

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.

NORTH LONDON HOSPITAL FOR CONSUMPTION.

EMPYEMA OF FOUR YEARS' DURATION TREATED BY
INCISION AND DRAINAGE; MELANCHOLIA;
REMARKS.

(Under the care of Dr. SQUIRE.)

THE treatment of empyema by incision and drainage in cases where it seems hardly probable that any good can be done in other ways, because of disease in other parts and the feebleness of the patient, receives encouragement from the record of the following case. Four years is a long time for the disease to exist in these days when the treatment is fully recognised, and cases seldom present themselves for help at so late a stage. Extreme emaciation and feebleness, some hectic, wearing cough with profuse expectoration, with signs of disease in the lungs, and albuminuria made the man's condition most serious. The onset of melancholia when otherwise the patient was progressing satisfactorily is interesting. For the notes of the case we are indebted to Mr. P. Moriarty O'Brien, resident medical officer.

G. S.—was admitted on Feb. 3rd, 1887, in a very weak condition. Family history good. The patient was strong, and had always been healthy till four years previously. He then had a rigor; no symptoms followed, and he was able to resume his work next day, and continued working for two months, when he again had a rigor, this time very severe in character. He was then compelled to give up work, as he felt very ill. Cough, with free muco-purulent expectoration, vomiting, dyspnoea, loss of appetite, sweats, and great thirst were present, but there was no pain to speak of. He was then admitted into Whitechurch Infirmary, where he remained nine months. During this time he improved, his breathing became better, and towards the end of the time he began to gain flesh, and to be able to walk short distances. On leaving the infirmary, he went to Andover Union, where he remained between four and five months, his condition remaining about the same. Since leaving the union he had been at home, gradually losing flesh and strength, and had been bedridden for the last two years. During the first seven months of this time, the expectoration increased in quantity. An abscess then formed in the right side, which broke and discharged a quantity of offensive pus. Three sinuses formed (two of which had healed during the last two months). Following this discharge of pus, the expectoration diminished in quantity, but remains considerable even to the present time—upwards of a pint in twenty-four hours; this, however, is steadily diminishing. For some months the discharge from the sinus remained very profuse, but gradually lessened, and is now less than an ounce in twenty-four hours.

Present state.—The patient is a medium-sized, fair-complexioned man. He has the appearance of having been very strongly built, but now appears very weak, and is unable to stand without assistance. His face has a pasty appearance, very unhealthy and pallid. The skin is hot and clammy; no lividity or duskiness. The finger and toe ends are clubbed. No oedema now present or recollected. Decubitus almost entirely right-sided; rarely dorsal; never left-sided. Tongue clean, moist, and fairly healthy in appearance; appetite good; bowels regular; no diarrhoea; no sickness except sometimes on coughing. There has never been any hæmoptysis, but the phlegm has occasionally presented streaks of blood. Night sweats slight, and occasional sweating of hands and feet, profuse at beginning of illness. The cough is not very troublesome; it comes in fits, and is accompanied by retching. The expectoration is profuse and muco-purulent (it amounts to upwards of a pint in twenty-four hours); during the fits of retching half a pint is brought up. There is no distress, pain, or dyspnoea

(formerly a marked symptom), and he speaks without effort. Specific gravity of urine 1024; slight amount of albumen, also slight mucous deposit. Pulse 96, regular, sustained tension, and firm. Temperature in the morning, 98°; evening, 101°. The following are the physical signs: On inspection the remains of a large chest are found, the bones being large and spaces wide; the coverings are much wasted. On the right side there is marked bulging in the lower mammary region from the fourth to the seventh rib, and laterally from the right border of the sternum to the anterior axillary line, but the whole right side appears fuller than the left. On deep inspiration the right upper front above the nipples appears motionless, and is much flattened; the same region on the left moves well. Clavicular hollows not marked. The sinus above mentioned is situated in the fifth space in the anterior axillary line, two inches and a half below and an inch and a half posterior to the nipple line. The inferior costal spaces on this side are difficult to define, the tissues appearing matted together. No fluctuation to be made out; no mapping out of the superficial veins, except about the shoulders, and here only slightly. Left mammary region below the nipple flatter than normal. Palpation shows absent vocal fremitus below the nipple on the right side; slight above this, and fairly good in scapular regions; good all over the left side. On percussion an impaired resonance is found over the front of the left apex, extending to the second rib; there is dullness in the supra-scapular region, but good note elsewhere. On the right side dullness, differing in degree and character, is found all over the lung. Good resonance is found in the mid-sternum, but less of resonance in other regions; high-pitched to the third rib and in the supra-scapular fossa. From this level to the fifth rib level, and over an area oval in shape, measuring five inches by four, the long diameter reaching to beyond one inch in the nipple line, there is a note, hollow in character; in the axilla there is absolute dullness. Posteriorly the mid-scapular dullness is less wooden in character than over the back generally. Auscultation shows over the left side coarse respiration. Inspiratory murmur exaggerated all over; more harsh in character over the apex, where bronchophony is heard; there is undue conduction of heart sounds all over the front. On the right side, practically nothing audible, respiratory or adventitious, beyond very faint entry of air at the extreme apex in front. Suspicion of scraping friction sounds over the mammary region; no ægophony, or any approach to it. Cardiac dullness commences at the upper border of the third rib, and extends on the left side as far as the nipple line. Impulse is seen in the third and fourth spaces; the maximum intensity is felt in the fourth space in the nipple line. Friction sound heard in the second and third spaces, on the left side occasionally double. Very faint sawing bruit localised at apex; sounds are ringing.

Feb. 16th.—The patient's condition has remained much the same as on admission. He has vomited once in twenty-four hours; during a fit of coughing, bringing up about half a pint of muco-purulent material. The opening in the right axillary line was enlarged by Mr. Godlee to-day, two small portions of rib removed, and a drainage tube inserted. Chloroform was the anæsthetic used. During its administration blueness of the face, pallor, and coldness of the extremities, with much troublesome cough, were noted. Forty ounces of fetid pus came away through the incision. The probe showed a large cavity extending almost to the apex; the ribs were very much approximated, extremely soft, and spongy. The wound was dusted with iodoform, dressed with boracic lint, over this being placed a pad of tenax, and then the bandage. The wound was dressed again in the evening, the discharge being profuse, coffee-coloured, and offensive.

17th.—Wound dressed this morning; discharge same as last evening. Much nausea existed after the chloroform, which was relieved by sucking ice.

19th.—From this date onwards the cough and expectoration ceased, the temperature not rising above 98.4°, and the general condition improving. The area mentioned above—viz., third to fifth rib—in which the note was high pitched, has extended into the axilla and upwards towards the apex. Some crackling sounds heard over the cardiac area; no bruit. Discharge changed gradually to a chocolate-coloured, thick, offensive pus.

March 2nd.—Felt faint twice to-day; pulse 104, full and feeble. Drainage not sufficient, so that it was necessary to turn the patient on his side to empty the cavity. Amount

diminished; still offensive. Harsh tracheal breath sounds now heard over inner half of infra-clavicular region; elsewhere no sounds to be heard; here and there echo and bell sounds on percussion of coins; on the left side the crackling sounds heard over the cardiac area have extended.

7th.—Wound dressed daily. Discharge lessening; reduced to two ounces to-day; not offensive now. The tube, which at first caused distress through pressure on the diaphragm, which ascended after the evacuation of the pus, was shortened, and now causes no pain. The patient is still faint on assuming the sitting posture. Cavity contracting to a sinus, and external opening showing great tendency to close.

20th.—Discharge now reduced to less than one ounce. Cavity much contracted. Tubular respiration extending a good deal over the chest. For the last few days the patient has been very troublesome, desiring to leave the hospital. Has suffered from melancholia during the last four or five days, and last evening, taking advantage of the relaxation of watchfulness on the part of an attendant, obtained possession of a knife and inflicted a wound on his throat. The wound was cross-shaped and jagged, but superficial. There was a good deal of venous hæmorrhage; this ceased on bringing the edges together. The wound was dressed with eucalyptic ointment.

25th.—Suffered no ill consequences from the wound in the throat, which is healing by first intention. There is still about an ounce of discharge from the chest. Melancholia still present.

April 2nd.—Wound in neck healed. Tube to be removed from chest in a few days. Patient up for the last few days; much stronger. Left the hospital this afternoon against advice, as he is still very weak.

On making inquiries as to the patient's present condition, it was ascertained that he had retrograded, and now resented any interference. His mental condition seemed to be much worse. In the words of the gentleman who saw him, "He seemed scarcely himself," and was the cause of much trouble and anxiety to those attending on him.

Remarks by Dr. SQUIRE.—It is now fortunately rare to see an empyema that has been allowed to burst through the chest wall. This burst at the point most commonly selected—namely, the fifth interspace anteriorly, between the serrations of the serratus magnus. The long continuance of the disease made permanent cure almost impossible; but free exit for the pus gave much relief, and the almost entire cessation of cough after the operation fully justified its performance. The weakness due to the long and wasting illness at last resulted in melancholia.

ROYAL SOUTHERN HOSPITAL, LIVERPOOL.

A CASE OF INCISED AND PENETRATING WOUND OF ABDOMEN, WITH PARTIAL DIVISION OF SMALL INTESTINE; PUNCTURE OF SIGMOID FLEXURE IN ONE, AND OF MESENTERY IN FIVE PLACES; COPIOUS HÆMORRHAGE; COLLAPSE; DEATH; NECROPSY; REMARKS.

(Under the care of F. H. WIGMORE.)

For the notes of this case we are indebted to Mr. R. Hamilton.

G. M.—, a fine, healthy-looking man, aged twenty-nine, was admitted on July 23rd, with an incised and punctured wound of the abdomen, two inches and a half long, and running obliquely downwards in much the same situation as the incision which is usually adopted for ligature of the left common iliac artery. About six feet of the small intestine protruded through the wound, and lay upon the abdomen, while the mesentery, bleeding profusely, was tightly nipped in the incision, and thus prevented any backward flow of blood into the peritoneal cavity. The general condition of the patient was one of great pain, prostration, and collapse. No time was to be lost. It was necessary to control the hæmorrhage. The man was therefore placed at once upon the operating table and ether administered. The mesentery was punctured in five places—in one torn from the small intestine, which at that spot was bruised, though not lacerated to perforation,—and the hæmorrhage from these was prevented by the introduction of five ligatures through the substance of the mesentery, including in their tightened loops the bleeding vessels. The gut was then examined, and found to be cleanly divided through half its circumference. With a continuous suture of catgut the edges were brought into apposition. In two places the bowel was slightly bruised. The whole

of the protruding gut and mesentery was carefully washed with a warm solution of perchloride of mercury (1 in 2000), and returned to the abdomen. There was no hæmorrhage, effusion, or fæcal extravasation into the peritoneal cavity, and the wound was closed in the usual manner with silver sutures. The spray was used throughout the operation, and a dressing of salicylic wool applied. At one stage of the proceedings the collapse was very extreme; the pulse failed, and the general aspect of the patient was that of impending death. A hypodermic injection of ether (fifteen minims), hot flannels, and an enema of two ounces of brandy to some extent rallied him, and he was put into a warm bed, with hot bottles. The temperature immediately after operation was 96°, pulse 160, and respiration 50.

As the collapse continued, two drachms of brandy were ordered to be given every quarter of an hour, with a hypodermic injection of ether alternating with them, and the continuous application of hot flannels. Any diminution in this stimulation caused an immediate failing of the pulse. After three hours and a half the general condition was to some extent improved. The bowels were moved twice during this period; the stools contained no blood. He passed his urine without instrumental interference. At 9 P.M. (five hours after the operation) he began to complain of nausea, and the stimulants were reduced and a grain of opium given. At 10 P.M. the temperature was 98°; pulse 120; respiration 47. At 10.30 A.M. he vomited, and this recurred eight times up to 1.55 A.M., when it ceased. Ice to suck, iced milk in very small quantities, and two drachms of brandy were given every hour. The pulse frequently failed, and this was met by hypodermic injections of ether. At 12.35 he complained of great abdominal pain, and an ice-bag was applied and continued until 4.25 A.M.; it gave him some relief. At 3.30 the temperature rose to 98.4°; pulse 150; respiration 27. At 7.30 A.M. the bowels were again moved. After this hiccough commenced; the temperature fell to 96.4°; pulse 84; respiration 46. At 9.50 A.M. he became quite collapsed and died, consciousness remaining with him to the last.

Necropsy by Mr. DIXON.—The abdomen was not distended, but retracted. The wound was healthy. The under surface of the great omentum was found slightly adherent to that part of the small intestine involved in the injury, and the coils here were themselves slightly matted together by threads of plastic lymph. There were no signs of repair in the wound of the gut. The bowel had sloughed in two places opposite points at which the mesentery had been tied to stop hæmorrhage, and corresponding with the bruises noted above. On lifting the intestine, fæces were extravasated through these perforations. No extravasation had occurred during life. Two small clots of blood were discovered adhering to the mesentery. A further examination disclosed a puncture of the sigmoid flexure close to the rectum. The perforation was just large enough to admit a probe of medium size, and was surrounded by a greenish slough, the outer margin of which passed into a congested zone, gradually shading off into the natural healthy colour of the contiguous gut. The other organs of the body were healthy.

Remarks.—This case illustrates very well the great and lasting collapse which immediately follows a serious injury to the abdomen and some one or other of the contained viscera, and the difficulty there is in rallying the patient from this condition of utter prostration. It might be interesting to note what part is played by mental emotion in the production and continuance of shock, and whether in such a state it is better to administer ether or chloroform when necessity requires an anæsthetic. When the patient's mind is quiet, large and grave operations may be performed without any of these serious and distressing symptoms presenting themselves. In this particular case the deceased was pursued some distance by a man who held a two-edged table knife, with which he intended to perpetrate the act he subsequently accomplished. The deceased is said to have turned round and met the knife in its descent, and then to have rushed about the street, crying out, and with his intestines protruding. Here, at any rate, mental emotion must have been considerable; and when his depositions were taken his pulse failed at the sight of the prisoner, and his already grave condition was aggravated. During the operation the pulse and general state became worse, and this notwithstanding the hæmorrhage had stopped and ether was administered. Under the careful use of chloroform in cases of this kind, a marked improvement has taken place. The exhibition of opium