

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.

MIDDLESEX HOSPITAL.

A CASE OF TRAUMATIC PNEUMOTHORAX FROM SWALLOWING A FISHBONE; RECOVERY.

(Under the care of Dr. CAYLEY.)

FOR the following interesting notes we are indebted to Mr. Herbert Canton, physician's assistant.

Ellen L—, aged forty-eight, housewife, was admitted on March 15th, 1881, in a state of collapse, complaining of a severe cutting pain in the chest, which was especially aggravated on attempting to swallow and on deep inspiration. Whilst eating her supper the previous night (twelve hours before) she accidentally swallowed a fishbone. She was eating the head of a plaice at the time, and felt the bone stick in her throat. This caused her great pain at a spot corresponding with the sternal notch. She immediately attempted to dislodge the bone by taking large draughts of water and thumping her chest violently. She eventually succeeded, and felt the bone move downwards, and again stick (apparently in mid-sternal region), and here it remained in spite of her endeavours to remove it. The pain then became more acute "in the swallow," especially in the latter position. For some hours she continued her efforts to remove the obstacle by swallowing large pieces of masticated food, bread, &c., but without avail. She stated that eight or nine hours after the accident her breath became gradually short, and she experienced a sensation as if a load were on her chest, and she became faint and exhausted. The symptoms increasing in severity she applied at the hospital on March 16th, at 10 A.M. for assistance.

On admission she was a fairly-nourished woman. The face was pale and somewhat livid, with an anxious expression; the breathing was hurried and shallow, and 44 to the minute; the skin was cold and clammy; the pulse exceedingly small and compressible, and the extremities were cold. There was no cough, and the patient had not spat any blood. Thorax: There was little or no movement of the left side of the chest, even on forced inspiration, and pectoral fremitus was almost absent. The percussion note was full and clear, and somewhat tympanitic in character. No cardiac dulness could be made out, no bulging of intercostal spaces; the bell sound could not be elicited. The breath sounds over this side were extremely faint, and vocal resonance was diminished, the voice having a muffled tone. Over the right lung there was full pulmonary resonance, and exaggerated breath sounds. The impulse of the heart could not be felt in normal position, and the sounds here were extremely faint; but in the epigastrium the impulse was markedly perceptible, and the sounds well pronounced. There was no bruit; pulse 76. The patient having been put to bed, warm bottles were applied to the feet, and brandy was administered. About half an hour later the patient rallied somewhat; her face became a better colour, and her pulse improved, but she still complained of pain in the chest. Two hours after admission she was seen by Mr. Hulke, who passed an œsophageal horsehair probang into the œsophagus. On expanding and withdrawing the probang no foreign body of any kind was brought up; the hair, however, was slightly stained with blood. This operation did not appear to cause her much pain, and no immediate relief followed. A hypodermic injection of morphia (quarter of a grain) was then given, and the patient became easy and quiet. About 10 o'clock the same evening she expressed herself as feeling much better, the pain being less acute, and she had taken some liquid food without much distress. Her breathing was less laboured, and pulse 74, of better volume; respiration 40. She did not sleep much during the night, though she had a second injection of morphia, but next morning she was decidedly better, the condition of the chest being about the same; the breathing was abdominal, cardiac

impulse more perceptible in epigastrium; sounds quite absent in normal position. Morning temperature 98° 6' F., pulse 88, respiration 34; evening temperature 98° 8'.

On the 18th, temperature 97° 8', pulse 75; patient complained of pain in the left mammary region. Auscultation revealed soft pleuritic friction in the anterior base and axilla; no dulness at base. The percussion note was less full on left side; vocal fremitus improved; voice sounds increased, as compared with previous state; slight pain in gullet, but not increased on deglutition.

On the 19th, temperature 98°, pulse 80, the pleuritic friction was rougher in character, and heard all over lower half of left lung. The apex beat was felt in fifth interspace to the left of the sternum, and not so well in epigastrium. The percussion note was less resonant, and there was some movement of chest wall during ordinary respiration. There was little or no pain in gullet, and no pain on deglutition. Pulse improved in force, and respiration 32.

On the 20th friction was heard over a larger area. Heart's apex beat was felt more distinctly to the left of the sternum than on the preceding day. Epigastric pulsation was less marked. No pain in gullet.

On the 21st percussion note was only slightly fuller on left side than right. Pleuritic friction was still present but less marked. Breath and voice sounds were more plainly heard. There was a little difference in the expansion of the two sides. The heart's impulse was best felt in fifth interspace, and slightly perceptible at epigastrium.

On the 22nd there was no appreciable difference between the expansion on the two sides. Resonance was still somewhat fuller over left, and breath sounds almost as well heard on this side as on the right. Friction scarcely audible, only an occasional pleuritic rub.

On the 23rd no friction was audible. Expansion and vocal resonance were equal on the two sides. The heart had resumed its normal position. No epigastric pulsation.

From this date the percussion note gradually improved until the 29th, when it became quite normal. The temperature throughout never exceeded normal, and at no time were there evidences of fluid in the chest. The respiration, which for the first three days was hurried, then became about normal and remained so. During her stay in hospital she never had any cough, and no spitting of blood. Patient was discharged on March 31st quite well.

Remarks.—From the above case it is evident that the fishbone pierced the œsophagus in some part of its course, and perforated the pleura, and probably also the lung, as a result of which pneumothorax ensued. It is very unlikely that air could have entered the pleura through the wound in the œsophagus. When the œsophageal bougie was passed the supposition was that the bone was pushed through into the pleural cavity, setting up pleuritis, and subsequently becoming encapsuled. It is remarkable that no hæmoptysis or physical signs followed the wounding of the lung.

ST. BARTHOLOMEW'S HOSPITAL, CHATHAM.

A CASE OF RAPIDLY GROWING ANEURISM OF THE ARCH OF THE AORTA; DEATH.

(Under the care of Mr. G. H. PATTERSON.)

FOR the following notes we are indebted to Mr. W. B. C. Deeble, M.R.C.S.

William B—, aged forty-six, was admitted on Aug. 10th, 1881, suffering from an impacted calculus at the orifice of the urethra. This was removed, and after an attack of orchitis the patient became convalescent.

On Sept. 6th, 1881, the patient complained of not feeling so well, and thought he had caught cold; there was a little cough. This got better, and then he complained of rheumatic pains in his shoulders and arms. On the 11th the cough was more troublesome. During the night he had a fit of coughing, and whilst this was on a tumour the size of a large walnut appeared between the right ear and the angle of the jaw; it was soft and fluctuating. At the same time another swelling appeared extending over the anterior part of the chest, at the sternum. This swelling was the size of an orange, but flat, had a distinct, distensible pulsation, and slight bruit; the skin was shining and tense, and the veins very much distended. It pitted on pressure. The pulsation shook the patient's head and the bedclothes. He looked very pale in comparison with his former healthy aspect, and very anxious. He complained of a cough, but

no pain. The pulses at the wrists were weak and unequal in volume. The right pupil was somewhat contracted. Ten grains of iodide of potassium were given every three hours. There was no swelling, or complaint of any, on admission into the hospital. On the 12th the swelling had increased in size; the skin was ecchymosed over the most prominent part of the tumour. Measurement of tumour: Longitudinally, from episternal notch to base of tumour, 8 in.; transversely, 16 in. The patient complained of phlegm accumulating in the air-passages, which he was unable to expel; no pain; voice a little husky; he wandered a little at times; pulsation increased. Next day he was in the same condition; the phlegm was still troublesome. Ordered steam inhalations, which gave great relief. On the 14th the swelling had increased very considerably, nearly to the level of the chin. Measurement: Longitudinally, 9½ in.; transversely, 17 in. It was much more prominent and pointed. Another tumour had appeared over the inner third of the left clavicle about the size of a Tangerine orange. Constitutionally he was much the same, but on the following day there was a slight oozing from the smaller tumour. On the 16th the breathing was stertorous. The patient had considerable cough, looked very emaciated, and complained of intense thirst. Next day the breathing was worse, the thirst continuing, but no pain. He wandered a good deal, became suddenly worse in the afternoon, and died at 5 P.M.

Necropsy, eighteen hours after death—Rigor mortis well marked; body thin; tumour subsided considerably; discoloration over the most prominent part. Point of suppuration through the second intercostal space on the left side. Considerable serous effusion in the pericardium. Chronic pleurisy on the left side. Heart somewhat hypertrophied. Aorta very atheromatous, with calcareous plates; also dilated. At the junction of the ascending and transverse parts of the arch of the aorta was a circular opening communicating with a large cavity (which formed the tumour externally). On opening up this cavity it was found lined with firm laminated fibrin, and filled with ante- and post-mortem clots. The tumour itself was of the dimensions of a good sized cocoa-nut. The lower part of the anterior wall was thin. The sternum and cartilages of the upper two ribs were eroded and perforated by an irregularly roundish orifice one inch and a half in diameter. The part of the sac projecting through the orifice formed about one-third of the whole; the bulk of the tumour extending to the chest wall was formed by ante-mortem clots outside the sac. The arteries coming off from the aorta were not affected. The larynx and trachea were inflamed, and the mucous membrane covered with a thick layer of muco-purulent secretion. About the seventh ring of the trachea, on the posterior part of the inner surface on each side of the tracheal muscle was a longitudinal ulcer half an inch in length, and the cartilages for the space of two or three rings were eaten through on the right side, forming a perforation. The cricoid and thyroid cartilages were ossified; calibre not diminished. The bronchi were filled with frothy mucus and the lungs œdematous. The sternum, after maceration, presented the following appearances: There was a perforation three inches in circumference, with dentated edges, concave on the posterior surface. The bone was fractured at the third intercostal space. The right sterno-clavicular articulation was disorganised, the clavicle dislocated forwards, and its sternal end carious.

Remarks.—The interest of this case lies in the rapidity of the growth of the tumour, its sudden appearance, and in the fact that the man considered himself to be in perfect health till he noticed the swelling, and the length of time the patient lived after the aneurism became diffused is worthy of note, this having taken place on the 11th and death not occurring till the 17th of September.

DEVON AND EXETER HOSPITAL.

ANEURISMAL VARIX OF THE FACIAL; LIGATURE ABOVE AND BELOW THE SAC; RECOVERY.

(Under the care of Mr. BANKART, F.R.C.S.)

FOR the notes of this interesting case we are indebted to Mr. A. G. Blomfield, M.B., house-surgeon.

Stephen N—, aged twenty, was admitted on May 12th, 1881, with a pulsating tumour of the right side of the face. The history was as follows:—Two years and five months before, while attending a shooting party, he was accidentally

shot in the right side of the face and right arm, two shots entering near the angle of the jaw, and one below the inner angle of the eye. The bleeding from the face at the time of the accident was, he said, considerable, but no particular treatment was required to check it.

On admission there was seen a distinctly pulsating tumour, extending over an area of three inches, beginning three-quarters of an inch below the right lower jaw over the site corresponding to the course of the facial artery, and going upwards on the cheek over an area which would be intersected by a line drawn from the inner canthus of the right eye to the angle of the jaw. The pulsation was attended by a characteristic thrill or "hum." The thrill was most distinct just under and about one inch above the edge of the lower jaw; it was also very distinct below the inner angle of the eye. Above, in the corner of the right eye, was a small varicose, bead-like swelling, distinctly pulsating, bluish in colour beneath the skin, and communicating by means of a small dilated vessel across the top of the nose with a dilated branch of the left facial vein. Pressure on the facial vessels opposite the angle of the mouth, by a finger in the mouth and another on the cheek outside, stopped pulsation and thrill above this point, but not below. Compression of facial on the edge of the jaw only partially limited pulsation and thrill in the lower portion of the face, and not at all at the angle between the eye and the nose. These vascular pulsating swellings had, he stated, gradually appeared since the accident. He could fix no certain date when he first took notice of them, but he had especially noticed an increase in size during the six weeks previous to his admission. His general health was excellent.

On May 20th, finding that pulsation could not be entirely controlled by pressure, Mr. Bankart cut down upon the right facial artery where it crosses the lower jaw, and ligatured it above and below the points of communication with the aneurismal sac. A straight incision was made along the lower jaw, subsequently extended by a straight incision at right angles downwards. The facial artery below the jaw was hypertrophied and remarkably tortuous, and was joined on the jaw by a large branch from under the angle of the jaw. Above was a pulsating sac into which there was a direct communication from the facial main trunk. No difficulty was experienced in tracing the artery into and out of the aneurism. The lower ligature (silk) was put on a short distance from the sac, and it was then found that pulsation was kept up by the branch from under the angle of the jaw, and this was then tied. The result was to almost completely stop pulsation in the sac; pulsation still continued at the angle of the eye by a branch from the transverse facial which could be felt in the cheek. A ligature was then put on the facial above the sac, when the pulsation at the inner angle of the eye also ceased. Dry lint dressing was applied. The temperature on the evening of the operation was 100°, and on the fourth day it became normal. All the ligatures came away in the usual course, but one did not separate until July 21st. There was no return of pulsation after the operation, and on July 23rd he was made an out-patient so as to be kept under notice for a time. On September 21st he was discharged cured, there having been no return of pulsation in the sac, and none could be detected by examination. The veins below the right lower eyelid are still dilated and visible through the skin, but there is no pulsation.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

Congenital Macrostoma, accompanied by Malformation of the Auricles and by the Presence of Auricular Appendages.—A Successful Case of Simultaneous Ligature of the Subclavian and Carotid Arteries for Innominate Aneurism.

THE ordinary meeting of this Society was held on the 8th inst., Dr. Barclay, President, in the chair.

The following is an abstract of a paper by Mr. JOHN H. MORGAN, on Two Cases of Congenital Macrostoma, accompanied by Malformation of the Auricles and by the Presence of Auricular Appendages:—Case 1. One patient is a year old and very small, the deformity consists of a fissure-like