Clinical Notes, Suggestions, and New Instruments

A NEW METAL TIP POSSESSING OBVIOUS ADVANTAGES FOR USE ON GASTRIC OR DUODENAL TUBES

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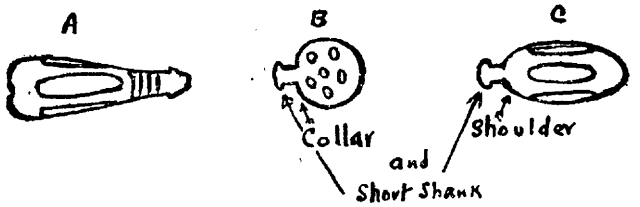
It is with reluctance that I am calling attention to a new tip for duodenal tubes because there are many excellent ones already on the market; but I feel sure that it will interest those members of the profession who are doing gastroduodenal work because it possesses certain definite advantages over any other type with which I am familiar. Perhaps I might better say that it does away with certain disadvantages common to nearly all others.

All duodenal tubes are swallowed rather easily by most patients, but many patients encounter temporary difficulty when the tub is withdrawn from the duodenal zone to the stomach, and more especially difficulty when it passes the glottis on its upward journey, at which time cooperative swallowing control is required on the part of the patient. This applies particularly to all tips of the olive or ball type on account of the shoulder or collar on the proximal side of the tip. They go down easily, but they are much more likely to "hang" at the glottis coming up.

To obviate this difficulty I have been trying out, during the past year, a tip quite similar to that designed by Rehfuss,



Three styles of tip for duodenal tubes: *A*, new style tip with no shoulder or collar and with a long and serrated shank; *B*, ball type tip with objectionable collar and short shank, and *C*, olive type tip with objectionable collar and short shank.

but of elongated pear shape instead of olive shape. The tip is ground down to a tapering proximal end of the same caliber as that of the rubber tubing. Therefore, in withdrawing this tip, all obstruction at the glottis is done away with. All patients, especially those well "tube broken" to many varieties of tips, are unanimously in favor of this one; and after all it is the patient who can furnish the best endorsement in such a matter.

The second advantage of this tip lies in the fact that its shank is slightly elongated and slightly serrated so that the rubber tubing, even when old, will stick closely to this tip under a stout pull without the necessity of its being tied and knotted with a silk thread. The latter point seems to me a very objectionable feature; for these knots instead of getting softer after boiling become distinctly harder, and I feel sure in many cases they traumatize the gastric or duodenal mucosa, especially in the latter zone where the tube may be left in situ for many days for feeding purposes, because the duodenal lumen is comparatively small and the peristaltic action vigorous.

The only duodenal tube with which I am familiar that does not possess the disadvantages I have just stated is the one designed by Jutte. This tube, I believe, is the easiest to pass to the stomach or duodenum, and I still continue to use it very frequently for such treatment as transduodenal lavage; but I do not like it for duodenal feeding because the perforations at the tip of the rubber tubing are so small that they frequently become obstinately plugged with the feeding mixtures. And for the same reason, I have discarded the use of this tube in diagnosis on account of the difficulty of aspirating many catarrhal residuums: and especially have I had difficulty in draining the biliary tract on account of the heavy viscosity of many biles.

Another point worth mentioning in gastroduodenal work is that the tube should be fitted with a glass window situated from about 8 to 12 inches from the proximal end, instead of with the metal connections in common use, so that the aspirated material may be inspected before it reaches the aspirating syringe, vacuum bottle or collecting vessel. By this means, material of special interest may be segregated for special study. This is of paramount importance in gallbladder and gallduct diagnosis.[1] A medicine dropper answers very well if the capillary tip is of the same caliber as that of the rubber tubing, or larger; or special small connecting glass tubes may be obtained from any physicians' supply house.

These tips may be obtained through the Physicians' Supply Company, Sixteenth and Sansom streets, Philadelphia.

1828 Pine Street.

CAUSTIC BURN OF THE EYE FROM INDELIBLE INK OR LEAD *

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Though injuries to the eye from the introduction of indelible ink or indelible lead are not very rare, the recorded cases have not taken on the aspect of a caustic burn. Therefore this case is presented:

REPORT OF CASE

Oct. 13, 1919, Miss F. L., aged 20, waitress, complained of pain in her left eye, and said that some ink had entered it twenty-four hours before. She was unable to state how this had happened; she realized that something was wrong only by the symptoms she had suffered, and knew it was ink by the appearance of the eye.

Examination revealed R. V. 20/20, L. V. 20/30, tension 0, both eyes. The left lower lid was slightly swollen, and the palpebral and bulbar conjunctiva of the lower fornix was congested, chemotic, and stained an intense purple, the color of the common indelible pencil lead. The stain increased in intensity downward, and among the tarsal folds was a clean cut, almost black ulcer, as if a fragment of the lead had rested there and exerted its effect strongly at one point. With a probe, it was ascertained that the ulcer was quite deep, almost penetrating to the infra-orbital margin. Almost the entire conjunctival surface beneath the lower lid stained with fluorescein. The upper lid and underlying conjunctiva were negative. There was slight staining of the lower margin of the cornea; the iris was clear, and the pupil of moderate size, but it responded rather sluggishly to light. Examination of the media and fundus detected nothing further.

The eye was irrigated thoroughly with sterile water till the waste showed no color, and then as much as possible of some black granular matter on the ulcer was removed with wet applicators. Atropin, 1 per cent., and argyrol, 20 per cent., were used; and after the conjunctival sac had been filled with sterile petrolatum, a patch was applied and the patient was sent to the hospital for further attention. Petrolatum was used in the eye every two hours for the next day, at the end of which period, iritis was found to be setting in. Atropin was started immediately and used every four hours next day, with the petrolatum continued at two hour intervals. On the following day the pupil was well dilated; and the petrolatum having been discontinued for a short time, fluorescein showed epithelization to be taking place slowly; but the patient was complaining of pain over the left cheek bone, and there was intense tenderness over the left infra-orbital margin, and some swelling and redness. Nasal examination disclosed no indications of maxillary sinusitis, and further investigation by means of the roentgen ray was refused. Dry heat to the painful region was ordered, and atropin, argyrol and petrolatum were used three times daily. Slight adhesions that were forming were broken up with a

1. Lyon, B. B. V.: Diagnosis and Treatment of Diseases of the Gallbladder and Biliary Ducts: Preliminary Report on a New Method, J. A. M. A. **73**: 980 (Sept. 27) 1919.

* From the "Johnson Clinic."

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