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?

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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. Streetfield'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