea also occurred, but only lasted one day. These symptoms continued with slight increase until her admission into the hospital.

On admission she had a bright flush on the right cheek, and seemed much distressed in breathing, the respiration being fifty per minute, and she coughed occasionally, but did not expectorate anything. On the right side of the chest there were diminished expansion, dulness on percussion, and loose crepitant râles, audible both with inspiration and expiration, all over both back and front. The breathing was harsh and the voice-sound's increased, but neither bronchial breathing nor distinct bronchophony could be heard; the vocal fremitus was scarcely perceptible on either side. On the left side the breath-sounds were exaggerated and accompanied by a little crepitation. Pulse 135; temperature 103.4°; skin dry and hot; urine scanty and turbid with lithates; chlorides not diminished. She was ordered a mixture containing acetate of ammonia; a little brandy, and milk and beef-tea diet.

The symptoms continued unabated and the signs unchanged until the morning of the 24th, being five days from the first shivering, when the temperature was found to have fallen to 98.8°, and the symptoms to have considerably subsided, the physical signs remaining about the same. On the 26th the temperature was below the normal, and continued so for two or three days. The physical signs gradually returned to the normal, and she was discharged convalescent on Dec. 9th.

### LONDON HOSPITAL.

DISLOCATION OF FOOT INWARDS, WITH FRACTURE OF  
LOWER END OF TIBIA.

(Under the care of Mr. REEVES.)

IN consequence of the ambiguity of the terms employed by different writers on surgery, the descriptions of dislocations of the ankle-joint are not unfrequently very confusing and even conflicting. For instance, Sir A. Cooper

always spoke of dislocation of the tibia or tibia and fibula; while others, and especially the eminent French surgeons Petit and Boyer, referred the displacement to the foot or to the astragalus; and many recent authors have perpetuated the confusion by adopting one or other classifications exclusively. In conformity with the more modern and generally accepted nomenclature, the dislocation should always be described as affecting the distal and more movable portion of a limb, although the followers of Sir A. Cooper might very fairly claim that in cases like the subjoined the dislocation really does affect the tibia and fibula, because, the foot being firmly fixed upon the ground at the time of the injury, the tibia and the fibula are driven outwards by the force of the direct violence.

For the following notes we are indebted to Mr. Fredk. Treves, house-surgeon.

The subject of this somewhat unusual accident was a brewer's cooper, a heavily-made man of somewhat enfeebled health from excessive drinking. He was, however, sober at the time of the accident, which occurred in the following manner:—The patient was standing in the yard while near him a man was swinging round a "bed," or oval pad of about twenty-eight pounds weight, used for breaking the fall of casks. The "bed" slipped from the man's hand, and struck the patient with much force on the inner side of the right leg, about its middle third. The patient at once fell, exclaiming that "his foot was out," and was at once carried to the hospital on a stretcher. He had on heavy "bluchers" at the time, but of such capacity that the boot was easily removed from the injured foot by simply loosening the laces. On examination, a distinct bruise was seen on the inner side of the right leg at the point struck by the "bed," so that from the direction of the force the case appeared to be one rather of dislocation of the tibia outwards. The foot was carried inwards, so that the interval between the second and third toes was in a line with the inner margin of the patella; the dorsum was directed outwards, and the sole so turned inwards that the foot appeared to rest almost entirely on its outer margin. The foot was nearly at a right angle with the leg, and there was but a very trifling pointing of the toes towards the sound limb, so that its long axis differed but little from the normal. On the outer side was a large projection caused by the very prominent external malleolus, which, at its extremity, threatened to come through the skin, but it was not fractured, the whole fibula being quite intact and unaltered in position. So extremely was the sole of the foot twisted inwards that, in the sitting posture, the limb appeared to rest on the external malleolus. On the inner side there was a still larger projection, at the most prominent part of which the tip of the internal malleolus could be felt, while at the point where the swelling joined the leg crepitus was present. The symmetry of the heel was unaffected, and none of the tendons about the part appeared to be abnormally stretched. There was no great amount of pain, but, of course, total inability to move the foot. forcible extension failed to reduce the dislocation, but reduction was effected under the influence of chloroform, although not without difficulty. The patient remained in the hospital three weeks, the foot being fixed by a splint, and an ice bag kept on; at the end of that time the limb was put up in gum and chalk, he was made an out-patient, and had good use of the foot two months after the accident.

It would appear that in this case there was an oblique fracture extending from the base of the internal malleolus obliquely downwards and outwards to the articular surface, so as to completely sever, not only the whole of the internal malleolus, but some portion also of the articular surface of the tibia. As the blow was on the inner side of the leg this fragment would appear to have been broken off by the internal malleolus having been violently driven against the astragalus, which, together with the rest of the foot, was firmly fixed at the time of the accident. The fragment was displaced considerably inwards as regards its tip or lower extremity (a result of the direction of the force), and into the angle formed between the displaced fragment and the remaining portion of the lower end of the tibia the astragalus, together with the whole of the foot, was drawn up.

## BRISTOL ROYAL INFIRMARY.

TUMOUR OF THE LEFT SIDE OF THE CEREBELLUM;  
AMAUROSIS; PARAPLEGIA; SPINAL LESIONS.

(Under the care of Dr. EDWARD LONG FOX.)

THE subjoined case, beyond presenting many features of extreme clinical interest, has, as explained by Dr. Fox, an important bearing on the question of the coexistence of paraplegia with one-sided lesions of the cerebellum.

Emily T—, aged forty-five, married. On admission she had been suffering for twelve months with intense headache, and for two months had been quite blind. The pain in the head seemed to begin in the temporal regions, and to go round to the occiput. She had partially lost the senses of hearing, taste, and smell on the left side only. The right eye showed optic neuritis, the left well-marked atrophy of the disc. She walked with some difficulty, and suffered much from cramps in the legs.

She lived two months in the infirmary, and gradually lost all power over the sphincters, and became absolutely paraplegic. The upper extremities were not implicated.

*Post-mortem examination.*—On removing the dura mater cerebri, there was some lymph lying over the membranes of the convex surface. A large gliomatous tumour was attached to the anterior border of the left lobe of the cerebellum. At its outer side the tumour had become myxomatous. On section it was tolerably firm, with several small hæmorrhages in its substance; and the inner side of the tumour was just beginning to be myxomatous. The pons Varolii was much flattened on the left side from the pressure of the tumour, and the left fifth nerve was compressed. The lateral ventricles were full of fluid. The spinal cord looked to the naked eye healthy; but, after the usual preparation, it showed a large growth of connective tissue throughout a great portion of the cord, especially marked in the upper dorsal region. This connective-tissue growth existed throughout the entire structure of the cord, but it was best seen in the white substance, and perhaps more in the posterior than in the antero-lateral columns. Many of the bloodvessels were somewhat thickened. Some few of the nerve-cells were granular.

*Remarks by Dr. E. L. Fox.*—As Dr. Brown-Séquard has given a series of most interesting cases in which lesion on one side of the brain was accompanied by paraplegia, I venture to think that this case would have added another illustration to his views *had the spinal cord not been examined*. It does not seem that the cord had been examined in a large majority of cases quoted by Dr. Brown-Séquard in THE LANCET of Sept. 30th, 1876. I am far from saying that lesion on one side of the cerebellum may not induce paraplegia. I only say that most of the cases so quoted by Dr. Brown-Séquard prove nothing, because the condition of the spinal cord was not investigated. In seeking to effect a total revolution in the explanation of the connexion between nerve lesion and nerve phenomena, it would be well to draw conclusions only from those cases in which the chief nervous centres have been carefully explored.

## NORTH STAFFORDSHIRE INFIRMARY.

CASE OF RUPTURE OF AORTIC VALVE.

(Under the care of Dr. ORTON.)

THE following case, for the notes of which we are indebted to Dr. M'Aldowie, house-physician, is interesting alike from the unmistakable character of the evidence of the cause and nature of the injury, and the peculiar symptoms which supervened.

James C—, aged forty, married, was admitted on Oct. 19th, 1876. He had always enjoyed good health, never had had rheumatic fever, or any other severe illness. At Christmas, 1875, while lifting a heavy weight, he felt something suddenly snap in his chest. He immediately fainted, and was conveyed in an unconscious state to the Liverpool Infirmary, remaining insensible till next day. Ever after the accident he could hear a sound in his chest, which he described as like a "pigeon cooing." About a week after the injury he had a severe attack of cough and hæmoptysis. The cough did not trouble him for more than about three