found that, although antihistamine drugs did not have any effect on the vestibular symptoms when they had developed, there was evidence that these drugs, given prophylactically, were of some use in preventing the development of these symptoms. Some of the damage resulting from such allergy has been found to be permanent, particularly in older patients.

SUMMARY

A case is described in which various fairly common neurotoxic manifestations developed following treatment with streptomycin. In addition there developed a temporary paresis of an extraocular muscle.

It is possible that all of these neurotoxic manifestations have the common factor of allergy.

We are indebted to Dr. O. F. Thomas for the privilege of reporting the details of this case.

PETER O. LEGGAT, M.D., M.R.C.P.,
Senior Medical Registrar,

JOHN H. GIFFORD, M.B., Ch.B.,
Medical Registrar.

Aintree Hospital, Liverpool.

REFERENCES

- Bignall, J. R., *et al.* (1951). *British Medical Journal*, 1, 554.
Brown, H. A., *et al.* (1949). In H. M. Riggins and H. C. Hinshaw's *Streptomycin and Dihydrostreptomycin in Tuberculosis*, p. 107. New York.
Doman, C. M., *et al.* (1949). *Amer. Rev. Tuberc.*, 60, 564.
Hinshaw, H. C., and Feldman, W. H. (1945). *Proc. Mayo Clin.*, 20, 313.
Howlett, K. S., *et al.* (1949). In H. M. Riggins and H. C. Hinshaw's *Streptomycin and Dihydrostreptomycin in Tuberculosis*, p. 125. New York.
M.R.C. (1948). *British Medical Journal*, 2, 769.
Packard, E. N., *et al.* (1949). In H. M. Riggins and H. C. Hinshaw's *Streptomycin and Dihydrostreptomycin in Tuberculosis*, p. 272. New York.
Riggins, H. M., *et al.* (1949). *Ibid.*, p. 294.
Tucker, W. B. (1949). *Amer. Rev. Tuberc.*, 60, 715.

Unsuspected Foreign Body in Putrid Bronchiectasis

Foreign body in the bronchus has long been recognized as a cause of bronchiectasis, and a great deal has already been written about this condition. During the past two years at the thoracic surgical centre, in three cases of putrid bronchiectasis while doing a routine bronchoscopy we discovered a foreign body previously unsuspected in the bronchus. We therefore feel justified in presenting these three cases.

CASE 1

A woman aged 48 was admitted to hospital on August 31 with a history of pleurisy in June followed by a constant hacking cough and large quantities of foul-smelling sputum, but no previous history of chest disease. Radiographs showed a right basal opacity, and on culture the sputum showed *Streptococcus viridans* and diphtheroids. Multiple examinations for tubercle bacilli were negative. Cytological examination of the pleural effusion showed that the polymorphs and lymphocytes varied from 40% and 60% to 80% and 20%, respectively. Culture and guinea-pig inoculation were negative.

A bronchoscopy was done on admission to the centre. A foreign body was found in the right lower lobe bronchus below the apical opening, and on removal proved to be a piece of bone. After bronchoscopy the constant irritating cough immediately ceased, and the putrid sputum decreased from 2 oz. (57 ml.) daily and eventually disappeared. The patient has been well ever since.

On further questioning she remembered that whilst eating rabbit the previous November something went down the wrong way and caused a fit of coughing. This soon passed off and she thought no more about it. On reviewing her radiographs what was thought to be a calcified lymph node had now disappeared, and was obviously

a foreign body. Bronchograms taken at the time show saccular bronchiectasis of the right middle and right lower lobes. Repeated bronchograms two years later show persistence of bronchiectasis, but to a less degree.

CASE 2

A man aged 36 had been invalided from the Army because of putrid bronchiectasis five years previously, and was in receipt of 100% disability pension. He had not worked for three years. He was a plethoric man who looked much older than his years; there was gross clubbing of the fingers, the breath was foul, and he had 16 to 20 oz. (454 to 568 ml.) of putrid sputum daily.

Bronchograms showed gross saccular bronchiectasis of the right lower lobe and pectoral segment of the right upper lobe. Only "ghost" filling of the left side was obtained, but the left bronchial tree was accepted as being normal.

On bronchoscopy a foreign body was discovered in the left main bronchus. Just proximal to it was a polypoid projection of fibrous tissue. On removal the foreign body proved to be a back collar stud.

On further questioning the patient could remember having inhaled it 14 years previously. He went to hospital at that time, but after reassurance he forgot about it.

It is interesting to note that the foreign body was on the left side, and that it had been there for some time, as proved by the reaction of the bronchial wall proximal to it. Did it begin its sojourn in the bronchial tree on the right side and later migrate to the left?

Unhappily, his symptoms did not abate after the bronchoscopy and he was later submitted to operation.

CASE 3

A woman of 54 was referred for investigation of recurrent right-sided pleurisy and 3 oz. (85 ml.) of putrid sputum daily. She gave the history that she had had many attacks of pleurisy with cough and sputum since a nasal polyp was removed in 1914. A radiograph showed opacity in the right lower zone. Bronchoscopy showed a foreign body in the right main bronchus at the level of the right middle lobe opening. On removal this proved to be a piece of bone.

On further questioning she gave the information that she had coughed up several pieces of bone following removal of her nasal polyp. She ignored this, thinking it to be a normal occurrence after her operation. On reviewing the radiographs it can be seen that what was thought to be a calcified node was in fact the foreign body. Bronchograms show her to have collapsed bronchiectatic right lower and middle lobes.

The putridity has disappeared and her sputum is reduced to less than $\frac{1}{2}$ oz. (14 ml.), but it is too early to give a final progress note.

COMMENT

If it is remembered that an inhaled foreign body can be a cause of chronic bronchial infection, particularly of a putrid nature, then careful attention to this point in the history may elucidate the cause of some cases of bronchiectasis. It should be noted that, even when directly questioned, a patient may deny the possibility of the presence of a foreign body because the inhalation took place many years previously. This is exemplified by Cases 2 and 3, in which the foreign body was present probably for 14 and 36 years respectively.

It is felt that in these three cases much ill-health and time in hospital would have been avoided by early bronchoscopy.

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J. S. GLENNIE, F.R.C.S. Ed.,
J. F. DARK, F.R.C.S.,
D. C. LINDARS, M.B., Ch.B.

Baguley Hospital, Manchester.