

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.

GUY'S HOSPITAL LYING-IN CHARITY.

CASE OF DOUBLE CONGENITAL HYDROCELE; SUPPURATION; DEATH.

FOR the following notes we are indebted to Mr. H. Poole Berry, M.R.C.S., senior resident obstetric assistant.

B. M—, a primipara, had been in labour thirty-six hours, and had become exhausted. On the evening of March 2nd bow-forceps were applied by Mr. H. T. Sells, the junior resident obstetric assistant. She was then quickly delivered of a well-developed male child. Nothing unusual was observed in the condition of the child's scrotum. On March 10th the mother died of exhaustion, following an attack of puerperal mania. On the same day the attention of Mr. Miller (extern obstetric attendant) was drawn to the condition of the scrotum of the child, which was red and swollen. Hot fomentations were applied. On the following day, at noon, the child, then nine days old, was brought to the hospital. It was stated that it had not passed any urine since 5 A.M. on the previous day. The whole of the scrotum was much swollen, red, glistening, and somewhat tense. The possibility of extravasation of urine at once presented itself; but the fact of the inflammation being strictly confined to the scrotum, neither the penis, perineum, nor abdomen being in the least degree affected, seemed strongly to negative this view. As phimosis existed the prepuce was stretched with dressing forceps, and poultices were ordered to be applied over the pubes. Instructions were given to the nurse that the child should be brought to the hospital again in the evening if no urine had passed. At 9.30 P.M. the child was again brought, in much the same condition, but looking pinched and ill. It had been very fretful, but was now quieter. The inflammation was strictly limited as before, but was more intense in character, the whole scrotum looking more angry, giving the impression that sloughing might soon supervene. A No. 1 gum-elastic catheter was passed, and about two drachms of urine were drawn off. The child was taken home, and about ten minutes afterwards died.

A post-mortem examination was granted by the father, and was made the following afternoon (March 12th). The bladder was found to be empty, and the urethra normal. On cutting into the scrotum nothing abnormal was noticed until the serous membrane, on the left side, was incised, when pus freely escaped. In this cavity the testicle lay bare, and from it a probe passed freely into the peritoneal cavity. The peritoneal opening was distinctly perceptible to the finger, examining through an incision made through the abdominal wall, but was not sufficiently patent to admit its tip. The same condition existed on the right side. There was no diffuse peritonitis existing, though possibly some early peritonitis may have been present around the immediate neighbourhood of the rings. This was not certainly ascertained, as small an incision as possible having been purposely made into the abdominal cavity.

Remarks.—It seems possible that in somewhat analogous cases, where no post-mortem has been made, a similar condition may have existed, and that death may have been assigned to erysipelas, or to some other more or less superficial inflammation of the scrotum, the ante-mortem appearances in this case being certainly to some extent calculated to support such a view. A somewhat similar case has occurred recently at this hospital in which the inflammation being not so strictly limited, the idea of extravasation of urine was entertained, when, post mortem, a condition similar to that just described was found to exist.

SHEPPEY UNION INFIRMARY.

CASE OF ATTEMPTED SUICIDE BY CUTTING THE THROAT; ASPHYXIAL ATTACK; RECOVERY; REMARKS.

(Under the care of Mr. GEORGE BLAND.)

ON January 17th last a negro named B— was discovered almost insensible in a garret in his house at Sheerness, with a large gash across his throat, and his wife, a white woman, in a room downstairs partly burnt, with her head and face battered about, and her windpipe, right common carotid artery, and internal jugular vein completely severed. Her son, by a former husband, stated B— had attacked him also and inflicted several wounds, one penetrating the upper and anterior part of the left lung. He was seen by Dr. Arrol, who recommended his removal and accompanied him to the infirmary.

On admission he was in a state of extreme prostration. A large wound extended across the throat, higher and deeper on the left than on the right side. It severed the larynx, slicing off the anterior part of the cricoid cartilage and lower portion of the left side of the thyroid, penetrating backwards into the pharynx. The edges of the opening into the latter were much retracted, and would easily have permitted the passage of a good-sized plum. Hæmorrhage having ceased, stimulants and nourishment were administered by means of the stomach-pump. There was some difficulty at first in introducing the tube, for, owing to the altered position of the parts, the point of it impinged on the severed edges of the œsophagus. This was overcome by introducing the finger into the pharynx through the wound, feeling for the top of the œsophagus and so guiding the tube into it. The finger could readily be passed behind the thyroid cartilage and under the tip of the epiglottis, which could be distinctly felt flapping up and down, sometimes even it could be seen when the head was thrown well backwards and one looked up into the wound. After a couple of days the secretions increased greatly, large quantities of glairy ropy mucus and saliva giving considerable trouble. So tough was this mixture that it had to be extracted by winding it round the head of a small mop like a cable round a windlass. No air entered the mouth, breathing being carried on through the external wound. The hyoid bone, thyroid cartilage, &c., were drawn up beneath the root of the tongue, causing the wound to gape immensely.

On Jan. 19th, about ten minutes after the patient had been fed, his head fell forward and he became convulsed and gasped. Mr. Bland was standing a few yards off, and as he got to B—'s side he gave another struggle and an abortive gasp or two, a look of intense agony passing over his face, after which he collapsed and lay back apparently dead. No pulse could be detected at the wrist. As a forlorn hope, Mr. Bland threw back the man's head and passed the tip of a finger into the windpipe, pressing outwards, while with the other hand he pressed the ribs, as in artificial respiration. A very faint attempt at inspiration followed. A teaspoon being close at hand, the handle was inserted into the trachea, and the breathing began to improve, though still very slow and faint. A couple of hairpins were bent to a right angle, passed one at either side of the trachea, and used as retractors. In two or three minutes breathing was re-established. The severed cricoid cartilage had collapsed, while the divided edge of the left crico-thyroid muscle got tilted over and acted as a valve. This was subsequently snipped off.

Nothing particular occurred for some days, when Mr. Bland was hurriedly summoned to the patient. He was breathing with great difficulty, a large quantity of mucus having got into the air-passages was gurgling to the top of the trachea at each expiration and then being sucked down again. The opening was too large to favour its expulsion. The insertion of a tracheotomy tube at once had the desired effect, the constriction of the opening concentrated the expulsive force, just as a choke-bore gun barrel does, and he shot out an immense quantity of stuff through the tube, upon extracting which the trachea was found quite clear. An important point in treatment had now to be decided upon. The wound in the laryngo-pharyngeal septum was still very large, and presented no prospect of closing—that is to say, though the edges appeared to be healing a large opening would remain; in short, it would heal as a pierced ear does. For all practical purposes the larynx was destroyed, and even were it possible for it partially to unite in front, the

epiglottis as a safeguard would be next to useless, as air and mucus, and perhaps food eventually, would come down the pharynx and enter the trachea through the fistula already described. Besides this, inside the wound there was great oedema, large portions of mucous membrane being raised up and looking, and feeling to the touch, like hæmorrhoids. It was decided to retain the tube and not permit the external wound to heal, for it was felt had this been attempted, asphyxia, either instantaneous or gradual, would result before long. After about a month the man was able to swallow solid food perfectly and liquids partially. Even at this length of time it was easy to see a piece of bread pass down; it would stop for a moment at the fistula, and then suddenly disappear.

Remarks by Mr. BLAND.—This is a good example of the chief dangers in cases of cut-throat after the first shock is over. These are chiefly due to oedema and mucus trickling into the trachea, slowly asphyxiating an exhausted patient. Should difficulty of breathing arise from the former, I do not think there can be any second opinion as to propriety of performing tracheotomy; let the second be overcome, and scarcely any case need be regarded as hopeless, no matter how severe it may appear at first, provided the surgeon is prepared to give it plenty of attention. He must visit it frequently, and administer food and stimulants with the stomach-pump two or three times daily, seeing at every visit the wound is kept clean. As no two wounds are exactly alike, the detailed treatment of each must be regulated by circumstances, but I think it may be safely laid down that the old plan, not to sew up a penetrating wound, is perfectly sound, and that this plan of treatment may be carried further, especially in the early stages, and no attempt made to close the wound by keeping the head forward. The shock causes partial paralysis of the muscles of the throat, which is not recovered from for several days, and may permit the entrance of mucus into the passages. Food can only get there by neglect, as the use of the stomach-pump can always prevent this. Enemata will probably have to be frequently administered. In the above case so sluggish were the bowels that he never had a motion for over a month without one. Attention, of course, must be paid to the general treatment; but I think the chief points have been already indicated. Five weeks after the injury the external wound was somewhat larger in area than a shilling, while the opening in the laryngo-pharyngeal septum still existed. On Feb. 24th he was committed for trial, and I accompanied him to Maidstone gaol, handing him over to the charge of the prison surgeon. The tracheotomy tube was still in use, as I had not modified my opinion as to the propriety of not permitting the external wound to close. Most probably we shall hear of him again, as, in the event of his being convicted and sentenced to death, the question must arise as to the humanity of executing a man in his condition.

SHEFFIELD PUBLIC HOSPITAL AND DISPENSARY.

NOTES ON A CASE OF IMPACTION OF A FOREIGN BODY IN THE AIR-PASSAGES; TRACHEOTOMY; RECOVERY.

(Under the care of Dr. KEELING.)

FOR the following notes we are indebted to Mr. G. F. Gubbin, house-surgeon.

W. P.—, a boy, aged three years and a half, was brought to the hospital on Dec. 11th, 1882, by his mother, who said that whilst at school another boy had attempted to make her son swallow a bead.

On admission there was considerable dyspnoea, with cough and hoarseness, but a little while afterwards a marked remission of the symptoms occurred. Dr. Keeling performed laryngo-tracheotomy, but was unable to discover any obstructing body in the larynx; the lips of the wound in the trachea were separated, and the child was sent to bed. Examination of the chest made it quite evident that there was an obstruction to the entrance of air into the left lung. On Dec. 14th (the third day after the accident) a violent attack of coughing came on, accompanied by much dyspnoea, and it was supposed that the foreign body had become dislodged; consequently a pair of dressing forceps were introduced into the wound in the trachea in order to still further dilate it, and directly afterwards an expiratory effort expelled the foreign body through the wound. Slight inflammation

at the root of the left lung followed, but this soon disappeared. The wound in the trachea healed readily, and the patient was discharged from the hospital on Jan. 1st, 1883. The foreign body proved to be a pear-shaped glass pendant, with a loop of brass wire attached to it, weighing fourteen grains; it was considered to be a portion of an earring.

Medical Societies.

PATHOLOGICAL SOCIETY OF LONDON.

Sarcoma of Lower Jaw.—*Sarcoma of Bladder.*—*Bacilli of Leprosy.*—*Papilloma of Bladder.*—*Hydatid Cyst in Lung.*—*Ulceration of Intestine.*—*Disseminated Cancer.*—*Gastric Ulcer.*—*Polypus of Stomach.*—*Ulceration of Larynx.*—*Acute Atrophy of Liver.*—*Vacuolation of Brain.*

THE concluding ordinary meeting of the Pathological Society of London was held on Tuesday, May 15th, Dr. Buzzard, one of the vice-presidents, in the chair. By several members consenting to show their specimens as card specimens the session was closed without any arrears of work being left over.

Dr. GOODHART read the report of the Morbid Growths Committee on Mr. George Lawson's specimen of Recurrent Cartilaginous Tumour of the Lower Jaw, to the effect that the tumour was a spindle-celled sarcoma.—Dr. GOODHART also read a report on Mr. Roger Williams's specimen of Tumour in a Diverticulum of the Bladder, agreeing with Mr. Williams in stating that the tumour was a sarcoma.

Dr. THIN, for Dr. HILLIS, of Demerara, showed specimens and a drawing of the Bacilli of Leprosy. Dr. Hillis had sent from Demerara tubercles excised from patients suffering from tubercular leprosy, and sections had been prepared and stained, at Dr. Hillis's request, especially for the Pathological Society. The drawing shown had been made from the preparations, in accordance with Dr. Hillis's wishes, and gave an accurate representation of the bacilli.

Mr. MORGAN showed a specimen of Multiple Growths in the Bladder of a Man aged sixty-five. He had had symptoms of irritation of the bladder and hæmaturia for fifteen years. While in the hospital his urine always contained blood. An exploratory incision into the bladder was made in the perineum, and a tumour was felt, together with a velvety condition of the mucous membrane at the trigone; the tumour was removed by the lithotrite, and his symptoms were relieved for six or seven weeks. Then the symptoms returned, and the man died. There was some enlargement of the prostate, and about the trigone were several small tumours, all more or less pedunculated and formed of groups of villi. They were soft to the touch. The bladder was not much hypertrophied, and the ureters only a little dilated. Mr. Morgan thought that the tumours had developed since the operation. Mr. Boyd had examined microscopic specimens, and, although the tumour was too much macerated to prepare perfect specimens, he was able to determine that the growths were papillomata.

Dr. CURNOW showed a specimen of Hydatid Cyst in the Lung, obtained from a seaman, aged thirty, who was admitted to the Seamen's Hospital for cough, hæmoptysis, and loss of flesh. In January he suddenly expectorated a great quantity of watery fluid, followed by blood. In March he spat up some membrane, recognised to be hydatid cyst-wall, and it was then discovered that he had once been a shepherd in Australia. He died from exhaustion. The upper left pleura was obliterated, and in the upper lobe of the lung was a very large cavity, occupied by a loose hydatid cyst. The base of the pleura was full of pus; the tissue of the lung was compressed and airless. Echinococci hooklets were found in the cyst. In England such cases were very rare. In Australia they have been numerous. The case was at first taken for apex phthisis and basal empyema.—Dr. BUZZARD said that Dr. Bird gave the average amount of fluid drawn from such cysts as eight to sixteen ounces, and he doubted whether such a small cyst could have been successfully tapped.—Dr. WILKS asked if Dr. Curnow associated the hydatid with the shepherd's dog.—Dr. CURNOW replied in the affirmative.

Dr. CURNOW exhibited a specimen of Ulcerated Intestine,