

## 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.

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#### 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