

## Clinical Notes:

### MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

#### NOTE ON A CASE OF SIMULTANEOUS RUPTURE OF A CAROTID ANEURYSM AND AN ATHERO- MATOUS AORTA.

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THE patient, a woman, aged 77 years, was admitted to the Bethnall House Asylum in August, 1905. She was suffering from alcoholic dementia. When examined on admission her heart was found to be normal except for some accentuation of the aortic second sound. She had no physical signs of aneurysm, but the arteries were hard and thickened. The case was considered to be one of arterio-sclerosis, with chronic interstitial nephritis. During the year the patient had several attacks of syncope in which she became unconscious for varying periods. On Oct. 15th, 1906, at dinner, she was eating a piece of bread when her hands fell to her sides and she became unconscious. On the immediate arrival of the medical officer she was found to be dead. Death was surmised to be due to a fatal attack of syncope.

*Necropsy.*—On opening the pericardium some blood and serum were found to be present. The right ventricle was flabby and relaxed, while the left was firmly contracted. Neither of the ventricles contained any blood. The membrana ovale on the septum auriculi was bulged in towards the right auricular cavity like the finger of a glove. The aortic valves were thickened at their attached margins and there was some atheroma round the roots of the coronary arteries. The arch of the aorta showed some general dilatation, but there was no definite aneurysm. On opening the aorta throughout its length more atheromatous patches were found. One of these situated below the roots of the great vessels on the posterior wall had given way. The rupture was V-shaped and marked out the limits of the patch, one limb extending down to just within the limits of the pericardium. Hæmorrhage had taken place into the tissues in front of the bifurcation of the trachea. On removing the brain extensive hæmorrhage was found spreading all over the base beneath the arachnoid membrane. The blood clot being washed out from the cisterna basalis, the exposed arteries at the base were found to be degenerated extensively. An aneurysm of the left internal carotid was present between its entry through the skull and its division into the anterior and middle cerebrals. This aneurysm was three-quarters of an inch in diameter and fusiform in shape. It had ruptured on its outer aspect, causing the basal hæmorrhage. The rupture was three-eighths of an inch long. The atheroma of the arteries extended along their branches deep into the cerebrum. As regards the other organs, the kidneys showed advanced cirrhosis; the liver was large, greasy, and tough; and the spleen was tough and fibrous.

This case seems to be of great rarity on account of the simultaneous rupture of both the aorta and the carotid. Had one ruptured first the lowering of the blood pressure should, according to physiological teaching, have precluded the rupture of the other. The conclusion is that both occurred simultaneously.

Cambridge-road, N.E.

#### A CONVENIENT TEST FOR THE PRESENCE OF BINOCULAR VISION.

BY A. FREELAND FERGUS, M.D. GLASG.

FOR the testing of the presence or absence of binocular vision there are already ample means. In addition to Hering's apparatus we have the useful instrument designed by Claud Worth which for the investigation of this important function leaves little to be desired. The pictures devised by him which seem to me to be the best for the purpose are the circles. One can at once tell whether any patient has the sense of binocular vision by simply getting his answer to the question of whether the outer or the inner circle appears to be the nearer. By changing the position of the circles the surgeon can at pleasure cause the outer or the inner to appear the nearer to a person gifted with fully developed

binocular vision, and thus if invariably a patient answers correctly there is then no doubt as to his perception of the third dimension. The only objection to Worth's instrument is that it would cost a great deal to have a sufficiency of instruments to meet the requirements of a clinique where a very large number of squint patients are in attendance. Moreover, there are obvious difficulties in the way of a patient using such an apparatus in his own house.

Stereoscopic exercises must in many cases be carried on for a prolonged period if the best results are to be obtained after operations for squint. Most of the stereoscopes in ordinary use are, to my mind, unsatisfactory. Take, for example, Doyne's elaborate instrument or the more simple one of Landolt, both of which at one period I used extensively. With these we can test whether a patient can see with both eyes at the same time, for if he does he sees both the upper and the lower half of the figure, and by a little adjustment he can arrange the two halves to make one figure. But it is to be observed that the two halves appear at the same distance from the observer and therefore neither of these instruments gives any information as to whether the person being examined has the consciousness of the third dimension of space. These instruments have, however, certain uses; for example, they can be employed to train the convergence, positive and negative, but they do not serve for testing the sense of perspective. One of the most convenient methods of investigating this is afforded by those ingenious pictures which are called plastograms. These may be said roughly to consist of two superposed pictures of the same subject taken from slightly different points of view. One of the pictures is printed in green and the other in red and they are looked at through glasses similar to those employed by Professor Snellen for the detection of simulated blindness of one eye. If binocular vision with the perception of the third dimension be present, so soon as the spectacles are worn a stereoscopic effect is obtained at once.

How can we ascertain that the patient has the consciousness of the third dimension? It avails nothing to ask him if certain objects appear nearer than others. Just as a man examining a picture knows that some objects are nearer than others, so the person examining the plastograms can easily tell without having the perception of the third dimension that some objects in it are meant to appear closer to him than others. For example, he knows that a statue must be nearer to him than the building behind it. All doubt on the matter can easily be dispelled by asking the patient to sway himself slowly from side to side while examining the plastograms. Anyone who does so and who has fully developed binocular vision will find that the objects in the foreground appear to move in the same direction as he moves. If he shuts one eye this apparent movement at once ceases; the condition of its being present is that both eyes are used simultaneously. It is to be observed that some of the pictures are much better adapted for the purpose than others, and before using any particular picture the surgeon should satisfy himself of its suitability.

Glasgow.

## A Mirror

OF

### HOSPITAL PRACTICE, BRITISH AND FOREIGN.

N illa 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.

#### LONDON HOSPITAL.

A CASE OF CÆSAREAN SECTION FOLLOWED BY THE  
REMOVAL OF A FIBROID TUMOUR WHICH  
FILLED THE PELVIC CAVITY.

(Under the care of Dr. H. R. ANDREWS.)

A WOMAN, aged 33 years, was seen in consultation on March 7th, 1906. She had had pelvic discomfort and increasing difficulty in passing urine for several days, culminating in complete retention on March 5th, when two and a half pints of urine were drawn off by catheter. After the bladder had been emptied she had had frequency of

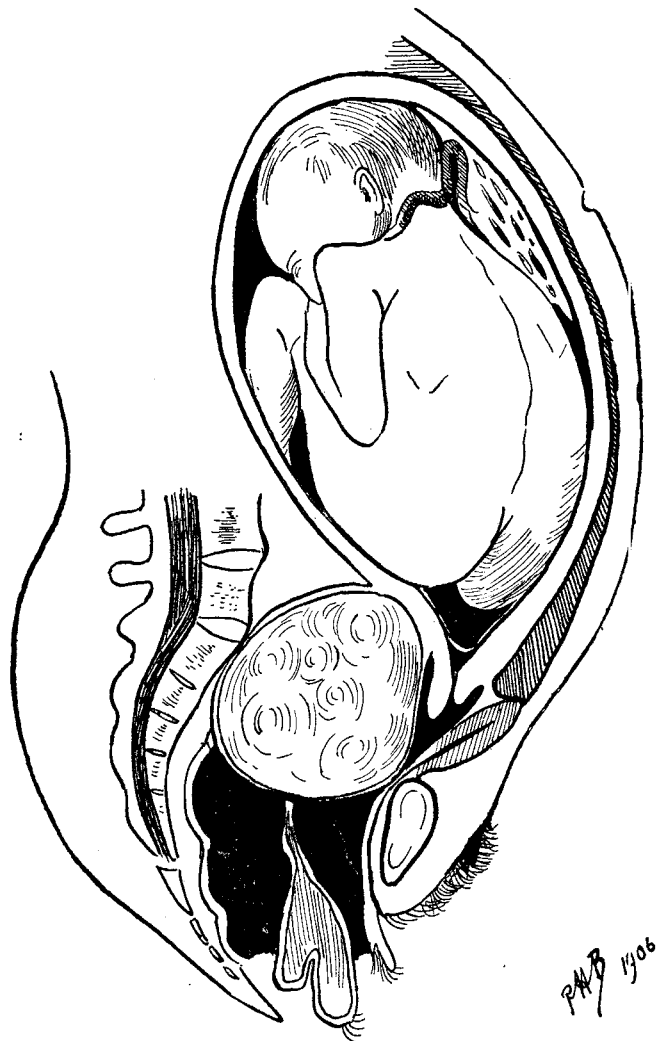
micturition but no difficulty. The patient was a tall, well-built, healthy woman, who had been married five months. Menstruation had been regular all through 1905, but the last two periods had been missed, the last menstruation occurring in the first week of January, 1906. Abdominal examination revealed a softish swelling, slightly moveable from side to side, in the hypogastrium, rising up out of the pelvis to a point halfway between the pubes and umbilicus. The breasts showed signs of activity. On vaginal examination the cervix, which was distinctly softened, was felt high up in front. The hollow of the sacrum was occupied by a hard round swelling which practically filled the pelvis. The diagnosis made was that of early pregnancy, of about two months' duration, the body of the uterus being perched on a fibroid which was probably cervical. As retention had occurred so early, although the pregnant uterus was above the pelvic brim, it seemed that frequent catheterisation would probably be necessary as pregnancy advanced, but, reasoning from cases of persistent retroversion of the pregnant uterus, it was thought possible that the bladder and urethra might gradually accommodate themselves to the presence of the tumour. If the tumour were removed immediately the uterus would almost certainly have to be removed as well, and in the unlikely event of the tumour being removed without the uterus abortion would very probably occur. If, on the other hand, the pregnancy could go to term, with the help of catheterisation, Cæsarean section would be necessary, followed by hysterectomy or myomectomy. The patient was told that the best thing to do was to wait until full term, if possible, with the hope of obtaining a living child by Cæsarean section rather than to operate at once and either do away with all chance of her becoming a mother or bring the present pregnancy to an untimely end. She was rather anxious to have the tumour removed at once, even though the operation might involve removal of the uterus, but eventually agreed to wait for a time to see whether she had much discomfort from pressure and from catheterisation. Retention of urine occurred again on March 13th and 18th.

On March 22nd she was admitted into the London Hospital where Dr. Lewers saw her with Dr. Andrews. He said that although the fibroid was probably cervical it might prove to be moveable under an anæsthetic. The patient was anæsthetised accordingly and it was found that the tumour could be pushed up easily for a short distance, so that although it still filled the brim it did not occupy much of the cavity of the pelvis. A large ring pessary was inserted to keep the tumour as high up as possible. The patient returned home a few days later. The tumour soon settled down into the pelvis again but possibly not quite so deeply as before. During April and May there was occasional retention of urine, relieved by passage of a catheter. The patient found that micturition was easier if she assumed the knee-chest position before attempting to pass urine. She took urotropin occasionally during April and May, for a few days at a time, to diminish the risk of cystitis. After the end of May she had no trouble with her urine and no discomfort of any sort that could be attributed to the presence of the fibroid although it remained apparently filling the pelvis. The ring pessary was removed some time after the end of May.

The patient was readmitted into the London Hospital on Oct. 10th, in excellent health and free from any unusual symptoms. The greatest circumference of the abdomen was 41 inches. The child, a good-sized one, was lying in the second position of the breech, but the breech was high up above the brim which was not occupied by any fetal part. In the brim a firm mass could be felt indistinctly. The cervix was out of reach, a large, hard, rounded mass filling up the pelvis as before. No attempt was made to push the tumour out of the pelvis, as it was evident that even if it could be pushed up above the brim it would still obstruct delivery. Dr. Lewers saw the patient again and agreed that Cæsarean section was necessary.

On Oct. 11th, about four days before the expected date of labour, Dr. Andrews operated, performing Cæsarean section. After extraction of the fœtus, placenta, and membranes the tumour was pulled out of the pelvic cavity, coming out with a loud "sucking" noise. It was found to be a sessile subperitoneal fibroid of about the size of a cocoa-nut, growing from the left posterior quarter of the uterus just above the cervix. Its base of attachment was about four inches in diameter. No other fibroid could be seen, so Dr. Andrews decided to remove the tumour and leave the uterus.

An incision was made round the base, and the tumour was enucleated with ease by blunt dissection with the fingertips. Dr. Andrews thought that there was no communication between the interior of the uterus and the myomectomy wound, but his assistant said afterwards that he was quite certain that Dr. Andrews had opened the uterine cavity. However, this point was of no importance, as is shown by the after-history of most cases of Cæsarean section. There was free bleeding from the myomectomy wound, easily checked by a few buried catgut sutures. After sewing up the Cæsarean section wound with two layers of interrupted sutures of chromicised catgut the myomectomy wound was closed in the same way. The wounds were now of about equal length. The abdominal wound was then closed by through and through silkworm gut and buried catgut sutures. By the time that the abdomen was closed blood was issuing from the vagina, as had been seen in every case in which Dr. Andrews performed Cæsarean section before the onset of labour, the cervix being dilated by the contractions of the body of the uterus. This showed that mechanical dilatation of the cervix is quite unnecessary before the performance of Cæsarean section. The child, a boy, weighing 8½ pounds, was rather under the influence of chloroform at first, but cried lustily after a few hours. The mother made an uninterrupted recovery and was able to suckle the child from the first. Mother and child left the hospital on Nov. 8th, both very well, the child weighing 10½ pounds. On section the



fibroid was seen to be in a condition of necrobiosis, being red, rather homogeneous in consistence, and soft, and smelling of methylamin. Microscopical sections stained very badly.

*Remarks by Dr. ANDREWS.*—I think that this case is of interest as showing the gradual toleration by the bladder and urethra of pressure which caused retention of urine at first. There was probably more tension from upward stretching of the urethra than actual mechanical pressure. Obstruction to labour caused by a fibroid in the lower uterine segment usually necessitates hysterectomy; it is rarely possible to treat such a case by myomectomy, leaving a uterus which is still functionally perfect. The case was described and the tumour shown at the meeting of the Obstetrical Society of London on Nov. 7th. In the discussion that followed it was suggested that myomectomy

might have been performed when I first saw the patient, thus obviating Cæsarean section, and also that myomectomy might have been performed at full term or even during labour, allowing labour to take place naturally afterwards. Although myomectomy during pregnancy has been performed with success in several cases I do not think that it would have been good treatment in this case. The size and the low situation of the tumour would probably have rendered it impossible to remove the fibroid without removing the uterus itself. The tumour must have been twice as big as the uterus at the time that retention of urine first occurred and if it had been possible to remove the fibroid alone abortion would probably have followed. The tumour was larger and the period of pregnancy earlier than in most of the cases in which myomectomy has been performed without disturbance to the pregnancy. To have performed myomectomy at full term or during labour would have been impossible without making an abdominal incision from the pubes to the ensiform cartilage, as it would have been necessary to turn the uterus completely out of the abdomen before the fibroid could have been removed. Again, I should have been very unwilling to make a large wound in the lower uterine segment at the beginning of labour. The illustration, which was kindly drawn for me by Mr. P. H. Bahr, who watched the operation, gives a very fair indication of the anatomical relations, except that the tumour extended more deeply into the pelvis than is shown in the drawing.

## Medical Societies.

### MEDICAL SOCIETY OF LONDON.

#### *Arterio-venous Aneurysm of the Neck.—Encapsulated Sarcoma in the Pterygoid Region.*

A MEETING of this society was held on Nov. 26th, Mr. C. A. BALLANCE, the President, being in the chair.

Mr. JAMES BERRY made a communication on a case of Arterio-venous Aneurysm (aneurysmal varix) of the Neck, treated by operation, which had occurred in a female patient, aged 39 years. The case was chiefly remarkable on account of its rarity. The prominence, situated on the right side of the neck, was irregular and slightly larger than a man's fist. There were a well-marked thrill on palpation and a loud harsh bruit. The diagnosis presented no difficulty but the exact point of communication between arteries and veins could not be made out. At the operation, which lasted two and a half hours, the parts were freely exposed. The tumour, which was exhibited, consisted of tortuous and distended veins. With regard to the common cirroid aneurysms of the scalp, so often traumatic in origin, Mr. Berry raised the question whether these tumours consisted of dilated and tortuous arteries, as commonly taught, or of dilated veins, and he inclined to the latter view.—The PRESIDENT said that he had assisted some years ago at an operation on a case of cirroid aneurysm of the scalp in which the dilated vessels appeared to be arterial and communicated with the enlarged carotid arteries. He had also seen a cirroid aneurysm on the dorsum of the foot and in that case also the dilated vessels were arterial. In some cases, however, the dilated vessels might be venous. He did not think there was any rule. He congratulated Mr. Berry on the success of his difficult operation.—Mr. CUTHBERT S. WALLACE had found in South Africa that injuries of the neck were fruitful sources of arterio-venous communications and aneurysmal conditions. Proximal ligature was a safer method of treatment than excision but was not always available.—Mr. W. G. SPENCER remarked that in most instances cirroid aneurysms of the scalp appeared to be arterial; a pulse could be felt and if punctured the blood came out in spurts. He also referred to cases which he had met with where the tumour affected the arm and the leg.

Mr. SPENCER read a paper on a case of Encapsulated Sarcoma in the Pterygoid Region. The patient was a man, aged 30 years, who had suffered from recurrent attacks of rheumatic fever complicated by endocarditis and who had become weak and exhausted from the difficulty in swallowing, breathing, and sleeping consequent upon the bulging of the tumour inwards, so as almost to fill the fauces. The tumour also protruded behind and below the ramus of the

lower jaw. The encapsuled nature of the tumour was indicated externally by the mobility of the superficial structures and the absence of glandular enlargement, and internally by the mucous membrane of the pharynx and the soft palate gliding over the tumour without any sign of ulceration or of induration. The tumour was shelled out through a horizontal incision below the jaw without perforating the pharynx and without hæmorrhage. The tumour proved to be a fibro-sarcoma of the size of the fist, and six months after the operation there was nothing abnormal to be noticed except a linear scar. A similar case was described by Dr. (now Sir) Patrick Heron Watson in 1869<sup>1</sup> in which, after a large incision through the jaw into the mouth, the tumour was found and easily shelled out. Sir Felix Semon removed such a tumour from the lateral wall of the pharynx above the larynx for which a lady had worn a tracheotomy tube for two years.—The PRESIDENT recalled a case of fibro-sarcoma of the size of a Tangerine orange in the parotid region. The facial nerve was dissected out and the patient made a very good recovery.—Mr. BERRY referred to the case of a woman, aged 35 years, who presented a tumour which occupied the whole of the pharyngeal region. It was a fungating tumour, evidently of a malignant nature. It was, however, easily shelled out of a capsule and microscopically it was described as an endothelioma.

### CLINICAL SOCIETY OF LONDON.

#### *Amalgamation of Medical Societies.—Hæmorrhage into the Prefrontal Lobes.—Acute Peritonitis with Fat Necrosis.—Cystic Dilatation of the Ureter within the Bladder.*

A SPECIAL general meeting of this society was held on Nov. 23rd, Mr. H. H. CLUTTON, the President, being in the chair, when a motion in accordance with the recommendation of the council was adopted agreeing to the amalgamation of the Clinical Society with the other medical societies.

An ordinary meeting was then held and the following papers were read:—

Dr. J. WALTER CARR communicated a case of Hæmorrhage into the Prefrontal Lobes of the Brain. The patient, a man, aged 53 years, a painter, was admitted to the Royal Free Hospital in a semi comatose condition, with a history that he had suddenly become unconscious about seven hours before. He was said to have had albuminuria about five years previously and to have been getting thinner and to have suffered from anorexia and vomiting for some time before his final illness. On admission the temperature was 98·6° F., the pulse was 56, and the arterial tension was very high; the urine was almost solid with albumin and contained a considerable quantity of sugar, but did not give the reactions for diacetic acid and acetone. Otherwise the results of physical examination were quite negative and there was not the slightest indication of hemiplegia or of any unilateral symptoms whatever. The man gradually improved and after two or three days completely recovered consciousness. About the seventh day, however, he again became restless and drowsy, his temperature slowly rose, and he died comatose on the ninth day from the onset. After the first day or two the sugar completely disappeared from the urine and only an occasional trace of albumin was discovered. At the necropsy it was found that a small saccular aneurysm on the anterior communicating artery had ruptured into the left prefrontal lobe and that the hæmorrhage had subsequently extended (probably only shortly before death) into the right prefrontal lobe. The kidney showed an early stage of chronic interstitial nephritis. Dr. Carr commented on the difficulties of diagnosis in lesions of the prefrontal lobes. Many examples of these difficulties had been afforded in cases of tumour of this part of the brain but the recorded instances of hæmorrhage were few.—Dr. A. E. GARROD recalled the case of a man admitted into St. Bartholomew's Hospital with an apoplectic seizure who recovered. After recovery from this attack the patient became quite rational and took part in the work of the ward. Subsequently he died from a second seizure and after death evidences of old hæmorrhages were found in the prefrontal lobes.

Dr. JOHN FAWCETT read a paper on a case of Acute Peritonitis with Fat Necrosis unattended by Disease of the Pancreas. The patient, a woman, aged 59 years, was admitted into Guy's Hospital on Oct. 15th, 1905, for severe

<sup>1</sup> THE LANCET, May 29th, 1869, p. 744.