

return immediately upon discharge from the hospital to an unsanitary home, to evil associates, domestic troubles and casual labor. In Great Britain the Inebriates Reformation and After-Care Association has been formed to meet the inebriate when he leaves the hospital, and find him work and proper associates. The British association, however, is at a disadvantage in that its officers know nothing of the patient previous to his discharge from the hospital, and also are not equipped to continue the medical treatment of the patient, or even to win his confidence. At the Foxborough State Hospital an attempt has recently been made to improve upon the British mode of after-care by employing a physician, familiar with the methods of the hospital and acquainted with its patients at the hospital, to conduct this work. Through the out-patient physician the treatment of the patient is supplemented by instruction to the patient's family in the nature of the disease of inebriety and the methods of aiding its cure. Total abstinence is urged within the family. The patient is further linked with constructive social interests, — the church, sympathetic friends, temperance fraternities, and the like. The man is helped to secure employment through the employment agency of the hospital. Men who have been casual laborers before their treatment, and have been taught a skilled trade at the hospital, are placed by its officers at that trade. Most important, however, is the visit paid by the out-patient physician of the state hospital to the ex-patient, by means of which the treatment which was practiced at the hospital is continued. If the physician concludes that the patient has left prematurely, he is advised to return to the hospital; if he appears safe at his home, he is aided with frequent counsel and encouragement. Contact is also kept up through visits to the hospital by the patient. Reports are required both from the patient and from his family. In this manner the psychological treatment begun at the hospital is continued and supplemented by the sociological measures of the out-patient physician, and the patient, trained in strength of will in the hospital, is equipped with an environment favorable to the exercise of his strengthened volition."

The after-care department of the hospital as above outlined has been in successful operation during the past year. The results have been eminently satisfactory. Our confidence in this new departure of the hospital can best be expressed by declaring it our purpose to make its development an important part of our hospital work during the coming year. The Commonwealth of Massachusetts has obligated herself to carry out the recommendations incorporated in the special report before mentioned. An abstract of these recommendations is as follows: The immediate purchase by the commonwealth of a large tract of land for the establishment under uniform medical supervision of a new hospital for men, a women's hospital and the gradual development of a detention farm colony. The hospital for men to receive: First, patients who come volun-

tarily or who are committed by the courts; second, young habitual drunkards placed on probation by the court on condition that they spend a specified period at the hospital; third, suitable cases which may have been transferred on parole from the detention colony. The hospital for women to receive: First, patients who come voluntarily or who are committed upon application; second, cases placed on probation by the court on condition that they spend a specified period at the hospital. The detention colony to receive non-criminal habitual drunkards from the criminal courts on indeterminate sentence.

It seems unnecessary for me to say that the inauguration of such a plan and its complete success depends largely upon the co-operation of the medical profession with state officials.

Clinical Department.

CASE OF FOREIGN BODY IN THE TRACHEA. STATUS LYMPHATICUS. DEATH. AUTOPSY.*

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AND

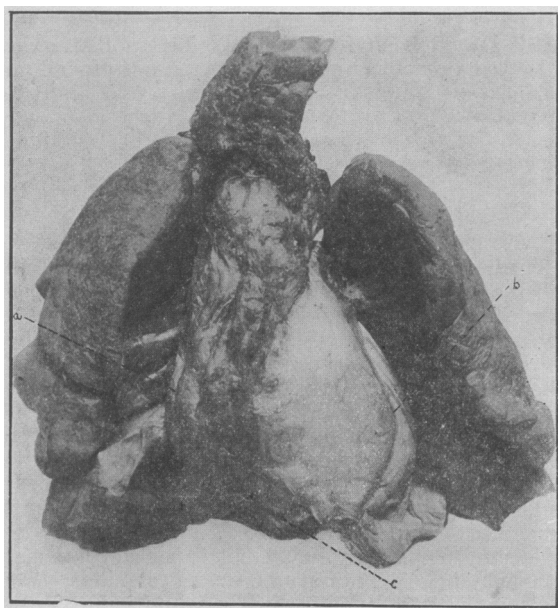
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THE patient, a white boy aged sixteen months, inhaled a hulled peanut kernel on Sunday afternoon, Aug. 21, 1910. His parents, who lived in a town in Connecticut, said that they had taken him to several hospitals, but could get nothing done for his relief. They brought him to the Massachusetts General Hospital on Tuesday evening, Aug. 23, two days after the accident. I saw him that evening. The temperature was 100½ (rectal), pulse 158, respiration 40. His mother said he had eaten nothing since the accident, and, having traveled a long distance, he was much exhausted. During the physical examination he lay listless and apparently indifferent to his surroundings, although one could not say he was unconscious. Two radiographs were taken, which gave no indication of the foreign body or of the enlarged thymus. Although the respiration was rapid and noisy there seemed to be little if any obstruction to the entrance of air into the lungs, and there was no cyanosis. In view of the exhaustion and of absence of any indication of the necessity for immediate interference, it was deemed best to wait until morning, when the external conditions would be more favorable for operative interference. The patient had rather a restless night, but slept some with a narcotic. In the morning (Wednesday, Aug. 24) the rectal temperature was 100, pulse 140, respiration 30. There was the same semiconscious state as on the night before, the eyes more or less fixed, the eyelids half closed, the body relaxed. Ether was given very carefully and in small amount. The child was placed in the Rose position, and with a small Jackson tube spatula an excellent view obtained of the glottis. Something could be seen moving up and down the trachea on expiration and inspiration. The glottis was sprayed with a little 1% cocaine solution and a small pair of tube forceps introduced into the trachea then opened. As the patient expired, the forceps were closed. It was at once evident that they had closed on some-

* Read at a meeting of the New England Otological and Laryngological Society, Nov. 28, 1910.

thing which required considerable traction to pull through the glottis. When the forceps was removed the blades held nearly a whole peanut kernel, which separated into three or four pieces as it was released. The kernel had probably broken in the forceps, as it is most unlikely that if it had been in pieces in the trachea it should all have been removed with one grasp of the forceps. After the operation, which took hardly more than five minutes, the pulse at the wrist was almost imperceptible, the respirations were feeble and the patient looked badly, pale but not cyanotic. It was evident that the child was in very bad shape and that something must be done; so, at the suggestion of one of my colleagues that there might be still more particles of peanut in the air-passages, I performed tracheotomy. The child stopped breathing during the operation, which was rapidly completed. On inserting the tube another small piece of peanut was expelled. Artificial respiration started the breathing again. An enema of warm salt solution with brandy and a hypodermic of strychnia were given and hot water bottles were put in the bed. He now breathed in a peculiar



Thymus. Status Lymphaticus. Massachusetts General Hospital. a. Right border of enlarged thymus. b. Left border. c. Lower border. Photograph by L. S. Brown.

manner, deep inspirations alternating with periods when the respirations seemed to have ceased. There was no obstruction to respiration. The pulse at the wrist was very faint and rapid. While we were watching him, he suddenly had a violent convulsion, clenching of the fists, flexion of the hands at the wrists, opisthotonos and twitching of the muscles of the face. This seizure lasted not more than a minute. As soon as it was over he was taken to the ward. He had not been there more than twenty minutes when the nurse reported that he was dead. I went at once to the ward and found that this was the case, also that, although the body was still warm, rigor mortis was already present.

AUTOPSY.

The permission of the parents having been obtained, an autopsy was made by Dr. Richardson on Aug. 25, eighteen and one-quarter hours post-mortem.

Anatomical diagnosis. — (A portion of a peanut was successfully removed from the trachea in this case,

but was followed shortly by death.) Tracheotomy wound. Status lymphaticus. Meckel's diverticulum.

A male child sixteen months of age, 82½ cm. long, very well-developed and nourished. Race: American. Head: Not examined. Trunk: The neck presents a tracheotomy wound in the usual situation. It is in good condition. On section subcutaneous fat in good amount; muscles not remarkable; peritoneal cavity free from fluid; peritoneum smooth and shining; appendix not remarkable. The anterior margin of the right lobe of the liver is one finger breadth below the costal border in the right mammary line. Diaphragm, right side, fourth interspace; left side, fifth rib. Pleural cavities free from fluid. Lungs free. The thymus gland is present and greatly enlarged. It is roughly in the shape of a much flattened pyramid and reaches from a point a little below the lower border of the operation wound in the trachea down over the heart to the diaphragm. It measures 11½ cm. in greatest length by 6 cm. in greatest width by 2 cm. in greatest thickness. The broadest portion of the gland rests over the heart. The narrowest and thickest portion rests over the trachea. The gland is rather firm and meaty and its lower peripheral portions thin out to an edge. As the specimen is preserved, the weight cannot be taken. The bronchial and tracheal lymph glands show some enlargement, but otherwise are not remarkable. The trachea and bronchi are free. The lungs are not remarkable. Pericardium not remarkable. Heart weighs 53 gm. On section the cavities of the right side are engorged with blood and there is a rather considerable amount in the cavities of the left side. The organ otherwise is not remarkable, except that it is rather large. Aorta and its great branches and the venæ cavæ not remarkable. Liver weighs 351 gm. Not remarkable. Gall bladder, no stones. Bile ducts free. Pancreas not remarkable; duct of Wirsung free. Spleen weighs 40 gm. On section the tissue is firm, dark red in color, with very prominent follicles. Adrenals: Not remarkable. Kidneys: Combined weight, 74 gm. Capsules strip, leaving smooth surfaces. On section the tissue is of good consistence, the markings are retained and the cortex measures 4 mm. The section surfaces are rather pale; pelves not remarkable. Ureters free. Bladder, prostate and testes are not remarkable. Esophagus and stomach are not remarkable. The small intestine on section shows very prominent Peyer's patches and follicles with some reddening of these in places. The lower part of the ileum presents a typical Meckel's diverticulum about 5 cm. long and of the same caliber as the intestines. The lumen of the diverticulum communicates freely with that of the ileum, and the mucosa is not remarkable. The large intestine on section shows prominent follicles with some reddening of them in places. The mesenteric and retroperitoneal lymph glands are more or less enlarged and pale. On section the tissue is not remarkable. The larger glands measure at least 2 cm. in greatest dimension. Bacteriological report: Culture on blood serum. Spleen. No growth.

In the analysis of this case interesting questions arise upon which one may speculate with possibly some profit even if no definite answers can be arrived at. Would it have been possible to diagnose this case *intra vitam*? Let us see what were the features present which are characteristic of status lymphaticus. Plumpness and a general rotundity of the limbs, a characteristic of these cases, was present, alone a very inadequate basis for diagnosis. There was no noticeable enlargement of the external lymphatic glands.

If the tonsils had been much enlarged they would have probably been noticed on passing the tube spatula, but no special note was made of the condition of the tonsils. The noisy respiration made percussion and auscultation very difficult and unsatisfactory, but even had it been otherwise, the site of the enlarged thymus over the heart and great vessels would have masked the greater part if not all the dullness caused by its enlargement. The same difficulty applies to the interpretation of the radiograph. The foreign body moving up and down in the trachea with respiration, if anything, only increased the shadow normally caused by the trachea. No one who saw the plates suggested that the shadow caused by the heart and great vessels was any larger than it should have been. Looking back at the case, the state of shock which was present when the patient was brought to the hospital was greater than one would expect after such an accident, merely from the irritation of a foreign body in the trachea and with little or no obstruction to the passage of air into the lungs. But this condition was attributed at the time to the excitement and exhaustion of the period following the accident. Dr. G. H. Cocks, in an article in the *Laryngoscope* for July, 1910, entitled "Status Thymo-Lymphaticus and its Relation to Sudden Death," says: "A finding of a lymphocytosis or diminution in the hemoglobin in the blood would aid in the diagnosis." But this diagnostic sign is of no value unless a blood examination is made a routine procedure before operation, which has not heretofore been our custom or been thought of as essential. If the diagnosis had been made before the operation, could any other possible method of procedure have prevented the fatal issue? It was quite evident that the patient's condition would not improve while the foreign body remained in the trachea. Its removal might have been attempted under local anesthesia, although this procedure is not free from danger in status lymphaticus. Dr. Cocks finds records of three fatal cases after local anesthesia. It should be remembered that under local anesthesia in this case we should have had the mental shock to the semiconscious child of the manipulation and instrumentation necessary for the removal of the foreign body. I question very much if the outcome would have been different. There was no evidence in this case of any mechanical compression of the trachea by the enlarged thymus. Death was apparently due to hyperthymization. In other words, death was due to a toxemia affecting the nerve centers and not to a mechanical obstruction to respiration although the mechanical effect on the heart of the enlarged thymus spread over it should be thought of as exerting a possible delaterious influence.

INCREASE OF CANCER IN ONTARIO. — During the seven years up to and including 1908, 8,769 persons of all ages died in Ontario from various forms of cancer. In 1902 the number was 1,048; 1903, 1,156; 1904, 1,253; 1905, 1,224; 1906, 1,411; 1907, 1,329, and 1908, 1,348. — *Jour. Am. Med. Asso.*

REPORT OF THREE RECENT CASES OF BRONCHOSCOPY FOR FOREIGN BODIES.*

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THE first case, a boy two and one-quarter years of age, was admitted to the Children's Hospital, in the service of Dr. J. L. Morse, Feb. 18, 1910. Four days before, while eating dried figs, he suddenly began to cough and choke. The following morning he coughed up a piece of fig, and the next day began to be feverish. Spells of coughing and choking continued at intervals. Physical examination made at the time of admission showed evident dyspnea; the left side of the chest moved less than the right in respiration; the breath sounds were diminished in intensity on the left side and entirely absent in the left back between the mid-axillary line and the left edge of the scapula. There was no dullness on percussion of the left chest. Auscultation and percussion of the right chest showed normal breathing throughout. The temperature was 103°, and the pulse 140 and the respirations 54. The history and the physical signs pointed to obstruction of the left bronchus by a piece of fig. An x-ray examination by Dr. A. W. George on the morning after the child's entrance to the hospital did not show any foreign body. Dr. Morse then referred the case to me for bronchoscopic examination.

The child was etherized and I introduced the smallest sized bronchoscope we had through the larynx into the trachea to the bifurcation. The right primary bronchus was clear, but the left was plainly obstructed. The mucous membrane was much reddened and swollen and the lumen thus narrowed was closed by a whitish plug. I was unable to introduce the bronchoscope into the bronchus and after a few ineffectual attempts to clear the bronchus with forceps I desisted for the time, hoping that my manipulations might have loosened the foreign body in its macerated condition sufficiently to enable the child to cough it out.

The child made a good recovery from the etherization, but the signs in the chest remained essentially the same. Evidently no air was going into the left lung. After a week, during which the child had a typical septic temperature, I made a second bronchoscopic examination. The appearance of the left bronchus was the same as at the first examination. This time I introduced a blunt hook into the bronchus a short distance beyond the apparent point of obstruction and withdrew it after making a slight turn. There was a little resistance to the withdrawal of the hook, but no foreign body could be made out and the bleeding which followed obscured the field of vision. Palpation and auscultation of the chest at this time showed that air was now freely entering the left lung. The child again made a good recovery from the ether, but his general condition did not improve, but grew steadily worse. A double purulent otitis media requiring paracentesis of both drumheads followed, and later definite signs of an abscess of the left lung. This was opened and drained through the chest walls by Dr. J. S. Stone, but the child survived the operation for only four days. Autopsy was not allowed.

It may be inferred, I think, that at the time of the second bronchoscopy the fig had become considerably macerated and was broken up and scattered into the lower bronchi by the manipulations. Whether the latter had anything to do

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