

MUCOCELE OF THE FRONTAL SINUS.¹

By W. SPENCER WATSON, M.B. LOND., F.R.C.S. ENG.

A WOMAN aged twenty-five, a black-borcerer of envelopes by trade, applied for treatment at the Royal Eye Hospital, Southwark, on Jan. 2nd, 1893, when she complained of swelling in connexion with the left eye, great pain in the eyebrow and frontal region, and double vision. There was a brawny swelling of the left upper eyelid, with redness and tenderness, especially marked just below the inner extremity of the supra-orbital margin. There was marked proptosis of the left eyeball, which was displaced in a downward and outward direction and restricted in movement upwards and inwards, and there was crossed diplopia. The free escape of tears by the lacrymal passages was not impeded. The ocular and palpebral conjunctivæ were injected, and the left pupil was sluggish compared with the right; but the tension of the left eye was normal, and nothing abnormal was noted in connexion with the fundus. There was one nebula on the left cornea and there were two on the right, being the remains of ulcers which she had when eleven years old. The left pre-auricular gland was enlarged and tender, as was also a gland at the angle of the lower jaw on the left side. The patient was anæmic and strumous-looking and had suffered from occasional enlargement of the submaxillary lymphatic glands. She had been attending the out-patient department of a general hospital since last October for anæmia and dyspepsia; with the exception of these and an attack of erysipelas of the right side of the face two years ago, she had enjoyed good health since childhood. The history which she gave of her present trouble was to the effect that she had an attack of erysipelas of the left side of the face three weeks previously, which, lasting about ten days, left the upper lid still swollen and painful. She did not remember having had any injury, and her family history was unimportant. The treatment adopted consisted in the application of frequently renewed hot boracic fomentations and the administration of quinine and iron. The patient was placed on a liberal diet and the bowels were kept well open. On Jan. 9th the proptosis was less marked, the outward displacement of the eyeball had disappeared, and the diplopia had gone, although the left cornea was at a decidedly lower level than the right. The swelling of the upper eyelid was much less and the tenderness diminished, the lymphatic glands were also less swollen and tender, and she had very little pain except when she tried to look well upwards, in which direction, as well as inwards, movement was a little restricted. It was noticed on this day that she had what seemed to be an ordinary coryza, which continued until the 18th, when she had an unusual, thin, slightly yellowish discharge from the left nostril, which was offensive to her, but not markedly so to others. There was enough discharge on that day to thoroughly soil one pocket-handkerchief. It continued, although less in amount, on the next day, and at intervals on the following two days. The nasal cavity was examined from the front by means of the nasal speculum, and it was noted that there was some polypoid enlargement of the upper and middle turbinals of the left side. It was noticeable that the alæ of the nose were remarkably flattened towards the septum and gave the aperture of the nostrils a slit-like aspect. There was nothing in the history to account for this, and the breath channels were quite unimpeded and the breathing free. The left nostril was ordered to be washed out with boracic lotion (four grains to the fluid ounce). On the 21st the proptosis had disappeared, the left cornea was a trifle lower than the right, the swelling and tenderness of the upper eyelid were very slight and those of the lymphatic glands had gone. The fomentations were discontinued and a dry warm pad of wool was kept applied. The temperature, which had previously ranged from between 99° and 100°, did not rise after this above 99°. On the 24th she was discharged to attend as an out-patient. The left eye was then not at all displaced, nor were its movements impaired. It gave her pain to look upwards and she had slight tenderness beneath the inner extremity of the supra-orbital margin.

Remarks.—Cases of enlargement of the frontal sinus from any cause rarely terminate so favourably as the case narrated and are too often accompanied by severe febrile disturbance, with formation of pus and bone mischief. In the above

case resolution occurred before the formation of pus. An improved condition of the patient's surroundings and rest in bed gave her an opportunity of recovery, which was impossible for her whilst at her work or even at home. It is a case that encourages the employment of the expectant plan of treatment before resorting to surgical measures, as well as attention to the conditions of the temperature and pulse.

Henrietta-street, W.

A CASE OF
PERITONITIS FROM PERFORATION OF THE
VERMIFORM APPENDIX BY A FÆCAL
CONCRETION; DEATH FROM
HÆMORRHAGE.

By OSMUND STEDMAN, M.D., B.S. LOND.

THE patient was a male, aged eighteen, who had always been healthy till his late illness; his occupation was that of a footman. His mother has a large goitre; his father is alive and well. One sister died of "ulceration of the bowels" about which no definite history could be obtained; his father's brother died of phthisis. The patient was quite well till the morning of Aug. 23rd, 1892, when he felt a pain across the lower part of the abdomen; he continued his duties during the morning, although he vomited several times, and he remained up during the day, but not at work. The following day, the pain and vomiting continuing, the patient remained in bed till the evening, when he dressed and sat up. The bowels had acted on Aug. 22nd; on the afternoon of the 23rd there was a slight action, and only a small quantity of fluid was passed.

Aug. 25th.—The patient was seen by me for the first time to-day. He is a well-developed lad of dark, scrofulous type. He lies on his back, the legs are extended, and he complains of pain across the lower part of the abdomen; he has vomited five or six times during the last twenty-four hours; the vomit consists of the contents of the stomach mixed with bile; the bowels have not been moved since the first day of his illness, but he passes flatus occasionally; the abdomen is somewhat tympanitic, with slight tenderness on pressure all over, but he can bear even firm pressure without much complaint; pressure gives most pain in the iliac fossæ, the left being more tender than the right; the abdomen is resonant all over except in the course of the ascending colon; no fulness is felt in the cæcal region; the rectum on being examined is found to be empty; the tongue is furred. Morning temperature 102°, evening 103°.

26th.—His condition is unchanged, the vomiting continuing. He was given a soap-and-water enema, but without result. Morning temperature 100.2°, evening 102.4°.

27th.—The pain has diminished; he has only vomited twice during the last twenty-four hours; an enema had no result. Morning temperature 100°, evening 102.4°.

28th.—Tympanites is increasing; the tongue is more furred, becoming brown and dry. An enema with long tube returned coloured with fæcal matter, with a few small pieces. Morning temperature 100°, evening 100.2°.

29th.—The tongue is less dry; the patient has vomited only once since yesterday. An enema with long tube was administered; he passed several hard scybalous masses. Morning temperature 99°, evening 100.4°.

30th.—There has been no vomiting since yesterday; the tongue is quite moist. An enema with long tube was administered, after which he passed a quantity of scybala, followed by a copious motion. Morning temperature 98.8°, evening 100°.

31st.—The bowels moved naturally. Morning temperature 98.4°, evening 102°.

Sept. 1st.—There has been no more vomiting; the abdomen is more tympanitic and is resonant throughout. The patient still complains of some pain across the hypogastrium; the tenderness has almost disappeared, except on deep pressure in the iliac regions. Morning temperature 99.4°, evening 100.8°.

2nd.—Morning temperature 101°, evening 103°.

3rd.—Morning temperature 102.2°, evening 103°.

4th.—The bowels have acted each day, and there has been no vomiting. The patient has emaciated extremely, the bony prominences becoming red; he was moved to the cottage hospital and put on a water bed. Morning temperature 102°, evening 103.2°.

¹ The notes of the case were taken by Mr. L. Vernon Cargill, F.R.C.S. Eng., house surgeon and registrar.

5th.—His condition is unchanged; he takes nourishment well. On this day a rough systolic murmur was heard over the whole cardiac area, not conducted into the axilla or along the main vessels. The heart and lungs had been frequently examined before, nothing noteworthy having been found. Morning temperature 99° 4', evening 101°.

From this time till his death the temperature varied between 99° and 100° 6'. The bowels acted each day and the patient vomited once on the 7th and again on the 9th.

Sept. 11th.—The patient's condition remains the same. The evening temperature, taken at 6 P.M., was 100° 8'. About half an hour later, on using the bed-pan, he passed a quantity of bright blood unmixed with faecal matter; the hæmorrhage continued at intervals till death, which occurred three-quarters of an hour after the onset of the bleeding.

Necropsy, sixteen hours after death.—Rigor mortis was present and the abdomen was much discoloured. On opening the abdomen flatus escaped in quantity, leaving the abdominal wall quite flaccid. There was some free liquid faecal matter in the hypogastric region, and floating on this was found a faecal concretion, about the size and shape of a date-stone, of a yellow ochre colour. The intestines were universally adherent. The adhesions were broken down without difficulty and in several places small collections of pus were found between adherent coils, in some cases mixed with escaped faecal matter. The liver was adherent to the diaphragm; on separating it a loculus containing about three ounces of thick yellow pus appeared. There was also a small collection of pus in the left iliac fossa, which had opened into the sigmoid flexure. On removing the intestines the jejunum and ileum were found to be perforated in three or four places. The ulcerative process causing the perforation had evidently started on the peritoneal surface and was caused by the collection of pus between the adherent coils of bowel above mentioned. In one or two places the bowel wall was ulcerated on the outside but not yet perforated, the mucous membrane remaining in one spot only. Peyer's patches were normal, as was the cæcum. On slitting up the appendix, which was three inches in length, a perforation was found. The hole was situated midway between the free and attached ends of the appendix and was half an inch long by a quarter of an inch broad. On the opposite wall of the appendix there was an ulcer of the same size and shape, which had destroyed the mucous and part of the muscular coat, but had not yet perforated. The faecal concretion exactly fitted these ulcers and had evidently lain in the appendix, causing ulceration on each side of it, and at last escaped into the peritoneal cavity. The sigmoid flexure and rectum contained a quantity of partly clotted blood, and the mucous membrane of the former was deeply blood-stained. The sigmoid flexure was perforated in two places. The ulcers had evidently started on the outside and were caused by the purulent collection in the iliac fossa; the lower of these two ulcerations had opened a vessel in the wall of the bowel, from which the fatal hæmorrhage took place. The pericardium contained half an ounce of clear fluid; there was a circle of adherent lymph the size of a shilling on the anterior surface of the apex, the valves being normal. Other organs were not examined.

Remarks.—The interesting features of this case which lead me to report it are two: Firstly, the slight amount of peritonitis set up by the escape of the calculus, which must have occurred during the night preceding the onset of the first symptoms (it has been noted above that the patient continued his duties during part of the first day after his illness commenced, that he was able to get up on the second day, and that at no time were the symptoms of peritonitis marked). The second point is the unusual mode of termination of the case—viz., from hæmorrhage, and that from a perforation commencing from the peritoneal surface of the bowel.

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A CASE OF POISONING BY BROMOFORM.

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AFTER reading the able paper by Dr. Burton-Fanning in the *Practitioner* of February, 1893, on "Bromoform in Whooping-cough," my partner and I determined to test its value in a number of cases of that disease which we have had on our list for the past two months. In each case the effect of the drug has been most marked, the paroxysmal cough

being greatly reduced in violence and the duration of the disease materially shortened. The form in which we have dispensed the drug is that advised by Dr. Burton-Fanning. My reason for writing this, however, is not so much to extol its virtues as to point out the necessity for impressing on those in charge of patients that the directions on the bottle must be obeyed implicitly or the results may be the reverse of those desired.

A girl aged four years was first seen on April 19th and a four-ounce mixture containing sixty minims of bromoform (two drachms every three hours) was prescribed for her. The first bottle produced the usual good effects and the mixture was repeated on the 22nd of the month. On the 28th I was summoned hastily to see the child, and on my arrival found her quite insensible, with pin-point pupils, livid, and breathing somewhat stertorously. Having in my mind the case of poisoning recorded by Dr. Burton-Fanning in his paper, I soon made up my mind that I was dealing with a similar case, and on questioning the mother found that, disregarding the "shake the bottle" label, she had half an hour before my arrival given the child the last dose in the bottle, which, I should say, must have contained about 15 or 20 minims of bromoform. I sent for the stomach-pump, in the meanwhile endeavouring to rouse the child by flicking her and placing her in a hot mustard and water bath. On using the pump the returned water smelt strongly of bromoform. I then injected strong coffee; by these means I roused the child sufficiently to be able to take her to the Infirmary, where I injected 5 minims of apomorphine (which acted in a very short time) and also applied the battery. The child slowly recovered, and by 3 30 P.M., although rather drowsy, seemed quite well. I think the danger I have pointed out in connexion with the administration of bromoform ought to be brought before the profession, as undoubtedly the drug will be largely used in the future, when its beneficial action in an intractable disease like whooping-cough becomes more widely known.

Queen-street, Lancaster.

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 PERITONITIS; ABDOMINAL SECTION; OVARIOTOMY;
RECOVERY.

(Under the care of Mr. EDMUND OWEN.)

THE rotation of ovarian tumours has long been recognised as a serious complication of such growths, especially since the publication of the paper by Rokitansky in 1865. The symptoms which follow such rotation, varying with the amount of obstruction to the circulation in the tumour caused by the twisting of the pedicle, and the effect of those changes on the tumour and its surroundings, have been well studied. Sometimes a part of the small intestine becomes twisted with the pedicle of the cyst, as in a case recorded by Hilton Fagge,¹ or the bowel becomes strangulated by the pedicle as recorded by Mundé,² or intestine adherent to the cyst is pulled on by the altered position of the cyst and compressed as met with by Ricard.³ Ricard's case was curiously like the one which we publish below—there was, however, a shorter history and there had been faecal vomiting. It was briefly as follows: A waitress aged twenty-four was suddenly seized with pain in the abdomen and severe vomiting, and four days later was admitted to hospital in a state of collapse with signs of acute peritonitis. She had previously enjoyed good health; nothing could be found to account for her symptoms. Abdominal section revealed the presence of a dermoid ovarian

¹ Guy's Hospital Reports, vol. xiv.

² American Journal of Obstetrics, vol. xiii.

³ Gazette de Hôpitaux, vol. i., 1891.