

Complications.—Apart from septic inflammation of the frontal bone which ought not to occur, other complications are few and of small importance. It is well, however, to warn the patient beforehand of the possibility of loss of sensation in the skin over the forehead owing to division of the supra-orbital nerve. Temporary diplopia is not uncommon owing to disturbance of or inflammatory exudation around the pulley of the superior oblique muscle. It does not, as a rule, last for more than a week or ten days.

A study of the results attained in the appended list of cases will show that efficient intra-nasal treatment alone will completely relieve headache and nasal obstruction, while in most instances the purulent discharge is diminished. The question therefore arises: "What should determine the surgeon in advising the external radical operation?" The answer will, I think, mainly depend upon the temperament and idiosyncrasies of the patient. Intra-nasal treatment, as in Case 6, may so benefit the patient that he or she may find no inconvenience from a small amount of pus which necessitates the use of only one handkerchief a day, a condition of improvement which the individual referred to speaks of as "cure," although there is a slight discharge of pus from each sinus. Neither can the surgeon regard the improved condition as one calling for immediate radical intervention, much as his surgical instinct may prompt him to regard inimically any pus-producing focus within the body. On the other hand, some patients are particularly sensitive to the presence of any abnormal nasal secretion, and however slight it may be they desire to be entirely rid of the same. Under such circumstances and again where the patient contemplates going abroad or to regions where an occasional skilled examination of the nasal cavities is not obtainable we may advise the external radical operation.

Concerning this procedure it may be said that if due regard is paid to the anatomy of the regions involved and care is taken in carrying out the details already indicated, it is an operation almost free from danger, leaving remarkably little scarring or disfigurement even after extensive removal of bone, and yielding results gratifying alike to both patient and surgeon.

Note.—Since the above article was written I have operated upon three more cases of frontal sinus empyema, the last of which I successfully skin-grafted by Thiersch's method, and the progress of this case leads me to think that this method will give ideal results and greatly minimise the time during which the patient is under treatment.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

CASE OF PANCREATIC DIABETES DUE TO CALCULI.

By E. WILLMER PHILLIPS, M.R.C.S. ENG., L.R.C.P. LOND.

THE patient was a naval pensioner, fifty years of age, and was first seen by me on the evening of Oct. 29th. He was then complaining (1) of passing a little blood per rectum when defecating; (2) a discharge in the interval which stained his shirt; and (3) of great weakness and wasting; he had lost in weight one stone in twelve months. He was a dark, tall, thin man and, except for absence of anæmia, looked as though suffering from malignant disease. There were no abnormal physical signs in his chest and nothing unusual was felt in the abdomen or per rectum. Sometimes he felt restless but lately he had been very drowsy. He had no thirst or polyuria. His tongue was clean and there was no perceptible odour in his breath. His bowels were open twice daily, the motions being very offensive. His pulse was 54 per minute. His urine was of specific gravity 1024; sugar was present, but there was no albumin. On Nov. 1st he passed five pints in 36 hours. On Nov. 3rd analysis showed 8.7 parts of sugar per 1000; no acetone, diacetic, or β -butyric acid was present. I noticed that the stain on his shirt looked greasy (or, as his wife expressed it, "as though vaseline had been smeared over it," and she had great difficulty in washing it out). Upon inquiry she said that the

motions were greasy and those I examined were mottled-grey, greasy-looking, and peculiarly offensive; once or twice there was solid fatty material upon cooling.

There were occasional slight pain in the pancreatic region and tenderness upon deep pressure, but nothing could be felt. The optic discs were very white and the man had had temporary amaurosis some time previously. At first he improved slightly upon careful diet, aperients, and pancreatic tabloids, and the extreme drowsiness passed off, but at the end of a month he would eat just what he liked with consequent drowsiness and weakness; one night he became excited and light-headed after a diet of milk, ginger-beer, brandy, sardines, and liver. After these bouts he would starve for a few days and improve, but on the whole the course was one of progressive weakness, aggravated for three weeks by severe hæmorrhage from prolapsed piles. The specific gravity of the urine varied from 1010 to 1032; that passed in the day contained sugar (12.500 per 1000 in May), but that passed at night did not. There was slight peripheral neuritis in the hands and legs. The lung broke down in May and he gradually died from exhaustion on June 14th. There was never any jaundice. I afterwards heard that he had suffered from frequent severe attacks of colic and vomiting for which he was invalided from the navy 20 years ago. Only a partial necropsy was allowed. The liver and kidneys were apparently healthy. The pancreas was hard and its duct was filled with calculi and calcareous matter. The largest mass was situated in the head of the pancreas and was tubular in shape; the next largest was at the splenic end; a third could be felt in the posterior part of the head; the entrance of every branch duct was plugged with concretions. No communication could be found between the pancreatic and common duct or with the duodenum. The substance of the gland was hard but it was not enlarged. It was examined by the Clinical Research Association and the report was as follows: "The pancreas shows great increase of fibrous tissue in parts with atrophy of acini and glandular tubules. A section of moderately large duct shows much shed epithelium from catarrh." The colours of the calculi and debris were chiefly yellowish white and dark grey mixed.

Remarks.—It was evident upon examining the urine and motions that there was obstructive disease of the pancreas, but cases of pancreatic calculi are sufficiently uncommon to merit record. The chief points of interest in this case are first the misleading symptoms for which he sought advice (hæmorrhage and discharge per rectum), and secondly the history of previous severe colic. In a case recorded by Minnich the symptoms of colic, intermittent glycosuria, and fatty motions led to the discovery of pancreatic calculi in the fæces. The peculiar odour of the motions seems to be almost pathognomonic of pancreatic disease; the great prostration and wasting also are more pronounced than in ordinary diabetes.

Southsea.

IMPACTION OF A BEAN WITHIN THE AIR PASSAGES; TRACHEOTOMY; EXPULSION THROUGH THE WOUND; RECOVERY.

By BRUCE HAMILTON, M.R.C.S. ENG., L.R.C.P. LOND.

THE following case presents features of special interest. A boy, aged 12 years, was playing with dried haricot beans when his elbow was accidentally jerked upwards with the result that a bean which he had been holding in his hand was shot into his mouth; fits of coughing and retching at once commenced.

I saw him within 10 minutes of the occurrence of the accident—viz., at 8.30 P.M. He was complaining of great difficulty in breathing and indicated the supra-sternal notch as the spot where obstruction was most felt. There was no evident laryngeal stridor and the character of the voice may be described best as "ventriloquial." He made many ineffectual attempts to relieve his embarrassment by cramming his fingers down his throat, an act that induced noisy vomiting but failed to give him relief. On examination of the chest no air was found to enter the right lung; the left lung was working naturally. No foreign body was seen in the larynx or trachea. Now and again he coughed up blood-stained mucus. It being

then practically certain that the right bronchus was blocked efforts were made to dislodge the foreign substance. Thumping the back, inversion, violent emesis induced by ipecacuanha wine, alike proved ineffectual, and the boy becoming sleepy he went to bed and slept placidly and uninterruptedly till morning.

Early the following day (12 hours after the accident) a fit of coughing occurred and similar attacks followed at diminishing intervals until at last a continuous struggle for breath terminated with unconsciousness and convulsions. The trachea was opened with one cut of the knife as the patient lay upon the floor where he had fallen, and at once restoration was partially re-established and consciousness returned, but it was not until the incision had been enlarged in a downward direction that a bean, greatly swollen, softened, and ruptured, was expelled through the wound with considerable force. The period of time that elapsed between the first cough in the morning and the onset of convulsions was about 20 minutes. The subsequent history of the case was uneventful.

The right and proper treatment in a case such as that which has been related is immediate tracheotomy, thus obviating the possibility of sudden death from laryngeal spasm should the foreign body become dislodged and be driven upwards; but it is by no means an easy matter to convince the friends of the imperativeness for surgical interference when they see the patient sleeping calmly. In the case in point, though probably there was present some degree of laryngo spasm at the time of operating, as evidenced by the partial restoration of respiration that at once took place after the trachea had been incised, I believe that the spasm was chiefly due to a participation of the adductores vocales in the general convulsive fit consequent upon hypervelocity of the blood rather than to reflex spasm brought about by peripheral irritation of the tracheal nerve-endings. Profuse hæmorrhage followed incision of the skin and may have been a factor in relieving spasm. The reason that asphyxia came on so precipitately towards the last may be partly explained by the nature of the foreign body. The testa would take time to soften and until that had been accomplished no great general increase in size could take place; but once the substance of the cotyledons began to absorb moisture a vast and relatively sudden expansion would occur, and any check upon expansion, such as the walls of the bronchus would have been likely to have exercised, would terminate with the dislocation of the foreign body into the wider lumen of the trachea.

Hampstead, N.W.

A CASE OF ADDISON'S DISEASE; TREATMENT WITH SUPRARENAL EXTRACT; DEATH.

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IN this instance the symptoms of Addison's disease supervened in a man who exhibited in several organs signs of old, but thoroughly and long since arrested, tuberculosis. The bronzing of the skin was observed by the patient's friends two months before his death and became rapidly intensified along with increasing asthenia, chilliness, and gastrointestinal irritability. Treatment with suprarenal extract was apparently without any avail, but it is only fair to say that this treatment was not instituted until very late in the course of the illness. The following notes give an outline of the case.

The patient was a man, aged 40 years, with a strong family history of tuberculosis. His present illness had begun two months before with darkening of the complexion accompanied or followed by feebleness and nausea. On admission to the Cheltenham General Hospital there was extreme pigmentation of the skin. The scrotum and penis were absolutely black. The face and hands were of a dark brown colour. The skin over the trunk was much pigmented. The legs and the feet were only slightly discoloured. There was some pigmentation on the dorsum of the tongue. The pulse was 66. The temperature was entirely subnormal. The knee-jerks were present. The urine was normal. There was considerable distortion of the spinal column, dating from an attack of spinal caries when 23 years of age. The symptoms most complained of were vomiting, great

weakness, and chilliness. Suprarenal extract was administered twice a day without any good effect. Small doses of liquor morphiae alone appeared of service in checking the vomiting. On the tenth day after admission the temperature, which for several days had never been higher than 97.4° F., suddenly rose to 101°; and with it the pulse-rate, which had averaged 55, increased from 50 to 100. No actual rigor was noticed. But two mornings afterwards the temperature had again fallen to subnormal and the patient was once more complaining much of chilliness. The nurse in charge administered a little stimulant and leaving the bedside was surprised and shocked to find on returning 10 minutes later that death had occurred.

Necropsy.—Signs of old arrested tuberculous disease in the spinal column were found. There were small obsolete strongly encapsuled tuberculous deposits here and there in both lungs and in the bronchial glands. There were no signs of active or even recent tuberculosis in any organ. There was very great displacement of organs due to spinal curvature. The right suprarenal capsule firmly adherent to the under surface of the liver was represented by an olive-shaped mass of dense fibrous tissue. The left capsule was adherent to the tail of the pancreas; it was normal in shape but with its proper substance entirely replaced by fibrous tissue containing several small caseous centres. Owing to spinal curvature the kidneys had fallen away considerably from their normal position and were no longer any guide to the situation of the suprarenals. There was much chronic thickening of the peritoneal and subperitoneal tissue in the neighbourhood of the distorted spinal column and the suprarenals lay in the midst of this sclerosed area. The spleen was diffident. The liver was very soft and fatty. The heart walls were very thin and soft and rotten.

Cheltenham.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

WESTMINSTER HOSPITAL.

THREE CASES OF PHTHISIS TREATED WITH "TUBERCULIN R."

(Under the care of Dr. W. MURRELL.)

IT is even more important to publish unsuccessful cases than to record those in which improvement has resulted, and especially is this so in connexion with new methods of treatment. Ten years have elapsed since the introduction of Koch's tuberculin, and yet it has not attained to a recognised position in the therapeutics of pulmonary phthisis. It appears to be of very little use in mixed infections or in advanced cases, and the striking beneficial results detailed by Professor McCall Anderson in his lecture¹ are certainly exceptional. Professor Anderson gives his patients large doses of cod-liver oil (three ounces a day), and this may account in part for the difference. The reaction produced by Koch's original tuberculin was certainly of some diagnostic value, but with the new tuberculin there is very slight reaction and therefore its use in diagnosis is less.

CASE 1.—An old soldier, aged 41 years, was admitted to Westminster Hospital on August 31st, 1898, suffering from phthisis. He had been ill for three years and during the greater part of that time had been under treatment. His symptoms were cough with muco-purulent expectoration containing tubercle bacilli in abundance, progressive loss of flesh, and night-sweats. His physical signs were deficient movement and dulness over the whole of the right side, with high-pitched breath-sounds accompanied by crepitant râles. Posteriorly there was dulness at the right base up to the angle

¹ THE LANCET of June 16th, page 1703.