

## A FOREIGN BODY IN THE LEFT BRONCHUS OF A CHILD EXPELLED THROUGH A TRACHEOTOMY WOUND ON THE FIFTEENTH DAY AFTER INHALATION.

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A LITTLE boy, aged one year and nine months, was seen by his parents on August 3rd to have a mouthful of chicken corn. He was told to spit this out, which he did, but not without a severe fit of coughing. From that date to the 7th he had repeated attacks of coughing without any very evident distress in breathing. In the intervals between these attacks he seemed perfectly well and was running about as usual. On the 7th he was taken home, a railway journey of 25 miles. On the morning of the 8th the child had a severe convulsive coughing fit with great respiratory distress and the breathing ceased for a few moments. Artificial respiration was performed. Natural breathing was restored and the coughing and respiratory distress gradually passed off. On the evening of the same day the child had a similar attack. Again on the evening of the 9th he had an attack of marked dyspnoea; the temperature was normal and the respirations were 76; there was deficient entry of air into the left lung. By observing the effect of position it was noticed that the child breathed the easiest when lying flat on his back. In this position it was thought that air entered the left upper lobe. The dyspnoea lasted for about two hours; the child slept all night; during sleep the respirations were 44. On the 10th there were two attacks of dyspnoea and coughing, each lasting about two hours; these were not so severe as the former attacks had been. There was one dyspnoeal attack on the following day and the temperature rose to 101·6° F. but it fell to normal again in three hours. This was the only time the temperature was raised. On the 12th there were no paroxysms of dyspnoea, but the respirations were from 50 to 60, while the temperature was normal and the pulse ranged from 120 to 130. The child seemed bright and playful. On the 13th he was brought up to London, a distance of 200 miles. There had not been any attack of dyspnoea since the 11th; the respirations varied between 40 and 50 and the pulse from 120 to 130. The child had been kept flat on his back since this was found to be the position easiest for breathing. Since the evening of the 9th the condition of the left lung had practically not changed, the percussion note was quite flat and the breath sounds were inaudible over the lower and very faint over the upper lobe; marked recession of the intercostal spaces was present. At times moist sounds were heard over the lung, and the child during the fits of coughing seemed to expectorate mucus into the mouth which was promptly swallowed. It seemed pretty clear that a piece of corn had found its way into the left bronchus and was obstructing it, and probably more the lower than the upper division of the bronchus.

Under chloroform anaesthesia the trachea was opened. This was incised as low as possible in the neck and a long opening was made so as to get as near to the bifurcation as possible by this route. An enlarged thymus considerably added to the difficulties of exposure; this extended into the root of the neck and obscured very much the tracheal opening. The trachea was held widely open with retractors and the thymus held down and instruments of various sizes and shapes were passed down the wind-pipe. Probes, curved wire, and various forceps were all tried without avail. The right bronchus could be entered but not the left. In spite of a thorough trial, lasting nearly an hour, the foreign body could not be extracted. The child was allowed to come nearly round from the anaesthetic, coughing was excited, and various positions were tried, but all were useless. A tracheotomy tube was inserted. On account of the large hole in the trachea and the enlarged thymus gland a silver tube could not be used, since it was not long enough and was jerked out at once by the elevation of the thymus during respiration; a long rubber tube was therefore employed. On the same evening the respirations rose to 72 and the temperature to 102°, and the child became very ill. During the night a severe dyspnoeal attack

occurred which was relieved by the inhalation of oxygen. On the following day it was noticed that there was deficient entry of air into the lower lobe of the right lung and an area of bronchial breathing was present at the apex of this lobe; numerous moist sounds were heard over the right chest and there was recession of the lower intercostal spaces. During the following two days the condition remained much about the same. The physical signs in the chest were unaltered; at no time could it be certain that any more air was entering the left lung. The temperature ranged from 99° to 101·6°, the respirations from 60 to 72, and more urgent dyspnoea occurred at times. The tube was left in and quantities of mucus were expelled through it. The physical signs suggested that the left bronchus was more or less completely occluded and the right one also to some extent; the foreign body, therefore, was probably lying at the bifurcation of the trachea. On the third day after the tracheotomy the tube was removed and a further attempt (without anaesthesia) was made to remove the foreign body. This was unsuccessful. A silver tube was now inserted. The process was repeated on the following day and again on the next day, when after a violent fit of coughing and dyspnoea which lasted for some minutes, and during which the child seemed nearly dead, the body was seen in the depths of the wound and was removed. During this paroxysm of coughing and dyspnoea it seemed pretty certain that the body must have changed its position and must have lain in the trachea; various forceps were passed down but it could not be grasped, nor even felt, not even in this short length of trachea. The body was a piece of maize swollen to two or three times its natural size; on drying it, it soon shrank down to its normal size and was absolutely unaltered; it was not even split. The tracheotomy tube was at once left out and the wound was allowed to close, which it speedily did, becoming merely superficial in six days. On examining the chest a few hours after the body had been expelled a marked change was noted to have taken place. Over the whole of the left lung and the lower part of the right lung there were intense bronchial breathing and numerous moist sounds. Day by day the breathing became less bronchial and more and more normal and the râles lessened; the last portion to clear was that near the root of the lung. During the first few days considerable quantities of mucus were expelled from the tracheotomy wound. This lessened and ceased in six days. The lungs did not return to their normal condition, as judged by physical signs, until eight days after the expulsion of the body. During the whole of this time the temperature was normal. The respirations for the first two days remained frequent at from 50 to 60; this frequency gradually diminished as the signs in the chest disappeared.

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## ON THE OCCASIONAL NECESSITY OF DRAINAGE OF THE UTERUS IN PUERPERAL INFECTION.

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WHEN a mere practitioner ventures into print upon a subject connected with the work of specialists he must indeed both excuse and justify his action. The details of the following case, interesting and instructive to me, may contain nothing new or of infrequent occurrence in the larger experience of accoucheurs but may, on the other hand, corroborate conclusions that are already generally admitted.

Even specialists and consultants will not, I believe, contest one advantage enjoyed over them by the general practitioner. His constant contact with the patient enables him to detect changes, to see cause and effect in treatment, and to realise the meaning of certain phenomena in a measure that cannot be appreciated by the brief examination, however thorough, of the physician called in consultation. It has often seemed to me that the consultant is at a great disadvantage, both as regards his ability to help the patient and as regards his interest in the subsequent course of the ailment, just because his examination of the patient must be so brief and so isolated. He cannot see for himself whether his treatment is properly followed or results in advantage to the patient: he sometimes does not even know if his diagnosis of a difficult case has been correct.

The case I would now refer to may be summed up as one