

Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A NOTE ON A CASE OF SACRO-ILIAC DISEASE.

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THE serious nature of tuberculous disease of the sacro-iliac joint has long been recognised, but its comparative rarity and the failure, until within the last few years, of operative measures devised for the relief of its later and more severe forms, may perhaps invest the record of the following case with some interest.

A youth, aged eighteen years, came under my care in May, 1897, complaining of pain in the lower part of the back and inability to walk. He had first experienced pain over the sacral region eight months before, and this had been getting worse. With the increase of the pain came a sense of weakness in the left lower limb and an inability to bear much weight upon it. Three weeks before I saw him a swelling had been noticed to be present over the region of the sacro-iliac joint. The patient's father and mother had died from phthisis. The patient was very thin and appeared to be in much pain. All the classical signs of disease of the sacro-iliac joint were present. Severe pain and sense of weakness were present in the sacral and gluteal region. The former was made worse by movement and by pressure on the iliac bones. Manipulation of the hip showed that joint to have perfect movement, although owing to the severity of the neighbouring lesion it caused pain in spite of my endeavour to immobilise the pelvis. The lameness, the inability to walk, and the alteration in the shape and the apparent length of the limb were well marked. The glutæi were wasted, as were also the muscles of the limb. An oval swelling, with its long axis almost vertical and about four inches in length, was present over the position of the left sacro-iliac joint. This swelling fluctuated and was obviously an abscess. The diagnosis of left-sided sacro-iliac disease was made and the operation devised by Collier and Golding-Bird was performed for its relief. Under an anæsthetic I raised in a forward direction a large semilunar flap, consisting of skin, fascia, muscle, and posterior ilio-sacral ligament, and having thoroughly exposed the bone I proceeded with a half-inch trephine to remove a crown of bone from the neighbourhood of the base of the inferior posterior iliac spine, just above the upper border of the great sciatic notch and immediately over the joint. In raising the flap the abscess, which overlay the joint beneath the muscle and fascia and which communicated with the joint by a sinus, was opened, and its wall was afterwards scraped and cut away. A probe passed into the sinus went into the joint, passing between the iliac and sacral surfaces to do so. On removing the circular crown of bone the joint was opened in its lower part. A distinct though small cavity containing granulations and minute fragments of bone and pus was present. The contents of the cavity were removed with a scoop and with the gouge and mallet the surrounding diseased portions of bone were excised. The disease appeared to have spread laterally, involving the ilium, rather than upwards, and it was confined chiefly to the lower part of the joint. Having removed as far as possible all the morbid material and otherwise cleansed the wound the flap was replaced in position and secured with silkworm gut stitches. Up to the first dressing at the end of a week all went well and the incision seemed to be healed, but at the second dressing tuberculous nodules appeared in the line of incision and in the flap and a collection of opalescent fluid beneath it. The diseased portions were again cut and scraped away and the wound was plugged with iodoform gauze. Iodoform emulsion was injected into the wound every two or three days and the plugging was repeated. The wound steadily but slowly healed. The patient was kept lying in bed with a long outside splint on the diseased side for several months and then allowed up in a wheeled chair. The pain and lameness disappeared and in January, 1898, he resumed his work as a cutler. I saw him in the last week of August. I found him free from any

trouble and in good health. A depressed, painless, firm scar, semilunar in shape, marks the site of the operation. The pelvis seems to be perfectly firm though from the amount of bone removed at the operation I had considerable doubts as to its future stability.

Sheffield.

A CASE OF SEPTIC PERITONITIS; LAPAROTOMY; RECOVERY.

BY H. W. MILLS, M.R.C.S. ENG., L.R.C.P. LOND.

THE patient was a strong, well-nourished woman, aged about forty years. There was a history of gonorrhœa many years ago. I had attended her on and off for some eighteen months previously for attacks of pelvic peritonitis, a pelvic abscess forming and discharging each time *per vaginam*. On the present occasion she had treated herself by rest in bed and hot douches, expecting the usual termination to her trouble. Such, however, did not occur; on the contrary, the pelvic abscess broke into the general peritoneal cavity and septic peritonitis resulted. When I saw her she was lying on her back in bed with her knees drawn up. The abdomen was greatly distended; low muttering delirium and constant retching had been present for twenty-four hours. The temperature was 103° F. and the pulse was 140. *Per vaginam* the cervix was felt high up and the uterus was fixed as if in plaster of Paris. There was bulging in the posterior and lateral fornices, especially in the left. On the following day, chloroform having been administered, I opened the abdomen in the middle line. The abdominal walls, omentum, and superficial coils of intestine were densely adherent, and the latter were with some difficulty separated sufficiently to admit three fingers into the general abdominal cavity. On withdrawing the fingers several quarts of brownish, very offensive fluid containing large thick flakes of lymph escaped and subsequently about a pint of evil-smelling brown pus. The upper part of the abdominal cavity was partly, at any rate, shut off by adhesions. The abdominal cavity was thoroughly irrigated with boiled water, the peritoneum was plugged with iodoform gauze, a tight binder was applied and the patient was put back to bed in a collapsed condition. She rallied, however, after a hypodermic injection of strychnine and an enema of hot, strong coffee and brandy. For several weeks her condition was critical, intestinal obstruction threatening on several occasions. The wound was dressed twice a day after the first twenty-four hours, the cavity being irrigated with boric acid lotion and later with lotio sodæ chlorinatæ, and subsequently replugged with iodoform gauze. A considerable amount of pus continued to escape for several weeks. Hypodermic injections of morphia had to be repeatedly given during the first three weeks after the operation for the relief of pain and for the troublesome and persistent attacks of retching. Eventually the discharge became serous and finally it stopped, the cavity contracted, and the abdominal wound granulated up. The patient made an excellent recovery and is now, a year after the operation, in the best of health.

Ruardean.

NOTE ON A CASE OF OXALIC ACID POISONING; RECOVERY.

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I WAS recently summoned to a case of attempted suicide and taking the stomach syphon-tube and hypodermic case I arrived within twelve minutes after the poison had been swallowed. I was shown a "tumbler" to the sides and bottom of which were clinging rather less than one and a half drachms of undissolved crystals having the taste and appearance of oxalic acid. The patient, a lad, aged fifteen years, was unconscious; his skin was markedly pallid and clammy and his extremities were cold. No pulse could be felt at the wrist. The pupils were fully dilated and his lower jaw was fixed in tetanic spasm, froth exuding between the teeth. He was said

by the friends to be just recovering from a strong convulsion. I injected one-tenth of a grain of apomorphia hypodermically. The stomach syphon-tube was then passed after levering the lower jaw open and upwards of a pint of warm water was introduced into the stomach. This was almost immediately expelled, no doubt by the action of the apomorphia. On a second attempt to pass the tube the patient began to struggle—consciousness having partially returned—and it was found impossible to wash out the stomach thoroughly. Vomiting, however, continued and the organ appeared to have been well evacuated. He had by this time sufficiently gained consciousness to be induced to swallow about half an ounce of powdered chalk suspended in water which was shortly afterwards ejected. With the aid of brandy, strychnine, and digitalis administered hypodermically he had recovered so as to be out of danger in two hours, the heart's action, however, failing several times during that period.

On inquiry I found that the lad had purchased half an ounce of oxalic acid from a local druggist and that the whole of this quantity had been used in making the solution, all of which he drank except what had remained undissolved. This made the quantity taken upwards of two and a half drachms. In a previous case of oxalic acid poisoning to which I was called the patient died within a quarter of an hour of swallowing the fatal dose. The quantity taken in that case was unknown, but was probably over half an ounce. According to Taylor, one drachm is the smallest quantity of oxalic acid which has been known to destroy life at the age of sixteen years, death occurring in eight hours. Under three minutes is given as the shortest known period of survival after an unknown quantity of this poison had been taken.

Sydenham.

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.

KING'S COLLEGE HOSPITAL.

A CASE OF CHRONIC GLANDERS; RECOVERY.

(Under the care of Mr. WILLIAM ROSE.)

IN THE LANCET of Sept. 24th we published the history of a case of glanders in which much difficulty was found in arriving at a correct diagnosis. In the following case the diagnosis was greatly simplified by the very definite history of the disease in several horses among which the patient had worked. In this case the infection had occurred at three widely separated spots and at each there was much tendency to spread locally, but no absorption of the poison and generalisation of the disease took place. The difficulty of removing all the local disease by scraping is well shown in the sinus in the leg, which continued to extend for more than a year after its first appearance. The general health of the patient suffered very little considering the extensive and long-continued suppuration, and the favourable result demonstrates that if by persistent operation the local poison can be removed complete recovery may ensue. For the notes of the case we are indebted to Mr. C. A. Sprawson.

A young man, aged nineteen years, was admitted into King's College Hospital on Feb. 8th, 1897, suffering from multiple abscesses. His previous and family histories were quite unimportant and no evidence of syphilis could be obtained. His habits were very temperate and by occupation he was a carman and a worker in stables. About a month before admission to the hospital an abscess appeared, according to the patient's account, on the left side of his forehead; for this he consulted a medical man. A fortnight later two other abscesses appeared, one on the extensor surface of the right arm and the other on the outer aspect of the right leg. The abscess on the forehead was opened and as the patient did not seem to improve

he was sent to the out-patient department of King's College Hospital, where he was seen by Mr. Carless, and the next day he was admitted to the ward. When examined on admission he was seen to have on the left side of his forehead a wound resulting from the opening of the abscess; from it pus was still flowing and a "pocket" passed from it downwards beneath the skin. With a probe bare bone could be felt. This cavity was syringed out with solution of carbolic acid (1 in 40) and packed with iodoform gauze. The house surgeon, Mr. G. Atkinson, opened the abscess on the arm and dressed it similarly; it was shallow, but extended under the skin. On the peroneal aspect of the right leg was seen a tense fluctuating swelling nearly 5 in. long; it was extremely tender and was evidently a large abscess. The patient's general appearance was healthy; his temperature was normal on admission, but it rose to 101° F. on the following day. The urine was acid and contained neither albumin nor sugar. There was no discharge from the nose and at first the patient denied that he had ever had any such symptom, but later he acknowledged that during the three weeks preceding admission there had been a watery discharge from the nose, which at the time he attributed to an ordinary cold. The case was not thought at first to be one of glanders, but on the day after admission inquiries elicited that in his work as carman the patient had much to do with twelve horses, and that six weeks before admission six of these horses, one after another, developed swellings in the neck; they were seen by a veterinary surgeon and were killed. In his own mind the patient had never connected the disease of the horses with his own illness and none of his fellow workers seem to have suffered at all in the same way, though about three months earlier one of them had a wound of a finger which took a fortnight to heal. On Feb. 22nd Mr. Rose incised the abscess in the leg and evacuated some blood-stained pus; there was no bare bone; the cavity was packed with gauze. The abscesses were dressed daily; it was found necessary on two occasions to make a counter-opening for the abscess on the forehead, as there was much burrowing; when the first counter-opening was made some pus escaped and some of it was caught in a sterilised tube and sent to the British Institute of Preventive Medicine for examination; the report on this pus stated that though no bacilli were discoverable microscopically in this pus, yet when guinea-pigs were inoculated with it they soon developed the typical symptoms of glanders. By March 12th the temperature had become normal, the patient's general health was good, though he was somewhat troubled with night sweats, but the healing of the abscesses progressed very slowly, and on April 6th it was found necessary to lay open the leg further downwards owing to the burrowing of the abscess. On May 7th the abscess in the arm had nearly healed, but as the burrowing of the abscess on the forehead had increased, the skin between the three sinuses was cut through and the cavity well scraped with a sharp spoon. The sinus in the leg was treated similarly. At first the wounds seemed to improve after this treatment, but later they all continued to spread, and Mr. Rose laid them open again, scraped them, and swabbed them out with liquefied carbolic acid. Every third day after this the wounds were swabbed out with carbolic acid and soon began to look more healthy. On June 14th a note was made that the patient's general condition had not been so good lately; he complained of headache and pains in the back and at the same time he showed a distinct *tache cérébrale*. The wounds also commenced to burrow again; they were therefore once more scraped and wiped out with pure carbolic acid. The carbolic acid was used every other day and all the wounds improved greatly and by July 14th the arm was well. Towards the end of July an attack of pharyngitis caused a temperature of 103° for a few days, but the wounds continued to improve, so that early in August he was able to get about on crutches. The ulcer on the head was smaller, but still discharged some greyish pus, which crusted round the wound causing a peculiar appearance which had been noticed during the whole of the case. The sinus in the leg increased in length and on Sept. 1st Mr. Carless laid it freely open and applied carbolic acid to the interior. By Sept. 20th both wounds were looking better; the ulcer on the forehead had healed except for a patch as large as a sixpenny-piece. The burrowing of the sinus in the leg continued and on Oct. 30th Mr. Rose made a counter-opening immediately below the external malleolus, avoiding the peronei.