

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

THE TREATMENT OF PULMONARY TUBERCULOSIS BY INTRAVENOUS INJECTION OF CHINOSOL WITH FORMALDEHYDE.

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IN THE LANCET of Nov. 12th, 1910, I published the effects of the above treatment in three cases of pulmonary tuberculosis. Since then I have had 22 cases under my care, and I think the publication of my results may prove interesting. It is quite possible that these results would have been even more successful had my patients continued to follow out my directions, but so-called "friendly advice" in several instances intervened and prevented my doing as much for them as I could have done.

Regarding the three cases already published, Case 1 is still at his daily work and feeling as well as ever he did. Case 2 decided to try a sanatorium, and I lost trace of him, although in an indirect way I hear he has not made any more progress. Case 3 took a relapse and put himself under other medical care. Of the cases unpublished:—

CASE 4.—Male, aged 44. Both lungs affected; all right lung and upper left lobe. Abundant coarse moist râles over upper right lobe front and back with fine râles over all affected region. Temperature; sweats; profuse expectoration laden with tubercle bacilli. Pretty severe hæmoptysis on several occasions. Pleurisy. Loss in weight over a stone. Regular medical attendant's prognosis, "hopeless." Present condition: Adventitious sounds absent. Appetite good. Sweats absent; temperature normal. Cough and expectoration practically absent. Gain in weight 17½ lb. Back at his own work for over three months.

CASE 5.—Female, aged 26. Had been in sanatorium for six months; no benefit derived. Upper and middle lobes of right and upper portion of upper left lobe affected. Dry râles over all affected region. Cough; sputum; tubercle bacilli present. Good deal of weakness with shortness of breath. Not much loss of weight. Present condition: complete absence of adventitious sounds; quite strong again. Gain in weight 6½ lb. Sputum negative. Back to work.

CASE 6.—Male, aged 26. Ill two years. Hæmoptysis very often. Temperature; sweats; much shortness of breath; sputum positive. No appetite. Very weak. Upper and middle lobes of right lung affected. Dry râles. Slight loss in weight. Present condition: Temperature normal; sweats and hæmoptysis stopped. Appetite good. Breathing much better; feeling stronger. Adventitious sounds gone. Cough and expectoration almost absent. Doing light work.

CASE 7.—Female, aged 16. Ill for a year. Upper lobes right and left affected. Temperature; cough; expectoration; sputum positive. Never menstruated. Slight loss in weight. Regular medical attendant's prognosis, "hopeless." Present condition: Temperature normal; cough and expectoration absent. Last four months menstruated regularly. Gain in weight 6 lb. Adventitious sounds all absent. Back to usual occupation.

CASE 8.—Male, aged 36. Upper and middle right and upper left lobe affected. Temperature; sweats; hæmoptysis; shortness of breath; weak. Loss in weight. Cough and profuse expectoration; sputum positive. Regular medical attendant's prognosis, "hopeless." Present condition: Temperature normal; sweats stopped; no hæmoptysis. Breathing normal; weight normal. Cough and expectoration practically absent. Adventitious sounds disappeared. Able for work.

These cases all seem as if the disease has been arrested and point to the great benefit—to some patients—of the treatment. Of my 17 other cases 5 are improving, but it is too early yet to say how long this will continue as they are still under treatment. With regard to phthisis, seemingly more than to any other disease, any new treatment is criticised from the standpoint of a specific, but can we really say that there is a specific for any disease? I do not think so.

Naturally one agrees we have heard of many cures for pulmonary tuberculosis, but they have been, in the majority of cases, unable to stand the test of time. If pulmonary tuberculosis is due to a specific microbe, why does the one treatment not have the same effect on all? This question opens up the query, Is tuberculosis due to a particular microbe? For a considerable period I have held to the opinion that while tuberculosis may be due to a particular micro-organism, yet there must of necessity be different species or varieties of such, else why do we get patients in whom the lung lesion is comparatively small having a most disproportionate systemic infection, resulting in a condition upon which no treatment seems to have any effect, and other cases in which the lung lesion is large, with a small systemic infection and most amenable to treatment? They cannot all be explained by the principle of mixed infection. No; the probability is that when our bacteriological knowledge is improved we shall find there are, as I have already said, various species of the tubercle bacillus, some of the species being more virulent than others. I am pleased to see from one of the journals that Mr. J. Penn Milton is working at a similar theory on practical lines, and I await with interest the publication of his results in this direction.

To enable whichever treatment we select to do the most good for the patient early diagnosis of the disease is of the utmost importance, and the leading specialists in tuberculosis will, I am sure, agree that "the good old clinic with its minute auscultation is the best means to make a good diagnosis." Tuberculin tests are of the greatest service in assisting a decision in a doubtful case, but X ray photography is of practically no value for that purpose, as consolidation of tissue must have taken place before it will reveal anything:

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NOTE ON AN OPERATION FOR PHLEBITIS WITH THROMBOSIS.

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Dr. George E. Keith asked me to see one of his midwifery nurses who was laid up by thrombosis with phlebitis in the superficial veins of the right leg, and it had occurred to him that it might be a good plan to cut out the clots and the inflamed parts of the veins. The history of the illness was that the patient (about 50 years of age) had a recent attack of influenza, sufficiently severe to keep her in bed. Ten days after the onset of the illness she complained of pain in the leg, and on examination Dr. Keith felt two large clots—one in the vein above the knee and the other in front of the middle of the leg. The skin was red and swollen, but when I saw her, a week after the clots had been first discovered, the redness had lessened somewhat. The clots were nearly an inch each in length and there was a third small one near the ankle. The veins of the leg were slightly varicose, and there was a very small amount of œdema.

I have not noticed if veins have been removed in this condition, and the operation does not appear to be mentioned in the latest surgical works, but it seemed to me a most reasonable suggestion as it was important that the nurse should not be laid up in bed for an indefinite number of weeks, and the risk of removing a few inches of vein is certainly not greater than allowing a clot to absorb with the accompanying risk of separation. The only point which is doubtful to me is whether the saphenous vein should be tied first. In a markedly varicose condition of the veins I would certainly do so, but in an ordinary case it hardly seems necessary, provided that the vein is exposed and tied well above the clot.

In the case referred to there was no difficulty in the operation, and the veins were much thickened where the clots were situated. Immediately on the proximal side of the clots the veins were normal, thickening towards the distal end and continuing in this state for some distance beyond. As very slight pressure caused the clot to slip out of the vein, it showed how carefully such conditions must be handled. The patient was able to walk ten days after the operation.

This operation seems to be such a useful one that, even if the idea is not original, it is well worth drawing attention to it.

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