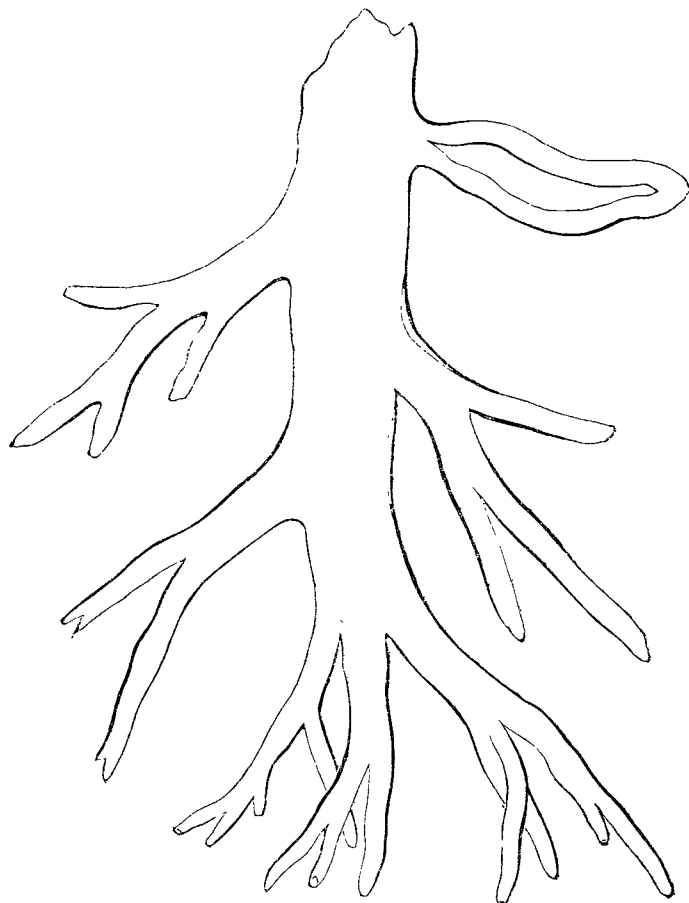


of that part of the aorta beneath which the left bronchus passes—i. e., the convexity of the arch, or the commencement of the descending portion; lastly, that the aneurism was small, as it revealed itself by no physical signs—there was no pain, no dysphagia, no pulsation, no murmur, the pulse was alike in both wrists. There was one circumstance in the form of this clot that, as I interpret it, strongly pointed to an aneurismal origin of it. Close to the large extremity of the main trunk, two branches seemed to arise by a common stem; but on separating these branches it was found that they were adherent at their extremities; in fact, that they formed a ring, (as may be seen on reference to the figure.) Now I cannot conceive how a



coagulum of this form—an unramified ring—could be moulded in a bronchial tube. I think it must have been formed in the aneurism, and dragged thence when the clot was discharged; that it was, in fact, a portion of the coagulated blood in the aneurism; that the size of the ring probably marked the size of the aneurism, and that the pedicle by which it was attached occupied the orifice of communication between the aneurism and the bronchus. This may seem making extensive deductions from small premisses, but I do not see how the annular form of this part of the clot can be otherwise explained.

Such was and is my diagnosis of this case, and its subsequent history has but confirmed my opinion. I have not seen the patient now for a fortnight (for, having expressed to the relatives my opinion as to the hopeless nature of the case, they imagined I had arrived at the end of my tether in the way of treatment, and that someone else might be richer in resource, and so sent for that someone else); but I have heard from Mr. Guy that the hæmorrhage still continues, that the patient is getting increasingly blanched by it, that casts are frequently expectorated, though not so perfect as the one I have drawn, and that there is still the same absence of symptoms, either of stomach or lung disease, and of signs of aneurism.

The great point of interest about this case, and that which to me appears to make it worth recording, is the peculiar circumstance that rendered certain the previously doubtful seat of the hæmorrhage, and at once reversed the diagnosis which had in the first place been formed.

In concluding, I cannot but remark that this case seems to me to confirm an opinion I have long entertained as to the nature of those cases of supposed plastic bronchitis in which hæmoptysis precedes or accompanies the discharge of the casts. I have always suspected that in these cases the fibrinous casts are the result of the hæmoptysis, and not the hæmoptysis the result of the detachment of the casts. It seems impossible to imagine how the discharge of a peculiar inspissated mucous exudation

(and the ordinary bronchial casts are nothing more) can be a cause of hæmorrhage; while, on the other hand, the decolorization of coagulated blood occupying the bronchial tubes would furnish pale and ramified casts. Moreover, it seems difficult to imagine why the discharge of the casts should in some cases always be attended with profuse hæmorrhage, and in other cases with none, except on the supposition of an essential difference in the nature of the casts in the two cases. I remember some time ago being told by a physician, of a case in which the late Dr. Todd expressed an opinion that the hæmoptysis was due to the detachment of bronchial casts, which he predicted in a few days would appear. In a day or two, when the bleeding was pretty well over, they *did* appear, and Dr. Todd got no small *kudos* for his prophecy, which was thought little less than miraculous. My informant expressed the belief, and I quite concurred with him, that the casts spat up after the hæmorrhage were nothing but decolorized fibrin whose discharge had, in some way or other, been delayed.

Montague-street, July, 1862.

REPORT OF A CASE OF PENETRATING WOUNDS OF THE THORAX; WOUND OF THE LUNG; PNEUMO- THORAX AND EMPHYSEMA;

AND ALSO INCISED WOUNDS OF THE THROAT, WITH
SUBSEQUENT HEMIPLEGIA; RECOVERY.

BY FREDERICK HALL, Esq., M.R.C.S.

A REPORT of the following case of severe penetrating wounds of the thorax, and incised wounds of the throat, will not, I think, be without interest to many readers of THE LANCET, nor fail in exciting the attention of the medical jurist. The extent to which the instrument penetrated the thoracic cavity, and each time wounding the lung, and the remarkable proximity the knife in its progress must have held in relation to the heart, render the escape of that organ from being wounded a miracle. The character of this case—its origin, course, and termination—appears to me to possess a peculiar interest; and I am assured by experienced army surgeons who have seen the case, that it is a very remarkable instance of recovery from severe self-inflicted injuries performed by an experienced hand. Fortunately in this case the patient at the time was suffering from violent mental excitement, and this rendered his hand unsteady and his anatomical knowledge obscure, so that the knife had a direction imparted to it very different from what was designed, or it would have certainly wounded the heart, and thus have caused a fatal termination. Now that the patient is convalescent and perfectly collected in his mind, he expresses his surprise that he has escaped the end he so unconsciously sought; but he supposes “that he must have forced the knife upwards, inwards, and to the right side, from the fact that he held the knife pointed against the intercostal spaces with his left hand, and then struck the extremity of the handle sharply with the right, thus giving a direction to the course of the blade very different from what he calculated it would take.”

In addition to these two penetrating wounds of the chest, there were two rather formidable-looking wounds of the throat—one on each side, so that a rather suspicious case presented itself for consideration; for, owing to the number and character of the wounds, the question might have arisen, under different circumstances and in a different place, as to whether they were the work of a suicide or had been received from the hands of an assassin.

There can be no doubt as to the lung being wounded, but it is very remarkable that no blood nor bloody sputa has from first to last been expectorated, nor has cough at any time been a symptom calling for especial attention; neither has the act of respiration been in any particular manner impeded. It is, however, certain that the lung was severely wounded, by the great collapse in which the patient was found, and also by the very free escape of air through the open wounds during each expiratory effort, as well also by the gradually extending emphysema, which at one time reached as far as the ankles, and was well marked in the subcutaneous tissue of the abdomen, thorax, neck, and face, and after the lapse of twenty-two days

could be very faintly heard crepitating in the cellular tissue about the mammary regions. This disappearance of the air from the cellular tissue day by day has been progressive and well marked, but the manner in which the escape of air is effected is not so very clear. By some it is considered to be effected by absorption. Mr. Fergusson, who did me the honour of seeing the case with me, expresses his opinion that the air escapes in a manner not well known through the skin, and he referred to an ordinary caoutchouc bladder, when distended by air, gradually collapsing from the transudation of its contained air through its walls. In this case, it is deserving of notice, that after the bowels had been freely purged, during which much flatus was expelled, the emphysema rapidly declined.

A case of severe fracture of the ribs occurs to my mind, in which the emphysema from laceration of the lung was exceedingly great, and distended the scrotum and face out of all proportion, but which, on the free purgation of the bowels, very materially diminished, and at the end of a few weeks finally disappeared. May not the air, I ask, in these cases, be taken up by the vessels by a kind of endosmotic action, and, reaching the surfaces of the lungs and alimentary canal, there exhale, to be ultimately expelled from the body?

The occurrence of complete hemiplegia of the left side imparts further interest to this case, and originates the question as to the cause producing it. Is it due to the same cause that led to the attempt of suicide? or does it arise from the shock to the system from the violence of the attempt and subsequent loss of blood? The paralysis is undoubtedly produced by an effusion into the cavities of the right hemisphere, and there is reason for believing that this did not exist at the time the wounds were inflicted because the patient had then the free use of the left superior extremity. The hemiplegia must therefore have supervened after the wounds had been inflicted. It was not until some few hours later, when the patient was in bed and the wounds dressed, that the existence of paralysis was suspected.

Ptosis of the left lid and distortion of the left angle of the mouth were the early indications of the approach of paralysis; then the left superior extremity became gradually powerless, and the inferior extremity of the same side soon became involved—reflex action in this limb was all but lost.

The treatment from first to last has been of a mild form, no active measures being called for. The wounds were simply cleansed and their lips approximated. No exploration of the chest wounds was ventured on; they were simply closed by slips of strapping, some rather large pads of lint, and, early in the case, a few turns of a common roller, so that the air had an easy escape from the cavity of the chest until the wounds granulated and closed. Sutures were only used to the wound in the left side of the throat.

Mr. Fergusson, who on the third day saw the case, and has for several days since then seen the patient, confirmed the mode of treatment which has ended with such satisfaction.

After making these preliminary remarks bearing upon the case, I will now enter as briefly as possible into the details.

S. M.—, aged thirty, a tall and well formed man, having an abundance of dark coloured hair, and irides of a dark brown. He is said to be of an excitable temperament, and lately given to a free use of alcoholic beverages. He has been much abroad, and has suffered from change of climate. Early in May he came to town, and on the second morning of his residence in his hotel I was called in haste to attend him, he being reported to be dying from severe wounds. On reaching his room I found him just raised from the floor, upon which he had been lying, and was now placed upon his bed—not in it. He was partly undressed. His face and lips were blanched; the general surface and extremities of the body very cold; the face, throat, and front and left side of the chest stained with much coagulated blood. A large mass of coagulum—about twenty or thirty ounces—was on the hearth rug, near which he was found lying by the “boots” when he entered the room; the bistoury was also found close to this. The patient was restless, partly unconscious, chattering incoherently in a low thick voice about many things connected with his pursuits. At the first glance a case of hæmoptysis was imagined to require attention, as the under-clothing &c. concealed the wounds; and on putting the question as to the frequency of such attacks, the patient, after a few moments’ consideration, said, “Oh, I have stabbed myself twice in the breast with a bistoury, and have sent it in as far as it would go, but have missed the heart.” On removing the under shirt the above statement was confirmed by the presence of three wounds—one of them being superficial. They were all close to the left nipple, but somewhat to the right of it, and near the sternum. The deep ones were of a formidable

kind, having entered the thoracic cavity and wounded the lung, as was shown by the escape of frothy serum and blood during the act of coughing or expiration. Each wound was about a quarter of an inch long, its lips were everted and clean, and the subcutaneous cellular tissue protruded. The two deep wounds entered the fifth and sixth intercostal spaces respectively, the superficial one being over the sixth rib.

The instrument with which these wounds were inflicted is an ordinary straight bistoury belonging to a surgeon’s pocket-case. It is, including the handle, seven inches long, of which three and a quarter inches belong to the blade. In the statement made by the patient be correct, of his having “sent it into his chest as far as it would go,” then at least five inches of the instrument may have entered the cavity. How the heart escaped being wounded it is difficult to explain.

On reaching the chest, and removing the coagula from the beard and throat, two severe wounds were found, one on each side of the throat: that on the right side being irregular in shape, very jagged, as if made by an unsteady hand, and also very superficial; the one on the left side was of a more formidable appearance, being about two and a half inches long, and extending obliquely from the inner margin of the middle third of the sterno-mastoid muscle to the thyroid cartilage. Fortunately this incision was comparatively superficial, and important structures escaped injury.

Treatment.—Some hot brandy-and-water was given to him, blankets were laid over him, and bottles filled with hot water were placed to his feet. A draught containing twenty minims each of Battley’s solution and chloric ether was now administered. The wounds of the chest were gently contracted by slips of adhesive plaster, then large pads of lint were laid over them, and the whole secured by a few turns of a common bandage, for without this support the dressing was being constantly displaced by the air as it escaped from the chest. The larger wound in the throat was secured by three sutures, and then covered by slips of wet lint, wet lint only being applied to the wound on the right side of the throat.—Evening (ten hours since the wounds were inflicted): Patient semi-comatose, restless, and constantly fidgeting the bandages, &c.; reflex action in the inferior limbs when irritated—very feeble on the right side, altogether absent on the left; left superior limb lies immovable by his side, and when raised falls with a “thud” upon the bed; left angle of the mouth retracted, and the cheek of the same side is flabby, and when he speaks he makes a frequent noise as if smoking a pipe; there is also well-marked ptosis of the left lid; respiratory action but slightly accelerated—24, regular; pulse is felt after some difficulty at the wrist; small and very feeble; scarcely, if at all, distinguishable at the ankles. The general surface and extremities are still very cold, but the lips have a little more colour in them.—Note: Hemiplegia of the left side has supervened in a very gradual manner since eleven A.M., the ptosis being first noticed about two P.M. Emphysema is becoming well marked, the integuments of the chest being distended so as almost to obliterate the outlines of the axillæ, and when compressed with the fingers crepitates audibly. Stimuli are to be cautiously continued; beef-tea is to be given at frequent intervals; and the evening being cool, a fire was ordered in his room.

May 3rd.—He had a tolerably good night, sleeping for several hours. When awake he talked incessantly. The wounds were dressed to-day: those of the throat are almost united, and those in the chest are smaller; through the one that passes close by the nipple into the chest, the air rushes with a shrill sound during expiration. Emphysema increasing and extending; the neck, face, and head are very tumid; pulse is gaining power. He was undressed and got into his bed to-day. He has mic-turated, and now talks less, and more coherently.—Twelve P.M.: Pulse stronger; the general surface warmer; some slight hæmorrhage from the chest wounds, but of no great consequence; hemiplegia well marked. The bowels being sluggish, two grains of calomel were given, and an ordinary aperient draught ordered for him two hours later.

4th.—Passed a good night; hæmorrhage from the chest rather free during the night, the lint pads being saturated; respiration regular and easy; no pleuritic or pneumonic inflammatory symptoms present themselves; the crepitation of the emphysema prevents auscultation being used; the emphysema reaches the wrists; pulse small—86–90. The wounds dressed; all are doing well. To-day the patient has been moved into a more convenient room. Mr. Fergusson met me later in the day, and confirmed the treatment. Towards night, being rather restless, a sedative draught was given.

5th.—Has slept soundly for ten hours. Pulse regular, full—86–90. Emphysema is more diffused, and is now felt about the

ankles. He is very cheerful, and expresses himself as being free from pain. An enema of thin gruel ordered to relieve the bowels.

6th.—After a second enema, which contained some castor oil, had been administered, the bowels were freely relieved, and much flatus expelled. The wounds of the throat are firmly adherent, and those of the chest are closing. Some slight degree of motion and sensation experienced in the left leg. Pulse soft, steady, and 86–90. He was allowed fish and gravy soup for dinner, and one glass of sherry.

8th.—Very free purging has supervened, since which the emphysema has much diminished, the face having almost assumed its natural expression. He has since the 7th taken two grains of calomel, with a quarter of a grain of opium, every four hours. He can to-day flex the left knee, raise the leg, &c. The chest wounds completely closed by granulations; the sutures from the wound in the throat were removed to-day, union being complete. To continue calomel pills every six, instead of every four, hours. A stomachic draught ordered.

10th.—With some little assistance he raised himself, and is now sitting up in bed reading. The ptosis of the left eyelid is very nearly removed; the left leg daily acquiring renewed vigour, but the superior limb is completely powerless and useless. He complains of feeling in it at times very singular pains. Emphysema very much diminished, most evident about the upper part of the chest. Respiration is regular, and on applying the ear to the right side puerile respiratory sounds are easily defined, and there is no question but that the upper portion of the left lung has some amount of functional activity; the condition of the lower portion of the same lung cannot, owing to the emphysema, be so well ascertained. The bowels are regularly relieved once or twice daily.

19th.—Much improved since last report. Mr. Fergusson since the 15th left the patient entirely to my care. He is up and dressed daily, and, aided by a stick, walks about his room. Emphysema almost removed, to be faintly felt about the pectorals and in the axillæ. Percussion shows the left side of the chest to be more resonant than the right side, due, no doubt, to the presence of air in the cavity. On applying the ear, there could be distinguished clear and distinct respiratory murmurs—this is over that portion of the chest corresponding to the middle and upper part of the lung. No murmurs could be detected in the base of the lung, and vocal resonance is far from clear. On the right side the respiratory sounds are clear, puerile, and rather prolonged; especially is this so at the apex of the lung. The cardiac sounds are clear, but rather faint. The pulsations of the heart's apex are not perceptible in the intercostal space. Hemiplegia is gradually disappearing. The patient walks freely, aided by a stick, a distance of two or three miles without being distressed. He can raise his left arm at the shoulder, and in a jerking manner advance the forearm; he has no influence over the flexors of the fingers. Temperature of the limb is increasing. Since the 11th he has taken six grains of iodide of potassium three times daily in a bitter infusion, and a pill also every night, containing two grains each of mercury-with-chalk and compound ipecacuanha powder. The gums being now somewhat tender, he is to take the pill every alternate night.

June 13th.—The patient now resides in the country, and walks out daily. He expresses himself as enjoying as good health as ever has fallen to his lot. He can now raise his left hand to his head after a slight effort, and can with some ease extend the left arm at a right angle, and hold it thus for some seconds. Supination and pronation of the forearm can be performed, but not very freely. To continue remedies, and exercise the left arm by the use of light weights. It is now only a question of time as to the entire recovery of the use of the limb.

Jermyn-street, July, 1862.

A CASE OF

CHYLOUS URINE SUCCESSFULLY TREATED BY TINCTURE OF MURIATE OF IRON.

By G. C. DUTT, Esq.,

SUPERINTENDENT OF THE BHOWANIPORE GOVERNMENT DISPENSARY.

I BEG to forward the following particulars of a case of chylous urine which came under my notice some few weeks ago. The case is so far interesting that it presented several peculiarities which have not (as far as I know) been mentioned by authors who have written upon the subject:—

Sh'aghur, a male Hindoo, aged twenty-four years, became an out-patient of the Bhowanipore Dispensary on the 25th of April last. He reported himself to have been suffering from chylous urine for four years, during which time he had been under several practitioners, and had taken a variety of medicines; but with very little benefit. As a last trial he came to me. On examining a specimen of his urine, it was found to be of a milky-white colour, thick, and full of coagula. There was no pinkish tinge in it. I am sorry to say I did not examine it for sugar. The patient stated that at the commencement he had slight pain in the region of the right kidney; but that it was removed by a blister, which, however, did not produce any effect on his morbid urine. He was dyspeptic; but his general health was good, and there was no evidence of any visceral disease or any local affection of the lymphatic system. He had a slight attack of intermittent fever while under my treatment, and which was cured by a few doses of quinine. The peculiarities of this case were that the urine passed during the day was clear and free from chyle, while that voided during the night and in the morning was deeply loaded with it. At night micturition was frequent, and the urethra would sometimes get blocked up by coagula. He was very much subject to night emissions.

I treated him at first for dyspepsia, which did nothing more than improve his appetite. For this purpose I gave him tonics, antacids, &c. I then tried gallic acid, in three-grain doses, three times a day, for five days; but with no better success. In fact, the symptoms were aggravated while under this treatment. I then resolved to try some preparations of iron, and accordingly ordered him fifteen minims of tincture of muriate of iron, in an ounce of infusion of quassia, to be taken three times a day. Before he had taken the medicine for three days the improvement in his urine was marked, and at the end of the week it was entirely free from chyle. I kept him under observation for more than four weeks after this, and intermitted the use of the drug for a week, and am happy to say that his urine continued free from chyle. He was discharged on the 6th of June as cured.

I have very little to remark on this case, especially as its pathology is involved in great obscurity. There are one or two points worthy of note: Was there any connexion as cause and effect between the dyspepsia and the chylous urine? I leave it to some of the numerous readers of THE LANCET to answer this question for me; but it is quite evident that there could not have been any organic lesion excepting a slight irritation of the right kidney at the outset. The night emissions may have been due to some irritation existing at the mouth of the bladder; the patient remained subject to them long after the urine had ceased to present any trace of chyle in it.

Bhowanipore, Calcutta, 1862.

A Mirror

OF THE PRACTICE OF MEDICINE AND SURGERY IN THE HOSPITALS OF LONDON.

Nulla est alia pro certo noscendi via, nisi quam plurimas et morborum et dissectionum historias, tam aliorum proprias, collectas habere et inter se comparare.—MORGAGNI. *De Sed. et Caus. Morb.*, lib. 14. Proœmium.

ST. BARTHOLOMEW'S HOSPITAL.

COMPLETE AND UNYIELDING ADDUCTION OF BOTH THIGHS;
SECONDARY TALIPES EQUINUS; SUCCESSFULLY
TREATED BY FORCIBLE EXTENSION.

(Under the care of Mr. COOTE.)

ELIZABETH L.—, aged seventeen, became the subject of a severe burn when about twelve years of age, in consequence of her clothes catching fire. She was more particularly burnt about the thighs, hips, back, and lower part of the abdomen, where numerous large cicatrices indicate the parts in which deep and extensive sloughs must have separated. On the outer surface of the left thigh there is a deep depression, leading to a cicatrix, the size of a five-shilling piece, and attached to