

CALOMEL POISONING

A CASE OF SOME VALUE TO OUR FELLOW
PRACTITIONERS

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The following report concerns a syphilitic patient who had a primary lesion of the lip two or three years ago and had been under treatment intermittently for lesions about the mouth and throat.

Miss X entered the Dermatological Department of the Boston Dispensary on December 30, complaining of sore throat, fever, malaise, sore face, inability to swallow, and huskiness of voice.

Four days previously, she was taken ill suddenly with the above symptoms, and two days later she consulted a physician who made a diagnosis of acute tonsillitis. He prescribed a cathartic, a gargle, and some other medicine to take internally. She felt a little better on the 29th but on the 30th her throat seemed worse and she returned to the dispensary. Examination showed a swollen face and neck, swollen lips, gums, tongue, and mucous membranes of practically the whole mouth and pharynx. Her tonsils were somewhat swollen, were red, with an occasional spot resembling a mucous patch. The gums were quite red, swollen, with a blotchy white appearance in places similar to the spots on the tonsils. The cheeks and folds between the cheeks and gums were also slightly red, and white patches were also observed in these places. There was considerable salivation but no mercurial odor, and it developed on questioning that a certain amount of pain was caused by forceful closure of the teeth. There was some tenderness beneath the jaw and palpation disclosed some enlargement of the submaxillary and submental glands. The case suggested hydrargyrisms although no history of mercurial medication could be obtained at first.

She had not been under antisyphilitic treatment for some little time and the question arose as to whether her condition was a recurrence of the syphilis. The white patches with the glands and, especially, the fact that she had apparently not been taking mercury for some little time supported this view. She was questioned in regard to medicine taken during the past few weeks. Questioning to "back up" our diagnosis was futile for twenty minutes. By persevering, however, we finally elicited the fact that the week previous a friend had been using some "Calomel, 1 grain," pills for a laxative, and she had purchased at a drug store a hundred of these pills and had taken them as follows: On the 22d, she had taken four; on the 23d, 24th, and 25th, she had taken three four times a day; and on the 26th and 27th, she had taken enough others to make the total number taken fifty-six. On the 26th, the patient had noticed that her throat and mouth were swollen and that it hurt her to swallow. The condition had continued, becoming steadily worse, so that she had consulted the physician.

There had been no special laxative effect from the pills for it had been necessary for her to take some other laxative previous to consulting her physician. She had not even noticed any discomfort in her stom-

ach or bowels, and the only complaint was of her throat and mouth.

The diagnosis in this case, until the full history was obtained, rested between a tonsillitis, a recurrence of the syphilis, and a stomatitis, probably of mercurial nature.

The case shows the importance of close and persistent questioning to bring out facts and also the importance of believing what one sees rather than what one hears in a dermatologic clinic. The history seemed very positive and was so very strong against mercurial medication, and was so clear as to repeated attacks of very unusual syphilitic manifestations of the whole mouth, tongue, throat, etc., that we were puzzled for a time. She made rapid recovery.

A FURTHER STUDY OF THE CHEMICAL
COMPOSITION OF URINARY CALCULI*

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Together with Dr. Max Kahn,¹ I have reported the analyses of twenty-five urinary calculi. The results showed, contrary to the usual statement, that the large majority of renal stones are composed of calcium

PERCENTAGE COMPOSITION OF TWENTY-FIVE RENAL
CALCULI

No.	Weight, Gm.	Moisture, Per Cent.	Calcium Oxalate, Per Cent.	Uric Acid, Per Cent.	Phosphorus Pentoxid, Per Cent.
1	5.8026	1.37	38.30	4.20	50.13
2	9.1904	4.30	40.60	6.72	58.16
3	0.5318	5.20	63.81	1.72	10.12
4	2.7525	2.80	7.72	90.10
5	16.5680	8.70	33.90	4.80	53.46
6	1.5012	5.10	3.53	91.20
7	1.3076	0.40	70.22	9.32	18.24
8	2.4723	1.06	91.30	6.71	3.82
9	3.1005	1.27	72.63	17.03	5.70
10	0.5246	0.60	98.60	1.12	7.30
11	5.7210	1.34	65.72	8.21	8.61
12	0.9205	0.78	90.76	7.92	6.82
13	0.4678	0.09	92.47	2.07	5.12
14	1.6240	0.63	90.82	3.17	4.18
15	1.9372	1.30	48.26	9.18	9.80
16	3.0042	3.20	47.22	6.72	7.56
17	1.2351	1.80	93.28	1.71	4.32
18	11.2678	1.65	94.27	0.62	3.74
19	8.3732	3.18	98.22	0.00	0.42
20	4.6002	2.75	94.17	1.82	6.10
21	4.7801	0.90	90.32	1.37	5.80
22	0.9763	0.09	95.12	0.24	6.22
23	1.2478	1.22	83.27	2.52	5.18
24	0.9908	0.78	39.93	7.62	3.42
25	3.2005	1.42	86.47	2.24	5.35
26	8.7632	5.81	82.17	9.35	3.72

oxalate and not of uric acid or urates. I now report the results obtained in the chemical analysis of a new series of twenty-six renal calculi of which, as may be noted from the tabulated data, only two were uric acid stones, while the balance, or twenty-four, were composed principally of calcium salts.

I was unable to demonstrate any trace of lecithin or cholesterol in the ether-alcohol extract of any of these calculi.

We have pointed out previously the necessity of changing our therapeutic ends with regard to the treat-

* From the Biochemical Laboratory of the Western Pennsylvania Hospital.

1. Kahn, Max, and Rosenbloom, Jacob: A Report of Some New Chemical Analyses of Urinary Calculi, *THE JOURNAL A. M. A.*, Dec. 31, 1912, p. 2252. Kahn, Max: A Study of the Chemistry of Renal Calculi, *Arch. Int. Med.*, January, 1913, p. 92; *Ztschr. f. exper. Path. u. Therap.*, 1914, xvii.

ment of renal calculi.² We again draw attention to the fact that the therapeutic measures for the treatment of insoluble calcium salt calculi are completely different from those employed for uric acid. The usual antacid treatment is just the opposite of what is indicated, on account of the fact that uric acid and its acid salts are soluble in alkaline mediums and insoluble in acid, the opposite is true for calcium oxalate and calcium phosphate, which are deposited in alkaline mediums and dissolved by acids. For these reasons all calculi obtained should be chemically analyzed and on the basis of their chemical composition more rational therapy can be instituted.

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SURGICAL MEASURES IN APOPLEXY

REPORT OF A CASE

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It may appear radical to advocate operative procedures on spontaneous intracerebral hemorrhage; nevertheless, a correlation of the pathology with the symptoms suggests, in selected cases, two rather positive operative indications: first, the relief of the general intracranial pressure due to the presence of the clot, and, second, the removal of the clot, if this be possible, in order to relieve the more delicate portions of the brain, should the clot remain, from secondary changes which may become permanent because of the surrounding reaction. The following case may be of interest in illustrating features which indicate operative procedures, and the results obtained are somewhat instructive when considered from an operative and pathologic basis:

History.—A patient referred to me by Dr. William Thompson of Dublin, Ga., six days previously had slight sensory disturbances of the left arm—tingling and pain—followed within an hour by complete paralysis. Similar disturbances in the foot were felt almost immediately, and with no delay paralysis of the whole leg ensued. The patient soon became unconscious, and during the next five days his condition became gradually worse. He was at this time in a comatose state, which was punctuated occasionally by attacks of great irritability.

Examination.—The patient was in a semistuporous condition, and did not answer questions. Occasionally some incoherent remarks were made. There was quite marked restlessness and flinging about of the right arm and leg at indefinite intervals. The left arm and leg were not moved. Occasionally a slight response could be obtained, and it was possible to demonstrate a slight grasp in the left hand.

Throughout the whole left side of the body there were definite disturbances of sensation, though occasionally the patient perceives marked sensory impulses very slightly. It was extremely difficult to elicit reflexes, and nothing of note could be ascertained from these. There was a definite weakness of the left side of the face, the left arm and the left leg. Both eyes were closed, and it seemed impossible for the patient to open them. Pulse, 60; blood pressure, 146; respirations, 8; Cheyne-Stokes. On forcible opening of the eyes there seemed to be a momentary nystagmus, but this passed off rapidly. The pupils were practically the normal size, but there was practically no reaction to a strong light flashed into the eye.

Examination of the disks showed on the right side a swelling of 2 D. on the temporal side of the disk, and 5 D. on the nasal side. The veins were somewhat enlarged and tortuous. In the left side a similar condition was seen, the swelling being more marked on the nasal side and less so on the temporal. In general, there was an edema of the right disk which was quite marked, and of the left disk which was very slightly less marked.

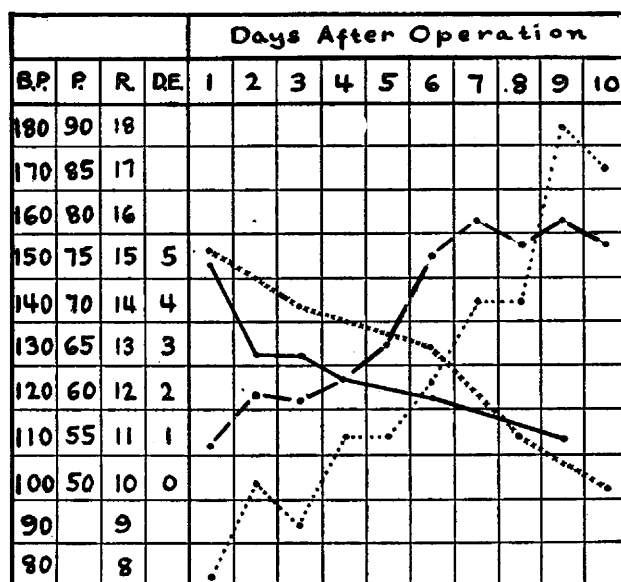
Considering the history and the examination, which showed increased intracranial pressure, it seemed advisable to perform an exploratory craniotomy with the hope of removing the clot or, in the case of finding cerebral edema only, of performing a subtemporal decompression.

Operation.—The usual muscle-splitting approach was

employed. A generous decompressive opening was fashioned, and the dura was opened so as to expose the operculum and that portion of the cortex overlying the basal ganglia. The brain itself was edematous and evidently under pressure. There was a distinct tendency of this to extrude through the opening. The fissura cerebri lateralis was demonstrated, and anteriorly there were no visible suggestions of underlying hemorrhage. Posteriorly, on careful separation of brain and dura, there was encountered a collection of clotted and semiclotting blood forming a cavity about the size of a golf ball or larger, which had as its external opening the lateral cerebral fissure between the gyrus centralis posterior and gyrus temporalis superior. Small portions of brain tissue were

extruded with the old clotted blood. This, then, suggested a lenticular hemorrhage which had worked out through the surface of the insula. A drain was inserted through the opening deep into the cavity and closure was made in the manner usual in such a field. The protective drain was brought through the middle of the incision.

Owing to the fact that this patient had been subjected to six days of pressure, I was not optimistic in the prognosis of the relief from permanent changes of the fibers of the internal capsule, even had the hemorrhage itself been located in the lenticular nucleus principally. The convalescence, as may be seen by the accompanying chart, was a complete success from the standpoint of the relief from the general increased pressure. The mentality cleared rapidly, and the facial paralysis on the eighth day was fast disappearing. The paralysis of the extremities cleared more slowly, and it is difficult to say whether or not the procedures had marked influence on this feature. Nevertheless, it is only suggestive that procedures such as this should be undertaken sooner, not only with the hope of avoiding fatal issue which was



Convalescence chart: blood pressure, solid line; pulse, line of dashes; respiration, line of dots; disk edema, line of crosses.

2. Schildecker: Am. Jour. Obst., 1914, lxx, 979. This article gives detailed directions for the treatment of the various urinary calculi.