

Clinical Notes:

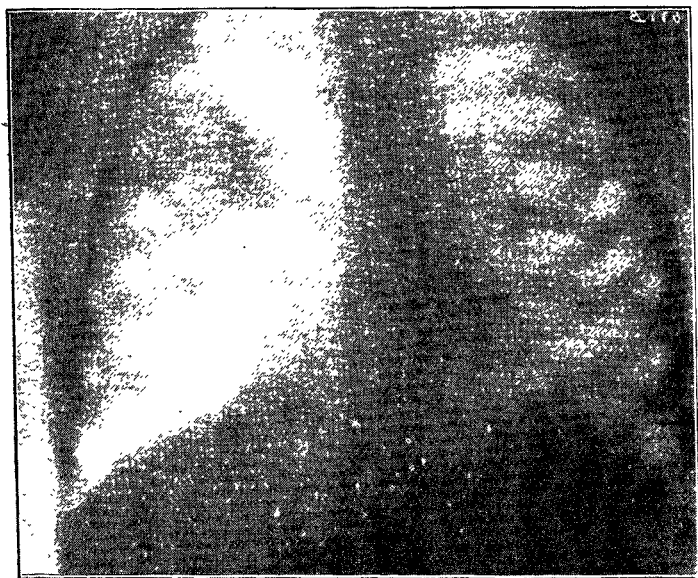
MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF TRAUMATIC PNEUMOTHORAX WITH SLIGHT SYMPTOMS.

BY R. STANLEY TAYLOR, B.A.,
ROENTGEN RAY ASSISTANT AT CHARING CROSS HOSPITAL.

THE patient, a boy aged six years, was taken to the hospital on Feb. 16th, 1904, with the history of having been knocked down and run over by a cab. There were a large scalp wound over the left occipital region and a superficial abrasion over the anterior ends of the right fifth and sixth ribs and costal cartilages, which were also somewhat tender

FIG. 1.



Skiagram showing appearance caused by collapsed lung.

on palpation but no definite evidence of fracture could be discovered. His respirations were a little laboured, varying from 36 to 40 to the minute; his colour was perhaps a trifle dusky and he had an occasional dry cough.

The chest was not carefully examined at the time of

FIG. 2.



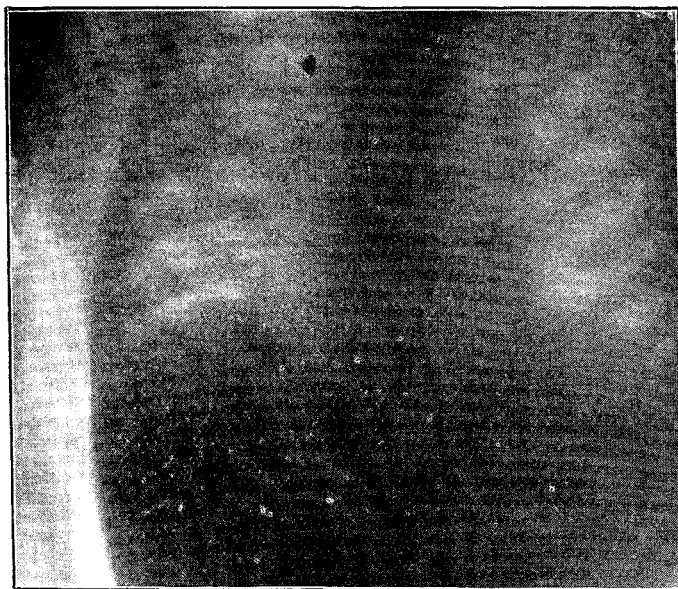
Skiagram showing lung to have increased in size.

admission but on the second day after the injury, when the first skiagram was taken, examination of the chest showed on the right side practically no expansive movement, very much diminished tactile fremitus, hyper-resonant percussion

note everywhere, that below the clavicle being particularly tympanitic, and weak breath sounds of an amphoric quality. A satisfactory bell note could not be obtained. The left lung was normal. The apex beat was situated in the nipple line in the fourth space and cardiac dullness extended from this to the left sternal border, the heart being little, if at all, displaced. The heart sounds were normal.

A skiagram taken on Feb. 24th (Fig. 1) showed the whole of the right chest to be abnormally transparent to the rays with the exception of an area of the size of a Tangerine orange opposite the second and third spaces, presumably caused by the collapsed lung. The symptoms disappeared in

FIG. 3.



Skiagram showing expansion to have been restored.

a few days and he, except for his head injury, did not appear to have anything wrong. The lung, however, took a considerable time to expand, although a definite increase in its size was shown by a skiagram taken on March 10th (Fig. 2). A third skiagram taken on March 22nd (Fig. 3) showed the lung to have expanded over the whole right side of the chest and the normal physical signs were restored. The patient was discharged quite well on March 24th.

The case is unusual in being one of traumatic origin, involving total collapse of the lung, but in which the concomitant symptoms were comparatively slight. The absence of any definite signs of fracture suggests the possibility of the condition being produced solely by rupture of the visceral pleura.

The x rays proved a valuable adjunct in diagnosis and the subsequent expansion of lung and absorption of air from the pleural cavity formed interesting subjects for the second and third skiagrams.

I am indebted to Mr. J. H. Morgan for permission to publish the notes of the case.

Charing Cross Hospital.

NOTE ON A CASE OF CÆSAREAN SECTION FOR RENIFORM RACHITIC PELVIS.

BY J. B. C. BROCKWELL, M.R.C.S. ENG., L.R.C.P. LOND.,
ASSISTANT MEDICAL OFFICER, POPLAR AND STEPNEY SICK ASYLUM.

A MARRIED woman, aged 22 years, a primipara, was admitted into the Poplar and Stepney Sick Asylum under my care on June 25th, 1903, at 4.30 A.M. Labour had commenced at about 6 P.M. on the previous evening, but the pains had ceased shortly before admission. On examination the patient was very short in stature (4 feet 3½ inches); the tibiae were short and very curved with the convexity forwards; there was marked scoliosis with a dorsal curve the convexity of which was to the right; and the sacrum was depressed leaving a marked depression between the ilia. The external pelvic measurements were as follows: (1) distance between the anterior superior iliac spines, 10½ inches; (2) distance between the widest points of the iliac crests, 11 inches; and (3) external conjugate, six inches.