

Thus of twenty-one cases recently examined the sign is recorded as specially marked in four only; in twelve instances the upper epiphysis of one humerus appeared, on careful comparison of the two sides, to be fuller and thicker than the normal; in seven, both, although the basis of inference was then necessarily unreliable; in two only—both atrophic—were the results of examination purely negative.

I am aware of the categorical contradiction, by no less an authority than Dr. Samuel Gross,³ to my report of the above symptom. I have, however, been in the habit of demonstrating it in the out-patient room since 1880, and am well satisfied of its existence in a large proportion of the cases.

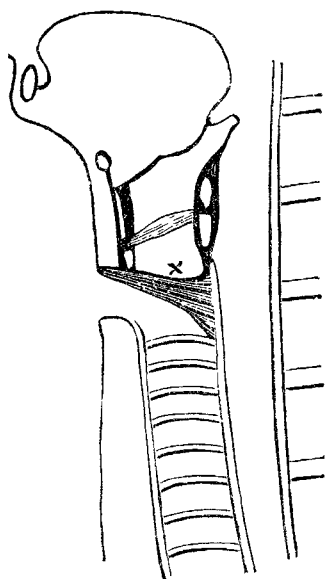
(To be concluded.)

NOTE ON THE TREATMENT OF TRACHEAL STENOSIS BY A NEW T-SHAPED TRACHEOTOMY TUBE.

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THE good results obtained by intubation in the cases of tracheal obstruction following tracheotomy recorded by Messrs. Pitts and Brook in THE LANCET of Jan. 10th show the value of that method of treatment in such cases. There is, however, another class of cases—viz., suicidal wounds of the trachea occurring in adults—in which the wound of the air-tube is always a transverse one; such cases are often only seen late in their history, and after cicatrisation and constriction have advanced to a considerable degree, and are correspondingly difficult to treat. In such a case I have found the T-shaped tube described below very useful, not indeed affording complete cure, for the tube has still to be worn, but rendering the patient's condition very comfortable, enabling him to talk and earn his living. The patient, a man aged fifty-two, "cut his throat" six months ago; the transverse wound completely divided the trachea below the cricoid; suppuration occurred, and dyspnoea came on three days afterwards; this was relieved by the introduction through the wound of an ordinary bivalve tracheotomy tube, and this he has never been able to leave out for any length of time since. On examination six months later, respiration was carried on entirely through the tracheal opening, the larynx being entirely shut off by a tough skin-like septum, which completely blocked the trachea at the upper level of the opening. The voice was of course absent. It was evident that free removal of the obstruction must be the first step, and this was done by first enlarging the opening downwards, and plugging the trachea with a Trendelenberg's cannula. The cricoid was then divided in the middle line, and the larynx laid open above the obstruction. (See engraving.) In this way the limits

VERTICAL SECTION OF LARYNX.

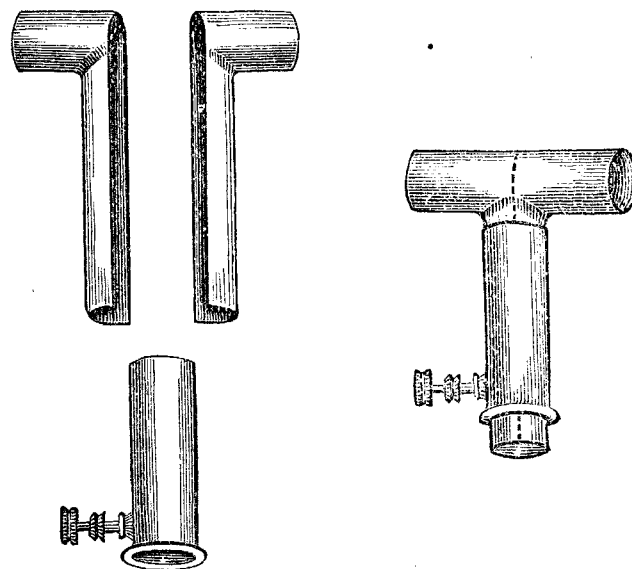


x, Fibrous septum.

and attachments of the membrane were made out, and it was cut away with scissors. The part attached to

the posterior wall of the trachea was very hard, almost cartilaginous, and had to be smoothed off with cutting forceps. The problem now remained how to keep the reopened channel patent and prevent reobstruction. For the first few days a piece of indiarubber tubing was worn entirely in the trachea, with a lateral opening opposite the tracheal opening, and secured by two threads. This, however, soon clogged with mucus; and as the outer opening contracted, its introduction became more and more difficult. After many trials and several disappointments I had the metal tube made in two halves, with a removable collar and screw. (See engraving.) This the patient now

T-SHAPED TRACHEOTOMY TUBE.



introduces easily himself one half at a time, and these, when held together by the collar and screw, form one rigid T-shaped tube, of which the long or tracheal portion passes through the cicatrising portion of trachea and keeps it patent; by blocking the outer opening with a plug of cork or the finger respiration is quite natural, and the voice clear and distinct. The patient has now worn the tube some months without any discomfort or sign of tracheal irritation. In this case the tendency to cicatricial encroachment was so great that I think it would have recurred whenever any tube was discontinued, even an intubation tube—in fact, he wore at one time a tracheotomy tube with the curve upwards, passing through the constricting ring; but in a short time, while wearing this, constriction began at the lower angle of the opening, by an encroachment all round of granulation tissue, leading to urgent dyspnoea until relieved by the downward tube. The T-tube combining the dilating advantages of an upward and downward tube was introduced in two halves, to get over the difficulty of introduction. If compelled, at any rate for some time, to wear some sort of tracheal dilator, the T-tube has the advantage over the intubation tube of allowing phonation. In these cases, then, of obstruction after transverse suicidal wound the T-tube will, I think, prove useful, and if not necessarily permanently, perhaps as a commencement before beginning intubation. It may be also that when healing is complete—that is, when skin and mucous membrane have joined all round and left no granulating and encroaching edge,—the T-tube might be discontinued, when the outer opening would soon comparatively close, though leaving a small aerial fistula. The tube was made for me by Wood of Leicester.

Leicester.

THE NORTH OF ENGLAND SURGICAL AID SOCIETY.

The annual report, in reviewing the work of this Society for the year 1890 (the second year of its existence), points with satisfaction to its augmented usefulness. In the nine months of 1889 forty-nine appliances were supplied; in the same proportion last year the number would have been sixty-six—the actual number was 121. The work has hitherto been carried on free of cost in rooms in the infirmary, but the committee have been compelled to begin the year by appointing (with the consent of the governors) one of the house surgeons of the infirmary to do the work previously performed by a subcommittee. The financial position renders necessary an appeal for funds to meet the increasing demands upon the Society.

³ International Journal of the Medical Sciences, March and April, 1888.