

# A Mirror OF 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.

## VICTORIA HOSPITAL FOR CHILDREN, CHELSEA.

### TWO CASES OF ACTINOMYCOSIS OF THE SKIN IN CHILDREN.

(Under the care of Dr. WALTER CARR, Mr. RAYMOND JOHNSON, and Mr. D'ARCY POWER.)

FOR the notes of the case we are indebted to Mr. A. H. Curtis, house physician.

CASE 1.—A girl, aged nine and a half years, was admitted to the Victoria Hospital for Children, Chelsea, on April 28th, 1904, under the care of Dr. Walter Carr. She had been in bed for seven weeks under the care of a medical man who had treated her for muscular rheumatism and endocarditis. She had also suffered from several attacks of breathlessness and cyanosis. A swelling was first noticed on her chest a month before admission. It was tender and increased rapidly in size until, on April 18th, it broke down in several places and began to ulcerate. The child lived comfortably and amidst healthy surroundings. There were no stables near the house nor had she had access to any corn through



CASE 1.—From a photograph by Mr. E. S. Worrall, radiographer to the hospital.

which she might have become infected. The patient was a pale nervous girl, well nourished, but rather flabby. There was no enlargement of the axillary or cervical glands. On the chest there was a swelling of uneven shape beginning at the lower end of the sternum, extending to the anterior axillary line and involving the nipple. It was ulcerated in several places, the ulcers measuring from half to three-quarters of an inch across. They bled easily and in several places there was a slight purulent discharge. The swelling was extremely tender to the touch and gave

no sense of fluctuation. The skin over it was of a purple-red colour, gradually fading to white at the edge. The neighbouring veins were dilated. Examination of the chest showed that the cardiac impulse and the area of dulness were obscured by the swelling. The heart sounds were normal except for a systolic murmur over the pulmonary area which was conducted upwards to the clavicle. Very rough friction sounds were heard during inspiration at the base of the right lung, extending from the back into the axilla. On May 5th a fresh focus of the disease, which rapidly increased in size, was noticed in the left mid-axillary line over the seventh and eighth ribs. The percussion note round the swelling was dull and some friction was heard on auscultation, though the friction at the right base had almost disappeared. The child at this time suffered almost daily from short attacks of breathlessness and cyanosis. The purulent discharge increased in quantity and the yellow grains characteristic of actinomycosis were clearly visible. The ray formation was demonstrated under the microscope by Gram's method of staining. The patient was given potassium iodide from the fourth day after her admission to the hospital. The dose at first was five grains and it was increased by two grains every third day until she was taking 90 grains a day. The result of this treatment proving unsatisfactory an operation was thought advisable and on June 10th the patient was placed under the care of Mr. Raymond Johnson. The sinuses were probed, and one going deeper than the others seemed to pass a short distance into the thoracic wall, though no actual connexion with the pleura or lung could be distinguished. Some of the diseased skin was removed and the sloughing tissue carefully scraped away. Each focus of disease was similarly treated and much benefit was derived from the operation, whilst the temperature, which had shown evening rises to 101° and 102° F., now remained normal. On June 23rd a third swelling made its appearance just behind the previous one. It was opened and scraped and the old granulations were again curetted.

At the present time—October, 1904—the physical signs in the chest are as follows. The position of the cardiac impulse and area of dulness cannot be defined owing to the condition of the thoracic wall. On auscultation a musical murmur is heard, systolic in time, situated over the pulmonary area, and conducted upwards to the clavicle and to the left axilla. At the apex the sounds are normal. The left side of the chest bulges slightly and its movements are not so free as on the right side. Round the margins of the growth, and extending upwards to the second rib and on the left side as far as the anterior axillary line, vocal fremitus is absent; the percussion note is almost completely dull and the breath sounds are bronchial in character. There is also a small patch of pleural friction at the upper part of the growth. At the back the physical signs show no difference on the two sides, as the right side appears now to be quite healthy. As to the growth itself there are no signs of active disease externally. There are four small patches of granulation tissue, the skin surrounding the largest patch being red in colour and the veins dilated. There is no pain but some tenderness is felt on firm pressure. The patient is markedly improved in health and is able to walk about the ward.

*Remarks by Dr. CARR.*—In this case it was impossible to say that the iodide exercised any inhibitory effect on the growth, for even when the child was taking the largest dose not only was there no sign of healing but fresh nodules continued to appear, and the temperature was persistently hectic in type. The improvement in the constitutional symptoms which followed immediately upon the first scraping was remarkable and clearly indicates that whenever practicable free removal is the essential factor in the treatment of actinomycosis, although the administration of iodide of potassium in large doses doubtless assists in the final eradication of the disease.

CASE 2.—A boy, aged 11 years, was admitted to the hospital on May 16th, under the care of Mr. D'Arcy Power, complaining of pain and swelling in the lower part of the abdomen. He said that this was caused by a fall at the beginning of April when a man knocked him down and fell across his chest. Nothing was noticed until about the middle of April, when a white swelling appeared below the navel which soon afterwards became red and began to discharge. There was no history pointing to the source of infection. The boy was thin and pale. He walked with a stoop and was evidently in pain. There was a large

inflammatory swelling in the hypogastric and right iliac regions in connexion with the abdominal wall. The margins of the swelling were irregular and indefinite, and in the centre were two foci each measuring rather more than an inch across. These foci were soft and fluctuating, whilst from one a red purulent discharge issued through two or three sinuses. The skin over the swelling was of a purple-red colour, merging into bright red at the margins. The surrounding abdominal wall was hard and indurated, the slightest pressure upon it giving rise to considerable pain. In the umbilicus was a small polypus with a purulent discharge issuing from beneath it. There were enlarged lymphatic glands in either groin and in the right axilla. The temperature on admission was 101° F. On May 18th Mr. D'Arcy Power made an incision over the growth and removed a large quantity of dark brown slough. He then thoroughly scraped the bottom of the cavity, which consisted of strands of coarse fibrous tissue invading the rectus abdominis muscle so extensively that the deep epigastric artery was exposed. There was no pus. Sections of the tissue, stained by Gram's method, showed that it consisted of granulation tissue containing typical masses of actinomyces. Iodide of potassium was given in doses of three grains increased every few days by three grains until the patient was taking 90 grains a day. The wound was dressed daily and continued to granulate satisfactorily until about three weeks later a fresh focus of disease appeared at the lower margin of the previous mass. This growth was accompanied by a rise of temperature to 100·8°. It was removed by scraping. On June 11th the patient had a troublesome attack of diarrhoea which lasted four days and was checked by salicylate of bismuth. Since then he has had three other attacks of diarrhoea, which were treated in a similar manner, and on each occasion the administration of iodide was stopped for a time. A third focus of disease appeared towards the end of July close to the former masses and this too was scraped, as well as the old granulating areas.

Up to the present time—October, 1904—the boy has been steadily improving in his general health. He was sent to the Broadstairs Convalescent Home on Sept. 22nd and he now has a narrow strip of granulation tissue across the hypogastric region which measures about three and a half inches in length. The skin surrounding this area is of a dull-red colour, thickened, firm and resistant to the touch, but the neighbouring abdominal wall is normal in colour and consistence. There is no pain and the inflamed part is only tender when firm pressure is made upon it. The boy walks about without discomfort.

*Remarks by Mr. D'ARCY POWER.*—It is so unusual to have two cases of actinomycosis in a children's hospital at the same time that I asked Mr. Curtis to put his notes together for the purpose of publication. The patients were a boy and girl, aged respectively 11 and nine and a half years. In neither case was it possible to trace the source of infection. In each case the disease seemed to be primary in the skin, although in the case of the girl there is, I think, very little doubt that the pleura and lung have become involved. In my own case I had no difficulty in recognising the nature of the disease when I first saw the patient as the appearances were wholly distinct from the dermatitis of tuberculous or syphilitic origin which is so common in a children's hospital. The scraping had a more rapid effect upon the growth than the treatment by iodide of potassium, but in the case of the boy we satisfied ourselves that this drug had a very definite action because the growth increased as often as the iodide was left off and subsided again when it was administered. I did not see any necessity for the injection of iodides, though this method of treatment may be necessary if the boy continues to develop fresh foci of inflammation.

## ROYAL SURREY COUNTY HOSPITAL, GUILDFORD.

A CASE OF STRANGULATED HERNIA "EN BISSAC" COMPLICATED BY THE PRESENCE OF AN UNDESCENDED TESTIS.

(Under the care of Mr. C. J. SELLS.)

FOR the notes of the case we are indebted to Dr. G. P. Hawker, house surgeon.

The patient was a man, 26 years of age, and the father of three children. On July 25th he noticed a sudden

swelling in the right inguinal region, which was accompanied by vomiting and a griping pain in the lower half of the abdomen. At this time he was constipated; later in the day he noticed that he could no longer see or feel the testicle which was normally situated over the external abdominal ring. On the 26th he was still sick frequently but the swelling became smaller. On the 27th he saw a medical man who gave him an opium pill and the pain disappeared; there was then no obvious hernia. On the 28th he left his bed and walked some distance when he was suddenly seized with pain in the epigastrium and vomiting and the swelling in the inguinal region again became prominent. On the 29th pain was still acute in the epigastrium and the vomiting was constant. Constipation had been complete since the 24th. When admitted into the Royal Surrey County Hospital on the evening of the 29th he stated that the testis was in the lower part of the canal in the morning and that the swelling had decreased since that time. There had been no difficulty or pain on micturition. He had had attacks of pain in the right groin for several years on lifting weights.

On admission he was obviously in great pain with a pulse-rate of 88 and a dry furred tongue. The pain was referred to the epigastrium and there was constant hiccough; the abdomen was generally distended and tympanitic but moved well. There was a swelling in the usual situation of an inguinal hernia extending into the scrotum; there was no testis to be felt anywhere on the right side; in the inguinal canal there was a semi-fluid swelling with no impulse on coughing and apparently a typical strangulated hernia. An ice-bag was applied and an enema was given with a good result. Two hours afterwards ether was administered and on examination the swelling was found largely to have disappeared from the canal and there was none in the scrotum. The finger could be passed well up the canal and only felt what appeared to be a fluid swelling between the finger and the abdominal wall. As the case was supposed to be one of inflamed retained testicle he was sent back to bed and was given some morphine and four grains of calomel with some "white mixture" in the morning. On the 30th he still had great pain in the epigastrium and the pulse-rate had increased to 100; hiccough was still present but the vomiting had ceased, notwithstanding the anæsthetic. In the evening the pulse-rate had risen to 120; distension was greater and faecal vomiting set in. At 1.30 A.M. on the 31st he was anæsthetised and operated on. When the inguinal canal was exposed a sac containing some thin yellow fluid was found but no gut was seen. On passing the finger up the canal the testis was felt and pulled down; it appeared to be quite normal. On opening up the canal further a diverticulum of the sac was discovered with a small piece of strangulated gut. The situation was just over the internal ring and only three-quarters of the gut was nipped. The colour was a bright red and it appeared as if the strangulation was of quite recent occurrence. The gut was returned, a radical operation was performed, and as it was impossible to bring down the testis into the scrotum it was removed. The after-history is unimportant and the patient made a perfect recovery.

*Remarks by Dr. HAWKER.*—The interest of the case was centred in the question as to how much of the symptoms was due to the retained testicle. From the onset of the vomiting and the swelling to the operation there was an interval of nearly six days. Though the gut was not entirely obstructed, if the strangulation had been present for long, the resulting inflammation would have caused a greater change in the appearance of the bowel both at the obstruction and above it; probably the gut had formed the swelling in the inguinal region and had gone back under the ice-bag treatment, and a small piece had become lodged in the diverticulum and eventually strangulated; the lower part of the sac still contained fluid which caused a bulging in the inguinal canal. The hernial protrusion probably took place on July 28th and the vomiting previously to that time was due to the retained testicle which itself caused the hernia.

**TIVERTON INFIRMARY.**—The new laundry, which has just been added to the Tiverton (Devon) Infirmary through the generosity of Mr. J. Coles, was opened on Oct. 15th. The Tiverton Infirmary has performed much useful work. Since 1868 it has treated 45,000 patients and since the new operating theatre was opened in 1899 there has been an annual average of 145 in-patients.