his guard. The feigning madman either breaks down in or overdoes his part; for every case of real madness is a consistent whole, and to imitate it well requires great intelligence, great endurance, and great dramatic power.

A CASE OF SCALD OF THE GLOTTIS, WITH RECOVERY AFTER TRACHEOTOMY.*

By T. SYMPSON, F.R.C.S.,
President of the Midland Branch.

ON December 9th, 1874, at about 7 P.M., I received an urgent message to visit a boy, aged 2½ years, living with his father on the Burton Road. On my arrival, I found the patient extremely restless, and breathing very rapidly, inspiration being accompanied by a harsh croupy sound. The lips, the tongue, and the inside of the cheeks and throat, were swollen, red, and blistered. The face was livid, the extremities were cold, the skin cool and clammy, and the pulse was feeble, and too rapid to be counted.

I was informed that, two hours previously, during the temporary absence of the housekeeper from the room, the child had drunk through the spout of a teapot some very hot water which had just been poured out of a kettle. For some time, he did not seem to suffer much; but, during the last half-hour, the symptoms had become alarming. As the performance of tracheotomy evidently offered the only chance of saving life, I sent to the hospital for our excellent house-surgeon, Mr. Lill, and, with his assistance, commenced the operation at 7.30, but had scarcely completed my first incision when the child ceased to breathe, and became livid, cold, and pulseless. I rapidly opened the trachea and inserted a cannula, through which Mr. Lill sucked out the blood from the air-tubes; and then artificial respiration was practised after Silvester's method, whilst vigorous friction was applied to the extremities by the attendants. In about ten minutes, the child gave a gasp, which was soon followed by others; and, at the end of an hour, we had the extreme gratification of finding respiration well established through the tube, warmth restored to the surface, and the heart beating perceptibly, though very feebly. The occurrence of reaction appeared to have been considerably hastened by the frequent administration of strong brandy and water. At midnight, the child was composed, and had slept quietly at intervals. He was ordered to take milk and beef-tea at short intervals; the temperature of the room to be kept at about 60 deg., and the air to be moistened by steam from a kettle having a long tube attached to its spout.

He progressed favourably until early on the morning of the 14th, when I was requested to visit him. On seeing him at 3.30, he appeared moribund; he had urgent dyspnoea, extreme restlessness, a clammy cold skin, and no pulse; and his lips and cheeks were livid. On removing the tube, I found it almost entirely blocked up by mucus, which I cleared out with a feather. I reintroduced the tube, employed artificial respiration, placed the child in a hot bath, and had sinapisms applied to the chest, with speedy relief to all the symptoms. The report in the evening was to the effect that he had appeared comfortable during the day; had breathed quietly through the tube, and had taken nourishment freely.

He went on well until the night of the 17th, when, at 11.30, he had become very fretful, and suffered from dyspnoea and frequent violent paroxysms of cough. The *alae nasi* were dilated, and there was marked retraction of the abdominal parietes and intercostal spaces during inspiration. On auscultation, fine crepitation was audible over the whole lower lobe of the left lung, and bronchial breathing near the spine. There was some dullness on percussion of the lower left half of the chest, posteriorly. Respiration could not be counted, on account of the cough. Pulse, 150; temperature, 103. A large linseed-meal poultice sprinkled with mustard was ordered to be applied to the side after the child had been placed in a hot bath. A mixture, containing ipecacuanha, spirit of nitrous ether, and solution of citrate of ammonia, was ordered to be taken every three hours.

These formidable symptoms appeared to be due to a chill, owing to the fire in the room in which the child lay having been allowed to go out, in consequence of a down draught in the chimney. The weather was extremely cold, and the wind very boisterous.

On the 18th, the paroxysms of cough were less frequent, and were accompanied by copious white frothy expectoration. Respiration was more free. Loud mucous *râles* were heard in the trachea. There was large crepitation over the lower half of the left side. Less dullness on percussion. Pulse, 136; temperature, 100. On the 19th, the child

had passed a quiet night. The cough was neither so frequent nor so violent, and attended with less expectoration. Pulse, 120; temperature, 99. The tube was removed, and the wound was found to be granulating healthily. From this date, the child progressed uninterruptedly towards recovery. He began to speak on the 23rd, and the wound had healed by the 30th.

The case I have just related presents various points of extreme interest, not the least of which is the survival of the patient; for we know that recovery is a very rare event when, from the severity of the symptoms in cases of scald of the glottis, it is deemed necessary to open the trachea; in proof of which I may cite the fact stated by Durham in the second volume of Holmes's *System of Surgery*, that, "out of twenty-eight cases of tracheotomy in scald of the larynx (of which he had notes), twenty-three terminated fatally".

Other noteworthy facts are the occurrence of apparent death just prior to the trachea being opened, and the gratifying result of perseverance in the practice of artificial respiration; the narrow escape from suffocation due to want of attention to the state of the tube on the 14th; the sharp attack of pneumonia, induced by sudden change of temperature in the room on the 17th; and the state of the general health of the little patient, who was delicate, rickety, often suffered from attacks of bronchitis, and who had fractured his femur a year ago, from which, however, he made a good recovery.

In conclusion, I would just remark, that occasionally recovery takes place in these cases independently of the performance of tracheotomy, even when they appear in a very desperate condition. One such instance fell to my lot some years ago in the parish of Nettleham, where the parents of the child refused their consent to the operation, but where a good result was obtained by the application of hot mustard and linseed-meal poultices to the front of the chest, the administration of frequent small doses of calomel, and of nourishment in the form of brandy and milk given at short intervals.

CASE OF PARACENTESIS PERICARDII: IODINE INJECTIONS.

By G. E. MOORE, M.R.C.S.,
House-Physician to King's College Hospital.

THE following case of suppurative pericarditis occurred in the practice of Mr. E. Pearl of Windsor, who kindly permitted me to watch and share the treatment with him.

I need not detail the pericarditic symptoms; suffice it to say, that the patient, a strong lad, aged 13 years, living in Windsor, was taken ill on the 15th of last October; that ten days after a loud "to and fro" friction-sound was heard, which was soon followed by extension of the area of pericardial dullness; that, from October 27th until November 7th, he gradually got worse, in spite of the application of all the ordinary methods of treatment; and that the heart-sounds became fainter and more distant, with gradual diminution, ending in complete subsidence of the pericardial rub. An abscess formed on the dorsum of each foot in the second week of the disease.

On November 8th, Dr. George Johnson was called in consultation. He diagnosed suppurative pericarditis, and agreed in the proposal to perform paracentesis, as, under ordinary treatment, the case was sure to prove fatal.

On November 9th, before the first operation, the boy was very exhausted, and desirous of some relief. There was great dyspnoea. Respirations 50 in a minute; pulse 160, very irregular. The præcordium was prominent. The heart-sounds were a confused murmur, heard only at the base. There was extensive pericardial dullness. Paracentesis was performed by Mr. J. W. Gooch of Eton with the aspirator, the previously formed vacuum being put in communication with the needle as soon as the distal aperture had passed through the skin. The puncture was made in the fifth left intercostal space, just internal to the normal situation of the heart's apex, and the needle was directed inwards, upwards, and a little backwards. By this means, twenty-one ounces of purulent fluid were drawn off. During the withdrawal of the fluid, the patient complained only of the needle pricking in the skin; there was not the least symptom of syncope, and he expressed himself as much relieved. Immediately afterwards, the respirations came down to 30 a minute. The pulse was 120, much stronger and regular. For about twenty minutes, there lasted an incessant cough, with a little viscid frothy sputum. Normal heart-sounds could be heard both at the base and apex. The pericardial dullness was diminished to almost the normal limits.

On the 10th and 11th, he seemed much better.

* Read at a quarterly meeting of the Midland Branch held on May 5th.