

lymph, the result of a localised peritonitis from the spread of inflammatory action from the ulcerated Peyer's patch, thus localising the mischief; and these are apparently the changes which took place here.

Barnes.

## Clinical Notes:

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

#### CASE OF DEFICIENT ŒSOPHAGUS.

By CHARLES STEELE, M.D., F.R.C.S.

THE following case appears to me to be of interest from both a surgical and an anatomical point of view.

I was lately asked to see in consultation an infant twenty-four hours old, who, shortly after being given nourishment, a little of which was taken readily, became very livid, had difficulty in breathing, and then returned the food and appeared no worse. The gentleman in attendance wisely introduced a sound, and found that it passed about five inches and encountered an impassable obstruction. He then asked me to see the child, and I repeated the sounding with the same conclusion. We diagnosed that there was either a membrane across the Œsophagus, or that it ended in blind terminations; and I advised that through the night enemata of dessertspoonfuls of peptonised milk should be given every two hours, and that by daylight the stomach should be opened and the Œsophagus explored; if a membrane could be made out across a continuous canal, that it should be perforated in order to give a hope of life; and that, if we found any distance existed between the extremities, we could do no more; the parents, however, might feel that every possible endeavour had been made to save their child's life. This was agreed upon, and the father willingly acceded. On the following afternoon I was asked to perform the operation. The infant took chloroform well. I opened the abdomen above the umbilicus in the middle line, exposed the stomach, and stitched it at four points to the skin, having some difficulty to keep the liver from protruding. The stomach was then opened, which was perfectly healthy, and of course empty. A bougie was passed down the Œsophagus as before, and another upwards from the stomach for a short distance; but they did not approach each other by what we judged to be an inch and a half. I then cut a gum-elastic catheter in half, and passed it from below, introduced up it a long slender steel probe, and pressed it upwards as much as was justifiable, in case the lower part of the tube might be twisted or narrowed, and capable of being rendered pervious. All was of no avail, however; so the stomach wound was closed with sutures, also the abdominal wound, and we felt sure that the Œsophagus was deficient for about an inch and a half. The infant slept for some time, and died twenty-four hours afterwards. The next afternoon we made an examination, and found that the Œsophagus terminated above and below in blind rounded ends an inch and a half apart, and there was no cord or connexion between the parts. All the wounded portions were quite healthy, and the appearances led to the conclusion that had there been only a membranous occlusion a happy result might well have been hoped for.

#### SUPPURATING HYDATID CYST OF THE LIVER PERFORATING THE LUNG; RECOVERY.

By FRANCIS W. JOSHUA,  
SURGEON TO THE GREAT MALVERN DISPENSARY.

MISS A. S—, aged fifty, of full habit, had in 1886 and 1887 several attacks of congestion of the liver and jaundice, but throughout December of the latter year felt perfectly well. On Jan. 6th, 1888, I was sent for, and found her in bed complaining of pain in the right shoulder and just below the right breast. Her countenance was anxious; temperature 101°; pulse 100; respiration hurried; no

jaundice; dorsal decubitus. The liver was two inches below the ribs (the percussion note dull as high as the fifth interspace); its contour was smooth and regular; no fluctuation could be detected. Gall-bladder distended; no tenderness on palpation. Three weeks later the liver was three inches below the ribs, somewhat tender to the touch, and quite firm. The temperature during this period was generally normal during the day, rising to 100° and 101° in the evening. The bowels were constipated, and the evacuations untinged by bile. On Jan. 30th an incessant dry hacking cough set in, lasting ten days, which was relieved occasionally by morphia. The patient was now very ill and weak; there had been no rigors. On Feb. 9th she coughed up a pint and a half of pure pus. The following day a few hydatid cysts of small size appeared in the sputa. She complained of great sense of oppression and severe pain in the upper part of the chest, more especially on the left side. The lung and heart sounds were normal, and the chest was resonant throughout, save in the hepatic area, where there was absolute dullness and considerable bulging of the parietes. During the next few days hydatids in varying number were spat up daily, most of them larger in circumference than a crown piece; their emission was always accompanied by most distressing paroxysms of coughing and extreme dyspnoea. On Feb. 17th the patient was very hoarse. At 1.30 P.M. she took a little solid food. At 2.30 P.M. a sudden rush occurred from the mouth and nares of a thin fluid, hydatids, and blood-stained pus. I saw her a few minutes later, when she was apparently moribund, no pulse at wrists, gasping inspirations (four or five in the minute), extremities cold, face cyanosed, and completely unconscious. Two chamber utensils were shown me nearly full of blood-stained hydatids. I injected thirty minims of ether hypodermically, repeating the injections in a few minutes, with but slight result. Then, on the supposition that hæmorrhage had taken place into the cavity, I injected four grains of ergotine. The pulse returned gradually, but the cheeks and lips remained perfectly blanched. I therefore injected into the rectum an ounce of brandy and half an ounce of turpentine with yolk of egg. Consciousness returned, and she was shortly able to swallow a small quantity of brandy-and-milk. On each succeeding day a few hydatids and some sanious matter were coughed up, until March 2nd, when the cough became more violent, and she expectorated a pint of pus during the day.—On the 7th she was jaundiced, and the temperature rose to 101°. On the 13th bile-stained hydatids were coughed up, and on the 14th a pint and a half of pure bile, which came up in varying quantities for a week, with one interval of two days. Then began an uninterrupted recovery, and on April 3rd she was able to bear removal to another room. At this time the patient was greatly emaciated. The hypodermic punctures had sloughed, and a bulla four inches in diameter over the left tibia left a corresponding ulcer. The liver gradually receded to the lower margin of the ribs.

*Remarks.*—The exceeding rarity of complete recovery in such cases renders the present one worthy, I think, of record. There was considerable difficulty in arriving at a correct early diagnosis, the (comparatively speaking) apparent smallness of the visceral enlargement, its firm and even outline, and absence of fluctuation leading one rather to the supposition that the case was one of malignant or amyloid disease.

Great Malvern.

#### ON THE SMOKING OF STRAMONIUM LEAVES, SIMULATING INSANITY.

By M. J. T. J. BLANCARD, SURG. M.A.

ON Aug. 30th, 1887, while on duty with a flying column at Leygi, Upper Burmah, I was called to see a man found unconscious near a well close to the outpost. The man was taken to hospital, and on examination the following symptoms were observed. Insensibility, with complete relaxation of voluntary and involuntary muscles. Pulse small and compressible. Surface of body cold and clammy. Pupils not reacting to light, but fixed in a dilated position. Deglutition normal. Sphincters relaxed; motions and urine passed. Reflexes absent. Breathing at first stertorous, but gradually becoming quicker, with intervals of sighing. When spoken to in a loud voice the man answered with a moan. Eyelids closed—not naturally, but as if done purposely. Head cool.

Liquid food introduced into the mouth was readily swallowed. This state of things was kept up for thirty-six hours, when the patient suddenly started up, and tried to escape. The two orderlies watching over him had to use considerable force in restraining him, the finger of one of them being severely bitten. Forty grains of bromide of potassium were with difficulty given, after which the man became quieter and fell asleep. When he awoke he was quite conscious, and was bewildered to find himself in a strange place. As I had observed a similar case some years ago, I, without preamble, asked him what he had been smoking. Taken aback, he blurted out the whole truth: that about a week ago he had smoked and chewed the leaves of the *Datura stramonium*, which grew profusely in the neighbourhood; that he had felt very sick; and that afterwards it was all a blank. To fill up the gap in his case, I waited for further information, and was told that the patient had been observed to be somewhat strange in his usual behaviour, laughing and crying without the least cause. He, however, suddenly disappeared, and was not heard of till his discovery as above narrated.

Ramsgate.

## 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.

#### ST. MARY'S HOSPITAL.

ACUTE INTESTINAL OBSTRUCTION; ABDOMINAL SECTION;  
RECOVERY; REMARKS.<sup>1</sup>

(Under the care of Mr. EDMUND OWEN.)

IN addition to Mr. Owen's remarks, we may refer our readers to the discussion at the Medical Society on Monday last, which excited much interest. For the following report we are indebted to Mr. A. H. Bindloss, B.A.

On the evening of Monday, July 30th, Mr. Owen was called in consultation to the wife of a small shopkeeper, in her fiftieth year, who since the previous morning had been vomiting incessantly. On the evening of Saturday (28th) she had, according to her usual custom, taken some purgative medicine, and early in the morning of the Sunday had been seized with such severe abdominal pains that, on getting out of bed to pass a motion, she had fainted and fallen upon the floor. After this, vomiting set in, and continued throughout the whole of Sunday and Monday. When Mr. Owen saw her (on the Monday night) she was sick every ten minutes, and was complaining of great pain across the umbilical region, but she did not show much sign of collapse. On making a careful examination of the surface of the abdomen, a small irreducible femoral hernia was found upon the left side. It had existed for many years, and on this occasion was so quiet and free from tenderness that it appeared unlikely that it could be the cause of her present distress. It was agreed, however, to cut down upon it there and then, and that, if it were found of no material import, and if the symptoms persisted after the herniotomy, the patient should be sent into St. Mary's Hospital next morning for abdominal section, so serious an operation being quite impracticable in her own house. \* \* \* \* The hernia proved to be a mass of omentum, which, being somewhat adherent to the sac, was carefully separated and returned into the peritoneal cavity. Next morning the patient was no better; so Mr. Bligh Wall, under whose care she was, persuaded her to come into the hospital.

On Tuesday (31st), at 2 P.M., she was taken into the theatre, and, after a brief consultation, it was unanimously agreed to open the abdomen. Even at this time she did not show much collapse, but her abdomen was enlarged, tympanitic, and tender, and she was vomiting constantly.

*Operation.*—A five-inch incision was made in the linea alba, and on opening the peritoneum about half a pint of dark sherry-coloured serum escaped. The small intestine

was purple, and on lifting up some greatly distended coils a pale and collapsed piece was discovered, and a firm band of omentum was found compressing, and obliterating the lumen of, the bowel. A few inches distant up the dilated piece of intestine was a ring-like constriction, which had evidently been caused by a previous and long-continued pressure by the same band. There were no signs of recent strangulation at that constriction, however, and the conclusion drawn was that that piece of the bowel had become accustomed to the pressure of the omental band, but that a sudden slipping of the intestine—perhaps the result of the purgation—had brought a fresh piece within its grasp, which had promptly become strangulated. It may not improbably have been this old-standing compression that caused the woman to resort to the weekly purgation. The omental band was about one-eighth of an inch wide, and the piece of bowel across which it lay gave ample evidence of the urgency of the need for its division. The band being torn across by the fingers, the intestine was at once free. The piece of omentum which had been returned from the femoral sac was seen in the left inguinal region, and, as it looked swollen and ragged, it was ligatured and removed. The peritoneal cavity was not washed out; the abdominal wound was closed by silk sutures, which passed deeply through the serous lining and kept the sides of the peritoneal incision in accurate apposition. The dressings consisted of boracic acid powder and pads of wood-wool, under a binder.

After being put back to bed the patient had no more sickness, and on the following day a little milk was allowed with iced water, which she kept down; and on the second day after the operation she took small quantities of peptonised beef and milk. The temperature remained under 100° F. She was passing a good deal of flatus per anum. At the end of a week the bowels were relieved by an enema, and the wound was dressed for the first time. The femoral wound healed by first intention, as did also the abdominal wound, with the exception of the lower end, from which there was a good deal of discharge for some days during the second week. Towards the end of September the woman left the hospital, well, and rapidly regaining her strength.

*Remarks by Mr. OWEN.*—The coexistence of the irreducible femoral hernia with the internal strangulation is an interesting rather than an important feature of the case. The absence of local tenderness about the hernia could not be taken as evidence that the acute symptoms were not dependent upon it; the only thing to be done was to cut down and explore. Had the patient's surroundings been more favourable, the abdomen would probably have been opened as soon as the hernial wound had been explored. As it was, there was a delay of sixteen hours before the laparotomy could be undertaken. This loss of time was much regretted, but it could not be avoided; on her coming into the hospital the operation was undertaken without a moment's delay. Certainly if it had not been done the woman must have died, for the rigid band was deeply embedded in the dark and swollen bowel, and ulceration must have occurred very shortly. This report affords further evidence of the value of early exploratory incision in the case of acute intestinal obstruction. Clinical experience gives almost daily testimony to the fact that a clean incision into the abdominal cavity is not in itself accompanied with much danger, though, of course, when a prolonged search has to be made behind dilated coils of intestine the out-look becomes more grave. One of the most distressing revelations of the post-mortem room is the demonstration of an acute internal strangulation, which, though suspecting it during life, the surgeon has not the opportunity of relieving; but more poignant still is the regret felt by the surgeon who, obtaining the tardy sanction to explore the abdomen, finds the strangulated bowel damaged almost beyond the prospect of recovery.

#### GUY'S HOSPITAL.

PROGRESSIVE CARIES OF THE TARSUS.—MULTIPLE EXOSTOSES.

(Under the care of Mr. BRYANT.)

*Caries of tarsus (left) and first metatarsal; incision and scraping; spread of disease; Pirogoff's amputation; recovery.* (From notes by Mr. Carter and Mr. Perkins.)—E. R.—, aged three, was admitted on Dec. 12th, 1887, and discharged cured on April 29th, 1888. The family history

<sup>1</sup> Abstract of a case read before the Medical Society on Oct. 15th.