THE ALBUMINURIA OF ADOLESCENTS, OFTEN THE BEGINNING OF BRIGHT'S DISEASE (?).

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IN the BRITISH MEDICAL JOURNAL for November 30th, 1878, I wrote a paper, quoting cases, on the frequency of albuminuria in adolescents, and expressed my belief that it was *physiological*—incidental to puberty. But in it I stated: "This albuminuria of puberty is often so persistent, and, even when it has disappeared, recurs again and again so often, that I fear many of the cases pass on to chronic Bright's disease—although this I can only surmise, as I lose sight of them; but long continued or often repeated hyperæmia is the cause of all kidney-disease."

Since then, I have had numerous cases; and, from this persistence, and from the increase of the albumen, I am led to believe that the condition is not only *pathological*, as Dr. George Johnson holds, but that I am seeing the very beginning of what becomes, in many cases, eventually true Bright's disease. I have no opportunity of following these cases up, and so this paper is only conjectural; though it may lead others to investigate further than lies in my power.

Their *history* is this. An adolescent has symptoms that make me search for albumen: either morning headaches, disappearing as the day goes on; or marked dyspepsia; or increased impulse of heart and arterial tension; or slight oedema observed in the face; or a feeling of debility, and even syncope: albumen is found, and is followed for years. The heaving heart and the increased arterial tension are sometimes so marked, that I can diagnose the albuminuria from it alone, and I am led to examine for it in consequence. Part of this increased cardiac and arterial impulse may be physiological, and owing to causes connected with puberty; part may be due to the hyperæmia of the kidneys.

It is intermittent in *character*, occurring perhaps at one time of day only; or one day, and then not again for several days; or several days, and then absent for weeks. It is also intermittent in *quantity*—sometimes copious, sometimes only a trace; but it is persistent in this intermission, and progressively increases.

Its *cause* varies. Sometimes scarlatina has preceded; sometimes it is hereditary; more often its cause is untraceable, it having arisen and progressed insidiously. Microscopically, there are no casts or cells. That this albuminuria is not connected with the secretions of puberty, as has been suggested, is beyond question; for, whether it be copious or scanty, old or recent, it can be got rid of in an hour or two by putting the patient to bed and giving milk only; and it can be reproduced almost at will, by getting up and giving more diet. That it is owing to hyperæmic kidneys is, I think, clear.

That many cases of the albuminuria of adolescents are only transient in character is without doubt; that many persist for years, and yet recover, is, I think, probable; but that a large proportion are simply the first stage of Bright's disease will, I believe, be proved in time.

SURGICAL MEMORANDA.

THE IMMEDIATE ARREST OF BLEEDING FROM THE NOSE.

THE literature of this subject is plentiful enough, but not very satisfactory—countless little manoeuvres are recommended, by one or more of which every surgeon fondly hopes that he may do battle in the next case to which he is summoned, probably in much haste and terror. Few emergencies more strikingly appeal for speedy relief, for many sufferers can ill spare the blood they are losing; and as even a little blood makes a great show, the bystanders are often faint and frightened, perhaps trying their own empirical nostrums before the doctor arrives. And few exploits more vividly declare a medical man's readiness and skill than when he first calmly hushes the tumult of family and friends, and then goes quietly to his work, with the assured confidence that he can then and there permanently stop the hæmorrhagic flow.

At a meeting of the Royal Medical and Chirurgical Society, on April 12th, 1881, a distinguished surgeon exhibited "a simple instrument for plugging the nares in epistaxis. It consists of a bag of India-rubber, which, after insertion in the nares, can be inflated with air to the required size; and, exerting equable pressure, speedily checks the hæmorrhage." This report, which I quote from one of the medical journals, gives the impression that the principle of the instrument was a novelty,

and that no one had ever heard before of air-inflation as a means of stopping bleeding from the nose.

As a matter of fact, an instrument of an identical kind was described by Dr. Taaffe of Brighton, in the *Lancet* for January 4th, 1873. I had one made after reading his letter, and it answered its purpose very fairly well for three or four years. On one occasion, however, it failed because the inflated surface did not seem large enough, and blood escaped from the posterior nares into the pharynx. Shortly afterwards, a more perfect instrument was devised by Dr. H. Cooper Rose, and an account of it was given in the BRITISH MEDICAL JOURNAL for January 10th, 1874. In an improved form it is again described (and represented by figure) in Mr. W. Spencer Watson's book on *Diseases of the Nose and its Accessory Cavities*. It now "consists of a gum elastic tube about five inches long, with lateral perforations near the end, and covered with thin caoutchouc membrane in the form of a spirally twisted bag for the last three or four inches of its length. To use it, the membranous bag is smoothly folded over the continued tube, and the whole being oiled (diluted glycerine is better) is passed along the floor of the nares till it reaches the pharynx. The bag is now inflated..... and if a stop-cock is fitted, the air is kept in by turning it as soon as sufficient tension is obtained." The cavity of the twisted bag could be injected with water, if it were desired; but I have never found this necessary. When I recollect what "bleeding from the nose" was in old days, I cannot be too thankful to Dr. Rose for his simple and effective invention. To be called to an obstinate accident of this kind, especially when other medical men had failed, was enough to make one sick at heart from the possibility of adding another failure to the dreary history; and then there was the consciousness that delay might mean impaired health or even death to the victim. The victory is half won when a man is armed with an apparatus which he knows is sure to succeed; and I am now speaking of cases in which he wishes to succeed, and which are not forms of natural bloodletting to be encouraged. The object of this brief communication is to recommend Dr. Rose's instrument for (a) facility of introduction; (b) the extent and evenness of the inflated area; and (c) the possibility of its remaining *in situ* for thirty-six or forty-eight hours, when it may be gently removed, and the hæmorrhagic nostril can be syringed with some cold astringent fluid for purposes of cleanliness and the washing away of blood debris.

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DEPRESSED FRACTURE OF SKULL, WITH CEPHALIC BRUIT.

J. C. was admitted into the Union Hospital here on September 6th. The day previous, he sustained "in a quarrel", a compound depressed circular fracture about the size of a halfpenny on the left parietal protuberance. He died on the 15th. On the fifth day of admission, a cephalic hissing *bruit*, synchronous with the pulse, could be distinctly heard by the ear at a distance fully one yard from the cranium. The patient heard it also himself, and directed our attention to it occasionally. It was intermittent, and continued audible till two days prior to his death. On *post mortem* examination, there was inflammation of the meninges. An abscess, containing about an ounce and a half of matter, was also found in the substance of the brain beneath the seat of fracture, and in close proximity to the longitudinal sinus. How was this *bruit* produced?

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MANIPULATION OF THE SCAPULA IN DISLOCATION OF THE SHOULDER.

At an early period of my practice in the country, about twenty years ago, I was called in to reduce dislocation of the humerus into the axilla of a neighbouring practitioner, a very muscular man, and attempted to do so by means of the heel in the axilla, but failed. I then placed my patient in a sitting position, and, having fastened one end of a round towel to an immovable object behind him, on a level with the shoulder, over which I brought the other end of the towel, crossing it at the back of the scapula, had the arm adducted and well extended. I then placed one of my hands over the acromion to depress the glenoid cavity, and the wrist of my other arm as nearly as possible beneath the head of the humerus to raise it at this stage; and the arm being gradually adducted and lowered, with continued extension, the dislocation was quickly and easily reduced. I have reduced many dislocations in this manner since, and am of opinion it is more efficient and agreeable than by the heel in the axilla. It resembles in principle the method communicated by Dr. Illingworth in the JOURNAL of October 15th.

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