

complete recovery of one child, who suffered from chronic hydrocephalus. It is interesting to note that, although we had not seen Mr. Parkin's earlier communication previously to our case, the same position was selected for operation in his case and in ours, with the exception of the difference in the side, his being on the right, ours on the left.

In conclusion, we venture to hope that, though we do not pretend to have proved this to have been a case of "tubercular" meningitis cured by operative treatment, we have adduced evidence tending towards establishing the tubercular nature of the case. We both of us feel that in this instance the patient owes her life to the operation, and in view of the desperate prognosis in this disease and of the successful result obtained by operative treatment in our case we have ventured to bring this paper before the society.

## Clinical Notes :

### MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

#### ACUTE ABSCESS OF FRONTAL SINUS WITH NECROSIS, SIMULATING ORBITAL CELLULITIS.

BY C. RAMAGE, M.D. EDIN.,

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THE case recorded by Mr. Mayo Collier in THE LANCET of Jan. 27th last, brought to my recollection a somewhat similar one which came under my notice while house surgeon in the Manchester Royal Eye Hospital.

A young man twenty-one years of age was admitted to the hospital as an in-patient under the care of Dr. Little (to whom I am indebted for permission to publish the case) on July 21st, 1891, complaining of severe pain and swelling in, with a purulent discharge from, the left orbit. He had enjoyed good health until two months previously, when he was attacked by influenza. While ill he noticed a swelling beginning in the left orbit, which became painful and, five weeks before admission into hospital, ruptured, allowing the escape of pus. There was no history of any accident. On admission the left eye was protruded and displaced downwards and outwards, but was fairly movable in all directions. The conjunctiva was injected, the cornea clear and the pupil active. There were much swelling and redness of all the tissues surrounding the eye, extending upwards over the frontal sinuses and downwards over the malar bone on to the cheek. The slightest pressure over the swelling, which seemed of a firm consistence, especially at the upper inner angle of the orbit, produced intense pain. There were two sinuses, surrounded by granulations discharging fetid pus. One was situated just above the left lacrymal sac and the other was half an inch above and external to it. There were a fetid purulent discharge from the nose and marked frontal headache. The same afternoon I made a free incision, connecting the sinuses, snipped off the granulations, removed a large sequestrum of dead bone, scraped out the frontal sinuses, removing a lot of cheesy looking material, and inserted a drainage-tube in the wound. Iodide of potassium was given internally, as the characteristic notched teeth were present. The patient did well, and on Aug. 7th he was discharged, the eye having resumed its normal position, with free mobility and unimpaired vision. The wound was closing from below upwards so as to obliterate the frontal sinuses, and the thickening over the upper margin of the orbit and on the cheek had completely subsided. There was no discharge from the nose. I saw the patient again on Sept. 17th, 1892, and found the eye normal regarding position, mobility, and vision. A cicatrix more than an inch long existed at the upper inner angle of the orbit, with a depression, into which the tip of the little finger could be placed, where the dead bone had been removed and the frontal sinus obliterated. The nasal passages were healthy.

The chief points of interest in the case are : 1. Acute supuration of the frontal sinus as a sequel of influenza. 2. The presence of a large sequestrum. This was almost three-quarters of an inch square and was exceedingly thin, the lower half consisting of the orbital plate of the frontal and the upper half of the vertical plate. It is very rare that

a large sequestrum like this is found. 3. The discharge from the nose, indicating that communication between it and the frontal sinus had been re-established. To the two latter factors the rapid and successful issue of the case is to be attributed.

Hornsey-road, N.

#### EXTRACT OF BONE-MARROW IN THE TREATMENT OF ANÆMIA.

BY J. DIXON MANN, M.D. ST. AND., F.R.C.P. LOND., &c.,  
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THE red marrow of bone being probably the chief agent in promoting the development of red blood-corpuscles, it seemed feasible to suppose that an extract of this substance, if introduced into the human organism whilst in an anæmic state, might act as a stimulant to the formative process and increase the rate of production of the red corpuscles. In adult animals—as the ox—red marrow is limited to the larger bones of the trunk, the thick parts of the skull, and the heads of the long bones ; the shafts of the latter contain yellow marrow, which is chiefly composed of fat. In young animals—as the calf—red marrow is more abundant and may be found in the shafts of the long bones as well as in the parts just named. As the tissue-forming power in young animals is more active than in older animals the bones of the former are preferable as a source of marrow extract. To prepare the extract the heads of the long bones, obtained from recently killed animals, with other portions of bone which contain red marrow, are broken into small pieces and digested in glycerine with frequent agitation. When the extraction is complete—several days being required—the extract is filtered off and is ready for use.<sup>1</sup> It is red or reddish-brown in colour and is devoid of any unpleasant taste or odour. It may be given in teaspoonful doses once or twice a day either out of the spoon or spread between thin pieces of bread. The first case in which I tried the extract was that of a little boy, the subject of hæmophilia. This child had repeatedly been in the hospital under the care of one or other of my colleagues or of myself for attacks of hæmorrhage. On each occasion the bleeding ceased ; but the patient never lost the pallor of pronounced anæmia, although he was treated with iron, arsenic, cod-liver oil, and all kinds of appropriate nourishment. The last time that he was admitted the red corpuscles were counted after the hæmorrhagic symptoms had subsided and were found to be 3,800,000 per cubic millimetre. The patient was then (Sept. 13th, 1893) put on marrow extract without any other treatment, and after an interval of three weeks the corpuscles were again counted ; they now numbered 4,190,000, and one month later they reached 4,400,000. Coincidentally with this increase there was a marvellous improvement in the appearance of the child ; his face acquired an amount of healthy colour never previously observed during his many visits to the hospital. In a second case, that of a young woman twenty years of age with long-standing anæmia, the corpuscles numbered 3,700,000 per cubic millimetre ; after taking the marrow extract for three weeks they increased to 4,000,000. She then left the hospital. In another anæmic girl the increase in nine weeks was from 1,350,000 to 3,680,000. A man was admitted for profuse hæmatemesis ; after the bleeding ceased the red corpuscles were found to be reduced to 1,070,000 per cubic millimetre. He was put on marrow extract without other treatment, and, when counted on the fifteenth day, the corpuscles numbered 3,050,000. I am indebted to our house surgeons, Messrs. Newby and Brown, for these observations. I am encouraged by these and many other favourable results to direct the attention of the profession to marrow extract as an agent capable of affording, to all appearance, valuable aid in the treatment of anæmia and also of oligæmia due to loss of blood from causes such as placenta prævia, hæmorrhoids, and wounds.

St. John's-street, Manchester.

<sup>1</sup> May be obtained from Mottershead and Co., Manchester.

PRESENTATION.—Mr. Maurice Treston, L.R.C.P., L.R.C.S. Irel., of Sparkhill, Birmingham, has been presented with a silver-mounted salad bowl and service by the Sparkhill Ambulance class.

## 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. Prooemium.

### WEST LONDON HOSPITAL.

#### A CASE OF BILIARY COLIC; CHOLECYSTOTOMY.

(Under the care of Dr. BALL and Mr. BIDWELL.)

THE following is an interesting case of operation for the removal of gall-stones from the gall-bladder, where there was no evident distension of the gall-bladder, nor jaundice. With regard to similar cases Mr. Greig Smith<sup>1</sup> has written: "No general rule can be laid down as to the weight of the indication arising from hepatic colic. After months or years of intense suffering many patients get well and remain so. On the other hand, a patient's life may be rendered miserable, or his active existence as a breadwinner may be cut short, by persistently recurring attacks of hepatic colic. A time then comes when patient and surgeon both agree that it is proper to interfere. In all such cases the patient's desire must have great influence with the surgeon." For the notes of this case we are indebted to Mr. J. H. Wilks, house surgeon.

A man thirty years of age was admitted into the West London Hospital on Nov. 27th, 1893, on account of severe attacks of abdominal pain. The first attack of acute pain occurred about two years previously, and was so severe that the patient lost consciousness and perspired profusely. He said that he was confined to bed for three days and that he became yellow. There was no further trouble until about eight months before, when he had a similar attack, again losing consciousness and becoming yellow afterwards; there was a third attack three months previously, and the last one occurred one month before admission. These attacks of pain commenced with a suffocating sensation, followed by very intense pain just below the ensiform cartilage; this pain lasted for about two days, but was only severe for about twelve hours; it was accompanied by vomiting, profuse sweating and shivering. When the pain occurred he always went to a hospital, where morphia was given him. These seizures were generally followed by constipation and a tight feeling across the chest; but otherwise his general health had not been affected, and there had not been any loss of flesh. He had not had any other illness, he came of a healthy family, and was temperate in his habits. The patient, when admitted, was a muscular and well-nourished man, apparently in good health, but slightly sallow. His appetite was good and his tongue was clean and steady, but he suffered from eructations and constipation. Nothing abnormal was noticed about the faeces; no gall-stones were found. The heart and lungs were normal. The urine was normal. There were no bile acids or pigment. The liver dulness extended up to the fifth interspace in the nipple line, but its edge was not felt below the costal arch. The gall-bladder could not be felt, but there was a feeling of resistance, and the patient complained of soreness in this region. There was no enlargement of the spleen. The abdominal muscles were very well developed and the walls were rather resistant. As the patient was very anxious to have some operation done to prevent the recurrence of these attacks, it was decided to explore the gall-bladder. On Nov. 29th the operation was performed by Mr. Bidwell, under ether. An incision four inches long was made in the right linea semilunaris, starting from the top of the ninth rib; the rectus, which was very well developed, overlapped the transversalis, causing some difficulty; at this point, too, the patient stopped breathing, and artificial respiration had to be undertaken. After a few minutes, however, the breathing became natural, and after the bleeding points were ligatured the peritoneum was opened. The gall-bladder, which did not reach the edge of the liver, was found to be closely packed with stones, without any fluid; there were some adhesions between it and the great omentum, which were ligatured and divided. A large flat sponge was introduced into the abdominal cavity, and,

after pulling up the gall-bladder into the wound, an incision was made into its fundus and the edges were clamped with pressure forceps. The stones were removed with forceps and a scoop, and were rather friable, many being broken during removal. The stones extended into the cystic duct; these, which were larger than the others, gave some trouble in removal on account of a definite constriction between the gall-bladder and the cystic duct; 212 stones were counted, and varied in size from a millet seed to a hazel nut. Before the completion of the operation bile began to flow from the gall-bladder, and required frequent sponging to prevent its entrance into the peritoneal cavity. The gall-bladder was stitched to the parietal peritoneum by a continuous fine silk suture, and a rubber drainage-tube five inches long was passed into the cystic duct. The peritoneum was sponged out, and several small fragments of gall-stones were removed on the sponges; the rest of the abdominal incision was united with silkworm gut sutures and the wound was dressed with cyanide gauze and wood-wool pads, the lower part being supported by strapping. The dressings were completely soaked with bile within a few hours after the operation, and were changed. On Nov. 30th the patient was comfortable and slept well without any morphia, and only complained of some pain in the wound. There was some distension in the right flank, but there was no abdominal tenderness or general distension. There had been no vomiting, and milk and barley-water were given by the mouth. The dressings were saturated with bile, and required changing twice in the day. The drainage-tube was shortened half an inch daily and was removed on Dec. 7th, although there was still a considerable quantity of bile in the dressings. He had a little bronchial irritation after the ether, but this quickly passed off. The temperature never rose above 99° 6' F. after the operation and after the fourth day remained normal. Solid food was given on the third day and the bowels were opened with an enema the same day. The wound healed readily with the exception of the tract of the drainage-tube, which, however, was closed on his discharge from the hospital on Dec. 23rd, 1893. The wound was supported with strapping for a month.

*Remarks by Mr. BIDWELL.*—I have recorded this case as the operation was performed solely on account of the sudden attacks of pain in the epigastrium; even the history of jaundice was not definite. There was absolutely no swelling and very little tenderness in the region of the gall-bladder, and as it reached the edge of the liver it could not have been felt, especially as the patient was a muscular man with well-developed recti muscles; yet the gall-bladder was closely packed with stones without, however, any fluid. The operation of cholecystotomy is now so free from risk in non-jaundiced cases (as has been shown by Mr. Mayo Robson) that it seems justifiable to operate even where, as in this case, only three or four attacks of biliary colic had occurred, instead of waiting till the patient is worn out by a long series of attacks. We must also be ready to operate where there are no physical signs of a distended gall-bladder and where the only symptom has been pain; but, of course, we must be prepared in some of such cases to find no stone. This happened to me lately in the following case. A patient for two or three years had suffered from attacks of epigastric pain, which occurred nearly every day, and were only controlled by hypodermic injections of morphia, which he took freely. After consultation with a physician it was decided to explore the gall-bladder, which I did, but found no stone; the gall-bladder, however, was thickened, and there were some adhesions about it. It was opened and drained, the patient making a rapid recovery. Three months later he left England, and wrote that he had had no further attacks of pain. In this case most probably the pain was due to the effects of inflammatory thickening caused by gall-stones which had been passed. In neither of these cases has any ventral hernia followed.

### WOLVERHAMPTON AND STAFFORDSHIRE GENERAL HOSPITAL.

#### COMPLETE ILEO-CÆCAL INTUSSUSCEPTION; NECROPSY; REMARKS.

(Under the care of Mr. WINTER.)

THIS case is a good example of chronic intussusception of the most common form—the ileo-cæcal. The account is a full one, and the chief points which are suggested by it as deserving of attention are referred to by Dr. Edward

<sup>1</sup> Abdominal Surgery.