After intubation, the tube is connected with a gas-bag by means of a metal angle piece, a short length of one-inch-bore rubber tubing, and the usual three-way stopcock, the mask having been removed. A flat angle piece curving straight down to the chin has proved very useful for intranasal operations; it does not get in the operator's way if it is held to the chin by a piece of adhesive plaster (Fig. 3).

Fig. 3.—Flat metal angle piece.

When administering gas and oxygen by this method it is advisable to keep up a small *plus* pressure (3 to 5 mm. Hg) in the bag. This is easily effected by suitable adjustment of the stopcock. Ether or chloroform can, of course, be administered by using a Shipway's three-bottle apparatus in connexion with the intubation tube. Before removing the tube it is advisable thoroughly to cleanse the pharynx and mouth of all mucus and blood.

When the operation is within the mouth a double intubation may be performed as follows: A catheter is passed down one side of the nose and the return airway tube down the other (a piece of tubing with a natural curve should be chosen and passed with its concavity towards the floor of the nose). The laryngoscope is now passed through the mouth and the tube and catheter viewed in the pharynx. After having passed the catheter into the trachea (BRITISH MEDICAL JOURNAL, October 16th, 1920) the hooked end of the directing rod, turned so that it curves towards the tube, is passed down into the eye at the end. By rotating the rod through a quarter-circle so that it now turns upwards, a secure hold of the tube is obtained, and it is easily directed between the cords.

The advantages of this method over the simple pharyngeal return airway previously described are that bubbling of blood is entirely avoided without packing the pharynx, and that if the lower jaw is pushed back, as often happens during intra-oral operations, the airway is not in the least obstructed.

CHANCRE REDUX.

BY

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CHANCRE *redux* is a condition which excited a good deal of interest among syphilologists of a past generation, but little appears to have been heard of it in recent years, though Wilfrid Fox¹ has drawn attention to the fact that it may be mistaken for the primary lesion; it has therefore been thought worth while to record the following cases from the venereal diseases clinic of the Royal Gwent Hospital, Newport, as further illustration of a condition which appears to be of importance both in diagnosis and prognosis.

CASE I.

A man, aged 25, first attended the clinic on August 15th, 1921. There was no history of previous infection. Exposure ten weeks previously; sore first noticed ten days ago. He had a slightly indurated sore on the ventral surface of the glans penis and the inguinal glands were enlarged; there were no other signs. General condition good. The *Spirochaeta pallida* was found in the sore by dark-ground method. The Wassermann reaction was weakly positive. Treatment was commenced forthwith (on dark-ground diagnosis) and an intravenous injection of novarsenobillon and an intramuscular injection of mercury given. In the ensuing eight weeks he received a total of 4.8 grams of the former and 8 grains of the latter. The sore was healed in a fortnight, and a Wassermann test done on October 28th was completely negative. He then took potassium iodide, 10 grains by mouth thrice daily, for six weeks.

On January 6th, 1922, he attended and stated that a sore had broken out a week previously. He emphatically denied re-exposure and said that eight days previously he had had an attack of vomiting, after which he had become somewhat jaundiced. He now had a small non-indurated sore on the inner surface of the prepuce—that is, not at the same place as the original chancre. This sore, on dark-ground examination, showed numerous *Spirochaeta pallida*, and the blood gave a strongly positive Wassermann reaction. As the urine contained some bile, salvarsan was withheld and he was given intramuscular injections of mercury only, 1 grain at weekly intervals. The sore was quite healed by February 1st, and no

other lesions developed; the jaundice quickly disappeared, but the Wassermann reaction was still strongly positive on February 15th. On March 1st arsenobenzol treatment was resumed, and he had eight further injections of 0.45 gram at weekly intervals. He stayed away from the clinic through the month of June, and on his return on July 19th his blood was slightly positive only. He took liq. hydrarg. perchlor. dr. 1 with potass. ioidid. gr. 10 in mixture by the mouth for two months, but in spite of this his blood relapsed, and on September 29th was back to markedly positive. He had two more injections of novarsenobenzol and mercury, but then stayed away from the clinic and has not attended since.

This case, I think, must be considered a relapse and not a reinfection, though, in view of the fact that he had what might be termed more than a maximum tolerant dose of novarsenobenzol, such a clinical as well as serological relapse is unusual. With a sore not more than eight to ten days old (he was attending the clinic at the time it developed), the Wassermann reaction was strongly positive, and in spite of treatment his blood has not remained permanently negative since.

CASE II.

A man, aged 21, first attended on April 13th, 1921, with a history of exposure three weeks previously and soreness of his penis for one week. He had phimosis with a profuse discharge. No *Spirochaeta pallida* but numerous *refringens* found; no gonococci; no ulcer could be felt beneath the prepuce—probably because it was too early. The Wassermann reaction was slightly positive. He was given 0.45 gram of novarsenobillon and 1 grain of mercury. Blood taken the week following was strongly positive. Seven more injections were given at weekly intervals to July 21st; he then stayed away until August 10th. He was then free from active signs, the prepuce could be easily retracted and the sore was quite gone, no scar being visible. The Wassermann reaction was completely negative. He was given potassium iodide 10 grains t.d.s. On August 24th he reported a slight soreness at the margin of the meatus; this was thought to be a simple balanitis and he was ordered to resume local treatment (hydrogen peroxide), but a week later there was a definitely ulcerated area and *Spirochaeta pallida* was found in the serum obtained from it. He did not attend the clinic again for a week, and the blood taken then was found to be strongly positive. He was given a second course of novarsenobillon and mercury injections. Within a fortnight the sore was quite healed and no further signs developed. Injections of the two drugs were given at weekly intervals up to October 23rd, and on the 30th of that month his blood was completely negative. He took potassium iodide for six weeks and then stayed away. He came again to the clinic on February 15th, 1922, and was found to be free from active signs and the Wassermann reaction was completely negative. A month later the blood, taken a week after a provocative dose of novarsenobillon, was still negative. He had no further treatment, and a like result was obtained in the following June and November.

This patient, like the first, emphatically denied re-exposure, and the strongly positive Wassermann reaction so early in the stage of the second sore makes it probable that his statement is correct, though it is not quite so conclusive as in the first patient, where the sore was a little older, though certainly not more than three weeks, and probably only two, when the blood test was done. It is unfortunate that blood was not taken on August 31st, the day *spirochaetes* were found in the sore, and when one considers the way the disease cleared up, both clinically and serologically, one is not quite so certain that this was not a reinfection.

But should either of these cases be called chancre *redux*? Hutchinson's² original description laid stress on the fact that the sore is almost invariably located exactly on the site of the former chancre. The first of these does not fulfil that criterion; the second possibly does if we do not regard it as a reinfection.

The point on which I would lay stress is that these cases may, if a full bacteriological as well as clinical examination be not done, be taken for reinfections, and that, unlike the latter, their prognosis from the point of view of a permanent cure is much more unfavourable—as witness the first case, who is still uncured, in spite of eighteen months' treatment on most modern lines.

More recently a patient came to the clinic showing what I would consider a classical *redux* chancre.

CASE III.

A man, aged 32, attended on January 10th, 1923. He gave a history of a chancre six years ago, and some months' treatment for it by mercury only. Beyond some sores on his head he does not appear to have noticed much in the way of secondary signs, and he had been quite free from symptoms for over four years, until his present trouble began. He had a gummatous ulcer on his palate, and, on what he says he is sure is the site of his primary sore, was a definite red indurated area which, though now dry, he said had been weeping recently. The Wassermann reaction was strongly positive; the site of the chancre was too dry to get any

material for examination by dark ground. He was put on novarsenobenzol and mercury injections; the induration and ulcer quickly became much less and disappeared in the course of about three weeks.

REFERENCES.

- ¹*Proc. Roy. Soc. Med.*, Section of Dermatology, 16, 1.
²*Syphilis*, Cassell and Co., 1909.

MEDIASTINAL GROWTH WITH VENOUS THROMBOSIS.

BY

J. A. MACLAREN, M.D., CH.B.

THE following case is of interest owing to the difficulty in arriving at a definite diagnosis.

In August, 1922, a medical man began to suffer from general malaise, shortness of breath, and cyanosis of ears and nose; x-ray examination was negative.

In October, when I was called in, there was complete thrombosis of the brachial veins and partial of the external jugulars; the face was puffy and congested, and the arms enormously swollen. The superficial veins of the thorax and abdomen were engorged. The respirations were quickened and shallow; the heart apex was outside the nipple line, and the liver two inches below the costal margin. The pulse was regular, varying between 70 and 80 a minute; there was no heart murmur, and the chest was clear except for slight dullness and diminished air entry at the right base behind. A sputum test was negative for tubercle bacilli; there was no history of syphilis, but there was a history of previous thrombosis of the right leg following enteric fever and malaria some thirty years ago. Treatment consisted in iodides and podophyllum internally, with fomentations to arms and support to arms and head. The oedema and hardness of veins gradually cleared up, and the heart and liver became normal in size. The chest dullness, however, did not disappear, and later the left base behind also became dull; there were no adventitious sounds except for a few occasional coarse crepitations. The extreme bases appeared to be clear and resonant and breath sounds were audible near the spinal column. The dull patches varied in position and extent from day to day, and were influenced by dry cupping. The patient's temperature never rose above normal, and he had no discomfort apart from slight shortness of breath, sleeplessness, and some flatulence.

In February, 1923, oedema began to reappear in the arms, and later in the right leg, and the heart sounds became muffled. There was then no appreciable dullness in the front of the chest. On the chance of there being a septic focus present I now inoculated him with antiseptic vaccine (P. D. and Co.), with the result that the oedema rapidly began to disappear and the chest dullness diminished. After the third weekly dose everything cleared up except a small patch of dullness in the right axillary line of the chest. Improvement in his condition continued till the beginning of April, when suddenly cough became troublesome, cyanosis began to return, and the heart sounds became weak. At this time there was some slight dullness to percussion over the middle of the front of the chest. The patient now lost weight and daily became weaker and more cyanosed, though he stated that he felt really better in himself except for the cough. Cyanosis increased, oedema of both legs set in, he suffered from orthopnoea, and died suddenly after getting into bed on April 19th.

Post-mortem examination revealed a soft growth, cheesy and breaking down in parts, adherent to the manubrium sterni. It extended down to the pericardium and surrounded the large vessels at the base of the heart. The apices of the lungs, especially on the right side, were involved, and on cutting into the lung substance secondary deposits could be seen studded throughout both lungs. Microscopically the growth showed all the characteristics of round-celled sarcoma.

The points I wish to emphasize are: (1) X-ray examination showed no evidence of new growth. (2) Until the last week or two of the illness there was no dullness over the anterior mediastinum. (3) The dull patches behind varied daily in size and position, and were influenced by dry cupping. (4) The antiseptic vaccine produced immense temporary relief, causing the dull patches, the cyanosis, and oedema to disappear. (5) What relation, if any, had the new growth to the thrombosis? Finally, I draw attention to this point: "In all cases of venous thrombosis affecting the upper portion of the body the existence of a mediastinal new growth should be borne in mind in spite of the want of direct evidence."

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

ACUTE PUERPERAL INVERSION OF THE UTERUS.

THE case here recorded is of interest on account of the serious condition of the patient when admitted to hospital, and the rapidity with which recovery followed the treatment adopted.

Mrs. M. W., aged 29, was admitted to Victoria Hospital, Southend, on April 16th, suffering from complete inversion of the uterus, following labour, which had occurred an hour previous to admission. She had been under the care of a midwife, who stated that labour had been normal but somewhat precipitate. As the placenta did not come away after half an hour she expressed it, and the "placenta and uterus came down together." The placenta was then removed. She also said that she had not pulled upon the cord, which was normal in length and was not twisted round the child. The haemorrhage was slight. Two years previously the patient had a normal labour, in which the placenta had been retained for an hour after the birth of the child.

On admission the patient was unconscious and pulseless, and in a condition of extreme shock. The shock was treated and consciousness returned in an hour, when the pulse could first be felt. The patient was lightly anaesthetized and Dr. Cleveland Smith succeeded in replacing the uterus by steady pressure for about ten minutes. Pituitrin was given intramuscularly and the uterus douched; it contracted immediately and there was no haemorrhage. For about three days following reposition she had a swinging temperature and an offensive vaginal discharge. This cleared up with douches and she was discharged from hospital three weeks later in perfect health.

The points of interest in this case were the extreme gravity of the shock, the slight amount of haemorrhage, the rapid contraction of the uterus after reposition, and the good results which followed upon early reposition with removal of the placenta as a preliminary.

I am indebted to Dr. Cleveland Smith for permission to publish this case.

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Southend-on-Sea.

IDIOSYNCRASY TO MERCURY.

Miss K., aged 26, came to me complaining of a painful eye condition. On examination the lids were seen to be oedematous with small pearly blebs on the skin surface; there was a good deal of injection of the conjunctivae, with similar blebs on them. She complained of excessive watering of the eye, blurred vision, and photophobia. On the posterior surface of the auricle and skin adjoining were erythematous pearl-like blebs. All down one side of the neck over the distribution of the fibres of the trapezius was a distinct shotty erythema.

The case appeared a puzzle until I went into the question of occupation. The patient had lately engaged herself as a dental nurse, and I ascertained that she had been clearing up amalgam fillings, and had touched some globules of mercury. Evidently she had rubbed her eye with the finely divided metallic mercury, and set up slight mercurial poisoning. She had some slight watering of the mouth, and the parotid was very tender.

Evidently the case was one of special idiosyncrasy to mercury, and I congratulated myself that I had not ordered her a mercurial ointment as treatment for the conjunctivitis.

After using a weak solution of potassium permanganate and some cocaine drops for the eye, the rash and other symptoms disappeared in a week.

Bath.

FELIX MEINÉ, M.B., Ch.B.Edin.

IN 1922 there were 386 cases of typhus in Germany as compared with 533 in 1921. Almost all of the cases occurred among immigrants and refugees.

ACCORDING to the *Journal Officiel* the number of marriages in France during 1922 was 383,220, or 73,000 less than in 1921 and 240,000 less than in 1920. The number of divorces was 27,684, or 4,873 less than in 1921 and 1,472 less than in 1920. The excess of births over deaths has diminished on the whole, but was higher in 1921 in nine departments—namely, Pas-de-Calais, Lozère, Corrèze, Ardèche, Saône-et-Loire, Haute-Savoie, Indre, Ain, Aube.