RECURRENT PNEUMOTHORAX.

By D. HOADLEY GABB, M.R.C.S.Eng.

THE references to pneumothorax in Neale's *Digest* are few. The accompanying case, with Dr. Byrom Bramwell's valuable notes, is, I believe, of sufficient interest to record.

Miss P., aged 56, came under my care on March 4th of this year. The history she gave of herself was: In 1874, after coming home from church on a cold night, she was seized with severe pain above the right breast, extending through to the shoulder-blade, with considerable distress and breathlessness. She was attended by Dr. Bramwell, Dr. Byrom Bramwell, and Dr. Charlton, of Newcastle; they diagnosed pneumothorax, with slight effusion; the lung was quite collapsed. After this illness, she had fair health; she gradually recovered. Five or six months after this, she saw the late Dr. Peacock, who found no traces of her ailment, and doubted the truth of her statement. From this to 1880, she was in her usual health, when, without obvious cause, she had another breakdown, and was again attended by Dr. Byrom Bramwell, who told her it was the same thing as before—a slighter attack, from which she soon recovered.

In 1882, quite suddenly, when sitting in her room, she was seized with uneasiness in the old place, breathlessness, etc. She was staying in town, and saw a consultant, who diagnosed pneumothorax. This was a slight attack, and the "effused" air was soon absorbed.

In 1886, she had bronchitis and pleurisy of the right side, but no pneumothorax.

In the autumn of 1887, she was suffering from debility, and consulted a man of considerable reputation at Newcastle, who pronounced her heart and lungs quite healthy. She derived much benefit from his treatment, and was pretty well until the day before I saw her, March 4th, as above, when she thought she had got a chill, and the uneasiness in her side once more reminded her of the old attacks. I could detect nothing abnormal in the breathing. Pulse 90; temperature 99°.

The next day I found her, to my surprise, down in her drawing-room. She was feeling better. I did not examine her chest. The following morning she was in bed, not being so well. Some crepitation, but no dulness on percussion, at the bottom of the right lung; other chest sounds natural. Temperature 99°; pulse quiet; the temperature has never been above this. On the fourth day of my attendance, marked amphoric breathing on the right side, from the bottom of the chest to the lower angle of the scapula; above there was a feeble respiratory murmur; over the front of that side of the chest the respiration was feeble; the percussion note exaggerated. The right side measured a quarter of an inch larger than the left. The marked complaints were breathlessness and oppression, increased on the least exertion; inability to lie down; slight cough; a little mucous expectoration.

On the 13th, the amphoric breathing had extended to the supra-scapular region.

Dr. Trollope saw the case in consultation, and agreed in the diagnosis. The lady left Hastings on May 19th, with no traces of her pneumothorax left.

"23, Drumsheugh Gardens, Edinburgh, May 24th, 1888.

"My dear Sir,—I am very much interested to hear of Miss P. again. I have for years been intending to publish a brief account of her case; it was the most marked case of apparently idiopathic pneumothorax which has come under my notice. I attended Miss P. twice for the same condition. The first was by far the most severe and typical attack. She was at the time of the first attack (and, indeed, as long as she was under my observation), very well nourished and apparently very healthy, and free from any symptoms or physical signs indicative of lung mischief. Her family history was, however, bad, and at the time of her attack of pneumothorax a sister was under the care of my father and self with well-marked phthisis. The first attack of pneumothorax was on the right side; and I think the second (for which I attended her in Newcastle), was also on the right side, but as to this I am not sure. The first attack developed suddenly, and was apparently produced by over-reaching in standing up to open a high drawer. I saw Miss P. very soon after the onset; found her pale and collapsed, breathing with great difficulty, and complaining of great pain in the right side, with short frequent cough. On examination of the chest, the physical signs were most typical of pneumothorax, the whole of the right pleural cavity being apparently full of air. (In the second attack, the pneumothorax was localised and limited.) The

patient was attended by my father and myself, and was seen in consultation by the late Dr. Charlton, of Newcastle. The air was gradually absorbed, and, as this condition progressed, some pleurisy, with, however, little effusion, gradually developed. The case was ultimately most satisfactory and complete; and I was unable, after recovery was fully established, to detect any abnormality in the shape or size of the thorax. The theory I formed at the time was that an adhesion at the apex of the lung had been pulled upon during the violent effort, and had ruptured the lung, which was possibly emphysematous at the affected part. I was never able to detect any evidence either of old or recent disease at the apex. The second attack developed, if I remember right, without obvious cause. The fact that there has been a third attack perhaps suggests the rupture of some very delicate emphysematous blebs as the cause of the condition. I look forward with much interest to your account of the recent attack. If you think fit, kindly add this letter to the report of the case. I will feel obliged also if you will remember me to the patient.—Yours very truly,

"BYROM BRAMWELL."

"23, Drumsheugh Gardens, Edinburgh, May 30th, 1888.

"Dear Dr. Gabb,—I am much obliged to you for sending me your notes. From the report you give, the case is even more interesting than I had supposed. There have evidently been at least four attacks of pneumothorax. I should like to know the exact condition of lung which has produced them. I do not think the patient's memory is to be exactly relied upon for the particulars. The second attack for which I attended her was either in 1878, or quite the early part of 1879, for I left Newcastle in April, 1879. I fancy the first attack was before 1874. My recollection of the manner in which the first attack came on—while striving to reach an article of dress on the top shelf of a high wardrobe—is quite definite; and I am confident that I saw the patient within an hour or so after the pneumothorax occurred. As the air was absorbed, evidence of pleurisy (well-marked friction) was developed, and there was also evidence of some but not much fluid in the pleura when the condition was at its height. Notwithstanding Dr. Peacock's doubts, there is no disputing the fact that the most typical and complete pneumothorax which it is possible to wish for occurred in this patient, without any evidence whatever of previous lung disease; and the condition was so completely recovered from that no evidence of former pulmonary trouble could be detected on the most careful examination. This of itself makes the case a very remarkable one; but the fact that there have been three similar attacks since (only less marked, in all probability, because the lung is partly adherent) gives great additional interest to the case. You might publish this as well as my first letter with your notes if you think fit. I look forward to seeing the report.—Believe me, yours truly,

"BYROM BRAMWELL."

IS IT DESIRABLE IN CERTAIN CASES TO SUBSTITUTE RESECTION OF THE OPTIC NERVE FOR ABLATION OF THE EYEBALL?

By CHARLES BELL TAYLOR, M.D., F.R.C.S.E.,

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NOTWITHSTANDING the great advantages obtained by the substitution of enucleation for the ancient and formidable practice of scooping out the whole contents of the orbit, it is clearly impossible to accept this operation as a final solution of the difficult problem of how to deal with a lost eye. The operation of exenteration, the substitution of a glass vitreous chamber, and the late Mr. Streatfield's proposal to destroy the whole conjunctival surface in certain cases after enucleation is evidence that modern surgeons are not satisfied with the existing state of things. Atrophy of the orbit and neighbouring tissue frequently follows enucleation; the glass eye excites traumatic conjunctivitis, and if the artificial substitute is withheld the orbit retracts. To a working man the annual expense is onerous, the glass eye a perpetual annoyance, and an empty orbit a constant receptacle of foreign bodies. Nevertheless, when the eye is crushed, contains a foreign body, or neoplastic growth, or belongs to a patient who cannot be trusted to take care of himself, or to return if threatened with sympathetic ophthalmia, it is best to remove it. If, however, although sightless, the eye is a good-looking organ, and only affected with neuralgia or recurrent inflammation, or belongs to a

patient who refuses enucleation, it is best to excise a portion of the optic nerve, which is quite as effectual as enucleation, and has the great advantage that it does not sacrifice the eyeball, or render an artificial eye necessary.

In thirty-one cases the author has obtained the most gratifying results from this operation. Motion in all directions is perfect, and, in fact, in some of them it is difficult to tell which eye has been done.

CLINICAL MEMORANDA.

A CASE OF INTESTINAL OBSTRUCTION.

Six weeks ago I was called to see a boy, 7 years of age, living about ten miles away among the Lammermoor hills, who, as his father thought, was suffering from obstruction of the bowels. On inquiry on my arrival I found that a week previously he had eaten a large quantity of hazel-nuts (*corylus avellana*), and had swallowed the shells as well as the contents. For several days past he had had intense desire to defæcate, but with no result, and seemed to be suffering excruciating pain. On rectal examination, about an inch and a half above the anus, I found an impacted mass, about as large as two fists, very hard, and with the sharp edges of shells presenting here and there. I had no chloroform, so had to put the child to considerable pain. By the use of warm oil, I gradually got the mass away in small pieces, not without some abrasion of the rectal walls. It consisted almost entirely of shells agglutinated together by a small amount, of hard fæces. For several days after there was paralysis of the sphincter ani, and consequent incontinence of fæces, but otherwise the child made an excellent recovery. The wonder is how such a large quantity of shells with sharp pointed and cutting edges, passed through the bowels without causing any inflammatory trouble.

Ed. Duns, Berwickshire. J. LOCKHART WILSON, M.B.

VENESECTIO AD 3XVI.

In a recent case I have been struck with the great value of a now all but discarded remedy, a remedy which in the past was in the first and foremost rank, but which has in recent years been relegated to an obscurity from which it will doubtless eventually emerge and again occupy a standard position in our therapeutical arsenal, a remedy so potent for good if rightly applied, so productive of evil if misapplied or used without due care and discrimination. It will be admitted that cases do occur in which the demand for it is self-evident, and but little scrutiny is required to induce its adoption. During the last twenty years of my practice I have bled several times, generally in well-marked instances of plethora, and to relieve prominent symptoms, and I have never once had occasion to repent of my deed. I can call to mind three cases in particular in which the benefit was so marked and immediate that there could be no manner of doubt as to the measure which yielded the result; such cannot be said of most of our remedies.

The therapeutics of the day are probably in advance of the therapeutics of our forefathers; but why should a remedy of such acknowledged power be well nigh entirely shelved? Were our forefathers always in the wrong? Take up the most popular standard work on therapeutics and not a line is devoted to the consideration of blood-letting. The case which leads me to these remarks is briefly this—W. H., aged 50, the subject of mitral regurgitant disease, with pulsating jugulars, heart's action irregular and tumultuous, pulse feeble and very intermittent, sense of fullness about the chest and abdomen, so that he was generally to be found with his waistcoat and upper part of his trousers open, liver enlarged, blood rushing to his face when he stooped, with occasional slight epistaxis, his lips, cheeks, and the lobule of both ears livid, his breathing so oppressed that he was frequently obliged to stop when walking or exerting himself at all, sleeps only for a short time, wakes up suddenly and becomes restless, etc. These symptoms failing to yield to mercurial and saline purgatives, digitalis, and diuretics, sixteen ounces of blood were taken from his arm, which resulted in a dark and very firm clot, surrounded with little serum. His symptoms were immediately relieved, his pulse became more regular and fuller, and should they in the future recur he will not, I am sure, fail to appeal for a repetition of the remedy.

Ticehurst, Hawkhurst.

JOHN TAYLOR.

SYMPTOMATIC HÆMORRHAGE IN TYPHOID FEVER.

UNDER the heading "An Unusual Case of Hæmaturia," Dr. Oliver, in the JOURNAL for May 26th, describes a case which he believes to have been one of typhoid fever. The history, symptoms, etc., leave one little ground for doubting the correctness of his conclusions. Last April a boy aged 11 was admitted into the infirmary under my care, covered with a purpuric eruption. He was found to be bleeding from his gums, and to be in a typically typhoid condition. He died twenty-four hours after admission. There was found *post mortem* inflammation and ulceration of the lower part of the ileum, enlargement of the spleen and mesenteric glands; the spleen also was dark and soft.

The reason why hæmorrhages take place in severe cases of typhoid fever, in one case from the capillaries of the skin, in another from those of the kidney, is not quite clear. It is probable, however, that before bleeding occurs a change must first have taken place in the walls of the capillaries (due possibly to impairment of their nutrition) in addition to the alteration in the constitution of the blood.

With regard to hæmaturia in typhoid, Murchison says, "In severe cases I have sometimes found the urine to contain blood, and in several instances I have met with copious hæmaturia." In another paragraph, "Sometimes bleeding takes place from gums, kidneys, bladder, and other mucous surfaces, constituting what has been called 'hæmorrhagic putrid fever.'"

Hull.

EDWARD O. DALY, M.D. Oxon.

THERAPEUTIC MEMORANDA.

NITRITE OF AMYL IN CHLOROFORM SYNCOPE.

ON reading the account which appears in the JOURNAL of June 7th, of a recent death under chloroform which occurred at the Royal Infirmary, Preston, one cannot help regretting that the remedy which would, in all human probability, have proved the most efficacious under the circumstances in resuscitating the patient, was apparently overlooked or not at hand, namely, nitrite of amyl.

Judging from the description of the death and of the *post mortem* appearances, this was a case in which it was highly probable that nitrite of amyl, from its well known action upon the heart and blood vessels, would have been of signal service, had a three-minim capsule of it been broken for inhalation when dangerous symptoms appeared, and artificial respiration was first commenced.

Gaining wisdom by experience, would it not be well if capsules of this powerful and convenient agent, which is considered to afford the quickest means of restoring the heart's action in such cases, were always included and kept ready for immediate use among the chloroformist's remedies for the prevention of death?

Bedford Square, W.C.

J. HIGHAM HILL, M.D.

THERAPEUTICS OF HAY-FEVER.

In a communication on the above subject by Dr. Carl Genth, in the JOURNAL of June 16th, I am pleased to observe the importance attached by him to the fact that the earliest symptoms of this disease appear, as a rule, in the eye.

I have always maintained this, and it has often occurred to me that sufficient importance is not assigned to it in the treatment of the complaint. In nearly all the cases I have observed (my own included), the symptoms of burning and itching at the inner canthus precede by some days the nasal catarrh. In accordance with this view, I have this season attempted to anticipate the conjunctival irritation by bathing the eye with a weak boracic or borax lotion for a week or two prior to the expected onset, and so far with considerable success; this should be continued throughout the season; and if, notwithstanding, there be some heat and irritation, it is very important not to rub the eyes, but to dab gently the margin of the lids and inner canthus with a weak cocaine solution (1 per cent.); this may be done frequently throughout the day, without producing inconvenient dilatation of the pupil, and, in conjunction with the wearing of coloured glasses to shield the eyes from glare, heat, wind, and dust, forms to my mind a very important part of the treatment of hay-fever. If once the conjunctivæ become swollen and inflamed, the whole train of catarrhal symptoms appears to follow.

With increased experience, I have come to the conclusion that it is a mistake to attack the nose with a too vigorous treatment, not-