CASE OF POISONING BY CARBOLIC ACID.*

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ABOUT ten o'clock on the morning of November 27th, I was called to see a man aged 36, who had swallowed carbolic acid with suicidal intent. He said that he had "swallowed poison". About five minutes afterwards, when I first saw him, he was evidently in mortal agony. His countenance was livid, his eyeballs protruded, and he uttered a continuous subdued cry, of wild and fear-inspiring tone, which was broken only by short gasping attempts at respiration, and ineffectual endeavours to vomit. This condition was followed almost immediately by a state of profound insensibility. Olive oil was poured into his mouth while the stomach-pump was being prepared. Warm water was then injected into the stomach, and withdrawn strongly impregnated with carbolic acid. A second injection of olive oil was administered, and this likewise, when extracted, brought with it a portion of the poison. The patient died, apparently asphyxiated, about thirty minutes after taking the acid.

From the first the pulse was very rapid, and so feeble as to be scarcely perceptible; the breathing was performed only by short and infrequent gasps, and the surface of the body was of a deep livid hue; the pupils were unaffected. Great difficulty was experienced in passing the gum elastic tube into the stomach. It was necessary to keep the forefinger of the left hand at the back of the pharynx, to prevent it curling up, while persistent and somewhat forcible pressure was employed to overcome the resistance made by the firmly contracted state of the œsophageal muscle. It falls to the lot of asylum medical officers to use the stomach-pump much more frequently than their brethren in general practice, and I have employed the stomach-pump on many hundred occasions as an aid in forced alimentation. In none of these was there any difficulty in passing the tube into the stomach after its point had got beyond the muscles of the pharynx. In the case under consideration, however, there was very considerable resistance offered by the œsophagus throughout its entire length; and great care and perseverance were required to perform what is usually a very simple and easy operation.

Secitio Cadaveris Twenty-six Hours after Death.—The superficial veins, especially those of the upper extremities, were distended with blood. The lips and chin were slightly excoriated. The dura mater was much congested with dark venous blood. The arachnoid at the vertex was thickened by gelatinous deposit. The brain-substance was apparently healthy. The lungs, filling well their cavities, were slightly emphysematous in front, and passively congested posteriorly; there were old adhesions at both apices. The pericardial sac contained about an ounce of serum. The heart was healthy; all its cavities were full of blood, which was very dark, perfectly fluid, and without a trace of coagula. Its microscopic examination revealed nothing abnormal. The mucous membrane of the larynx, trachea, and its subdivisions, was highly congested, granular, and softened; the tubes contained small quantities of olive oil and carbolic acid. The tongue appeared shrunken, pale, and indurated. The papillæ were markedly prominent; the lenticular papillæ particularly so. The mucous membrane of the œsophagus was peculiarly white and glistening, softened, and peeling off as if scalded. The inner surface of the stomach was extensively softened and eroded, its mucous and muscular coats being reduced to a state of pulp. The parts surrounding the orifices had sustained most injury, and these portions were of a dull deep slate colour. The small intestine was similarly affected, in patches of about the size of a crown-piece, to within a few inches of the cæcum. The liver, spleen, and kidneys were healthy.

That the fatal issue was hastened by the action of the acid on the air-passages there can be no doubt; and we have, in the same cause, also an explanation of the asphyxial symptoms and the rapidly supervening state of coma. Two cases of poisoning by carbolic acid have recently been reported in the JOURNAL of the Association. The first, that of a man who drank by mistake a glass of a mixture containing between two and three drachms of carbolic acid. He immediately fell insensible and was convulsed. Eighteen minutes afterwards, when seen by Dr. Mosler, the extremities were cold, the pulse scarcely perceptible; the heart's action was irregular, the breathing stertorous; consciousness was lost, and he was in a state of intense trismus. After evacuating the stomach, finding consciousness did not return, Dr. Mosler, supposing that some of the carbolic acid had entered the blood and was acting on the brain, bled the man to the amount of a pint.

Consciousness then returned. The patient was dismissed cured on the eleventh day.

The second case is reported as one of "poisoning from the fumes of carbolic acid". When first seen by the surgeon, the patient was in violent convulsions with trismus, and blood passing from the mouth in consequence of the teeth having wounded the tongue. He was placed in a warm bath, and in forty minutes the convulsions ceased. Convalescence was uninterrupted.

The patient under my care had taken probably an ounce of the undiluted acid. He became insensible about five minutes afterwards. There was no trismus, no convulsions, no stertor, but complete paralysis of all the voluntary muscles. I did not employ venesection, and the *post mortem* examination showed it would have been useless. And, further, I cannot comprehend in what manner venesection can counteract the effects of poisoned blood acting on the brain.

A CASE OF FEMORAL ANEURISM CLOSELY SIMULATING MALIGNANT DISEASE.

By GEORGE ALEXANDER GLOAG, L.K.Q.C.P., Bristol.

EDWARD P., aged 37, of a cachectic appearance, by occupation a pedlar, came under my care on November 5th, 1872, for the treatment of a tumour which occupied the anterior and inner region of the upper half of the right thigh. It was bounded above by Poupart's ligament, and had a circumference of 27½ inches at its centre, the circumference of the sound limb at the same part being 16 inches. The tumour had a tense elastic feel and a shiny appearance, the superficial veins were enlarged and prominent, and the disease appeared to have involved all the structures of the limb. No *bruit* or pulsation could at any time be discovered in it. It gradually increased in size, and on December 20th had attained a circumference of 30 inches. The patient suffered intense pain, which was of a paroxysmal character, and required large doses of morphia or chloral for its relief. During severe pain I found that the tumour became harder, and that it increased in circumference to the extent of half an inch, and again subsided as the pain diminished to its former dimension. The limb was œdematous below the tumour, the result of venous obstruction. Although there were no glandular enlargements nor symptoms of secondary deposit, the cachectic appearance of the patient, the intense pain he suffered, and the rapid growth of the tumour, together with the total absence of pulsation or stethoscopic sound, induced me to believe the case to be one of medullary cancer, for which operative interference was unjustifiable. About six months previously to the time when the patient came under my notice, a tumour, about the size of a small egg, appeared on the upper and inner side of the thigh, accompanied with such severe pain that the patient was unable to follow his occupation, and was obliged to remain in bed. It grew rapidly from week to week, and the pain increased in proportion. A month or so after the appearance of the tumour, he obtained admission into the Bristol General Hospital. He remained there six weeks, during which time the tumour increased considerably in size, and was then discharged as an incurable case, the tumour being considered of a malignant nature. The patient remained at home about a month, at the termination of which time he was admitted a patient of the Bristol Royal Infirmary. His case being considered one for which nothing could be done, he was removed to his own home in about a fortnight. The patient had usually enjoyed good health, and his family history was good; but he had suffered from constitutional syphilis, and was discharged from the army in consequence of defective vision, the result of specific iritis. There were no evidences of heart-disease.

The patient died on December 28th, and on the following day Dr. Norton, Mr. Dobson, and myself made an examination of the body. The knee was bent, the thigh everted, and free movement existed at the hip-joint. An incision was made from the anterior superior spine of the ilium to the symphysis pubis, and another from the centre of Poupart's ligament down the front of the thigh. The latter was afterwards prolonged across the inner aspect of the knee, so as to expose the upper part of the popliteal space. On making the longitudinal incision, the parts gaped widely, and a thin layer of muscular tissue was exposed. On dividing this the length of the thigh, a mass of clot presenting various shades of colour appeared. Some of it was partly laminated and of a firm consistence, and needed the assistance of the knife for its removal. Nearly fourteen pounds weight of clot was turned out of the cavity, which was bounded anteriorly and to its sides by the skin, a small amount of subcutaneous fat, and a thin layer of muscular tissue; above by Poupart's ligament; below by the quadriceps extensor tendon; and behind by the eroded femur,

* Read before the South Wales and Monmouthshire Branch.

the adductors, and vastus externus muscles, in a partially disorganised state. The integument showed no symptoms of thinning in any part. The anterior crural nerve was found deeply imbedded in the clot, and was the only recognisable structure in the tumour. An incision was made from the middle of Poupart's ligament to the umbilicus, and thence to the sternum. The kidneys were in a healthy condition; the liver was enlarged, and showed appearances of waxy degeneration. On cutting across the aorta, and dissecting the external iliac artery downwards, it was found that an aneurism existed on the right superficial femoral artery. The femoral artery was then dissected upwards from the popliteal, as well as possible, to the tumour, and the mass removed for preservation. It consisted of a quantity of laminated fibrine, situated in Scarpa's triangle, where it appears to have burst, and this, I believe, took place before the patient applied for medical relief, at which time the tumour was localised, and about the size of two fists. The epigastric and circumflex ilii arteries were considerably enlarged. The upper part of the femoral artery leading into the tumour was pervious; that immediately below it and leading from it was impervious.

This case of diffused aneurism is, I think, worthy of record, on account of the close resemblance of its symptoms to those of malignant disease. If the nature of the tumour had been discovered during its early stage, an effort to cure it might perhaps have been made. This case clearly shows that cachexia, rapid growth, and severe pain must not be accepted as sufficient evidences of cancer. In reviewing the history of this case, there are some points which should have suggested its non-malignant character; namely, the absence of lymphatic enlargements, or symptoms of secondary deposit, and of any tendency to ulceration of the skin over the tumour; the favourable family history; and the fact that the tumour was definitely bounded superiorly by Poupart's ligament.

ON SOME CASES OF IDIOPATHIC NEURITIS.

By JOHN M'CREA, M.A., M.D.,

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THE recorded cases in which distinct evidence of idiopathic neuritis of spinal nerves has been obtained are not numerous. Among them are three or four cases of herpes, described by Bärensprung and others, in which, death having occurred from other causes, *post mortem* examination revealed serious lesions of the nerves supplying the herpetic parts. Bärensprung's theory is that the herpes depends on irritation of trophic fibres which start from the ganglia on the posterior roots. He does not, however, consider that grave disorganisation of the nerves is necessary to explain all his cases, for he cites some as examples of the results of peripheral irritation. Similarly, Dr. Lockhart Clarke does not look on neuritis as the only nerve-disorder which causes herpetic eruptions, for he speaks of these as resulting from neuritis and neuralgia. And, indeed, the general retention of the terms, herpes zoster and unilateral herpes, shews that no very settled opinion is held as to the nature of the change in the nerve. I have endeavoured to gain some information on this point, by examining carefully some cases of the disease in a more advanced stage than that in which they ordinarily come under notice, that is to say, after the healing of the skin. Many observers have remarked the occasional occurrence of annoying sequelæ, such as numbness, tingling, pain, hyperæsthesia, and anæsthesia. But I think a mistake has been committed in considering these as occasional, passing, and non-essential. In all advanced cases that I have seen local nervous derangement, more especially anæsthesia, has supervened at some period and persisted.

I have seen during the last two years twenty cases of herpes following the course of nerves. Of these, one is still recent; one is in a child from whom I have not been able to obtain satisfactory information; and seven others I have lost sight of and been unable to trace. The eleven remaining I have been about to examine in their advanced stages. In none has the cutaneous affection appeared to be the beginning, the end, or the most important part of the morbid process. Herpes zoster and unilateral herpes are quite inadequate expressions, not to speak of the special inaccuracy conveyed in the terms "zoster" and "unilateral." The necessity for a new name for the disease becomes more evident from the consideration that herpes is not the only cutaneous phenomenon known to be associated with local nerve-affections; for lichen, acne, pemphigus, urticaria, and, as I have myself seen, erythema, have at times a similar association.

After the healing of the skin, the general condition of the part may be described as presenting hyperæmia, pigmentation, and hyperæsthesia. Then the vascularity diminishes, there are depigmentation and anæ-

thesia. These two sets of conditions may be found mixed in different proportions according to the stage which the disease has reached.

CASE I.—A woman, aged 30, was first seen on December 18, 1872. A zone of skin entirely destitute of pigment extended around the body immediately above the umbilicus. It completely surrounded the body, except a handbreadth at the spine. The upper and lower edges of the zone, which were almost straight lines, were not darker than the neighbouring healthy skin, as sometimes is the case in *laucoderma*. Every part of the zone was completely insensible to pricking and pinching. She said that seven years ago she was seized with an acute pain in this region, that a "red flush" appeared on the site of the present whiteness. That then an eruption "like pox" came all over it, that this eruption never extended farther, and that it faded away slowly, and was followed by anæsthesia and blanching.

CASE II.—A girl, aged 17, was seen on December 14, 1872, for amenorrhœa. I noticed on the right side of the chest and below the level of the axilla a characteristic series of herpetic marks, extending from the spine to the middle line in front. Some of these were pits, but most were merely blanched spots. The point of a pin when pressed with considerable force excited almost no sensation in some of them, and in all the sensibility was far below that of the surrounding skin. The disease commenced six years ago, when she was told by her medical attendant that she had "shingles." She had quite recently complained of numbness of the right leg. A year before the appearance of the eruption I treated her for chorea of the right side. Mr. Hutchinson, in the second series of cases of shingles attributed by him to arsenic (*Medical Times and Gazette*, 1869, vol. i, case 14), mentions, without, however, tracing any connection between the two diseases, an instance in which chorea and shingles occurred in the same person. Dr. Borelli, of Turin (quoted in Dr. Brown-Séquard's article in *Holmes's System of Surgery*), records a case in which neuroma and chorea were intimately associated. I saw lately a case of dental neuralgia in which each recurrence of the neuralgic fit (it was quotidian) was accompanied by violent involuntary rhythmical movements of the arm and leg of one side. Hence the connection hinted at above between the shingles and the chorea is not so fanciful as at first sight it looks.

CASE III.—A boy, aged 8, was brought to the dispensary on April 22, 1872. The right side of his neck was covered with an eruption of herpes. The cutaneous branches of the upper cervical nerves, especially the superficialis colli, the auricularis magnus, the occipitalis minor, the acromial and clavicular branches, had their course and distribution sketched out by ramifying groups of vesicles. On December 23, I examined him. A multitude of white marks were seen on the site of the herpes. Portions of the original eruption have left no vestiges, and no nervous grouping can now be traced. Some of the spots are quite insensitve; all are much more so than the surrounding skin. This is a comparatively recent case, in which it would be rash to infer that the changes are complete.

CASE IV.—A girl, aged 9, came to the dispensary with a zonular herpes, on May 30, 1872. The eruption, preceded by a few hours of severe pain, had appeared the day before. It surrounded the body, except a hand-breadth at the middle line in front. The lower edge of the zone was two fingers'-breadth above the umbilicus. In the hand-breadth above its upper edge, on the right side, was a half zone of white spots evidently representing an old herpes. I again examined the child on January 2, 1873. In the white spots of the old herpes, sensation was very much deadened. The new one was red and very sensitive, except a few spots here and there over it, which were less sensitive than natural.

CASE V.—A man, aged 60, was first seen on June 7, 1872. A severe pain in the right side ushered in a dorso-intercostal herpes of the same side. On December 26, the only traces left of the eruption were a few white spots, and these were quite insensible. He had considerable pain in a zone immediately above the herpes.

CASE VI.—A girl, aged 4, was seen on January 7, 1873. Her mother stated that eight months ago the child had had shingles. She had when I saw her a dark-coloured half zone, with irregular edges, passing round the body and slightly downwards from the spine to the sternum, crossing the inferior angle of the scapula, and passing below the nipple. The dark zone was thickly mottled with white spots. Some of them are pits, but the majority appeared only as patches of whitened skin. Although the point of a pin was firmly pressed against the white spots, the child never winced. When the pin was pressed with much less force on the healthy skin, the child instantly cried out. The dark skin was in several places unduly sensitive.

CASE VII.—A woman, aged 45, was seen on May 5, 1872. She had a right herpes commencing at the spine, passing round the body slightly downwards, below the mamma and on to the middle line