THREE CASES OF RECONSTRUCTION OF THE THUMB.

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The following three cases illustrate some methods of replacing a lost thumb.

CASE A.

A man had had his hand crushed by a pile-driver, losing thereby the thumb at the metacarpo-phalangeal joint and the whole index with its metacarpal bone. The third metacarpo-phalangeal joint was dislocated and partially ankylosed, and the interphalangeal joints of the middle finger were acutely flexed. The first and third metacarpal bones were firmly bound together by fibrous tissue.

In this case, after turning up a dorsal skin flap, I removed all the intervening fibrous tissue, taking care to preserve part of the insertion of the opponens, and brought the flap through so as to lower the web nearly to the metacarpal base, thus converting the metacarpal into a free digit. At the same time an arthroplasty of the dislocated joint was performed, while the flexed finger joints were left undisturbed, so as to enable the finger-tip to be opposed to the short thumb. The man had good use of his reconstructed thumb. The movements of the freed metacarpal were not perfect, but he could easily hold objects between the thumb and flexed middle finger, and could oppose the thumb to meet his remaining digits.

CASE B.

Owing to the explosion of a detonator a man had lost from his right hand the thumb at the metacarpo-phalangeal joint, and the index, middle, and ring fingers through the proximal phalanx.

In this case I transplanted the remains of the index on to the thumb metacarpal by the following method: A flap was turned up exposing the head of the first metacarpal and having its base over the dorsal surface of the trapezium. From the ulnar end of this incision a racket incision was made as for amputating the index. The index metacarpal was cut at its narrowest part and the finger left attached only by the flexor and extensor tendons and the tissue surrounding the radialis indicis artery. A large hole was made in the head of the first metacarpal, reaching its medulla. By blunt dissection the cut end of the index metacarpal bone was made to emerge between the flexor and extensor structures of the first interosseous space, and by a levering movement inserted as a peg into the hole in the metacarpal. The index tendons were realigned by blunt dissection and the gap covered by a flap from the dorsum of the hand, so arranged as to reach the palm and cover the web with skin. The man has control over his transplanted index, can move the transplanted joint, and can hold a pen with ease.

Those members of the British Medical Association who visited Shepherd's Bush at the Clinical Meeting may remember this case.

CASE C.

Pte. T. had lost the thumb at the middle of the metacarpal bone, and the index and middle fingers at the metacarpo-phalangeal joint; he suffered from very severe median causalgia. An injection of 65 per cent. alcohol into the median nerve in the mid forearm cured the causalgia, but unexpectedly did not cause complete anaesthesia or paralyse the median intrinsics. Later I reconstructed the thumb by the following method: A dorsal flap was turned up exposing the whole of the first two metacarpals. An incision was then made through the whole second intermetacarpal space including the palmar skin. The stump of the first metacarpal was exposed, and its medulla opened. The index metacarpal was divided at its middle and the base excised. From the excised base a small graft was cut, and by means of this, used as an intramedullary graft, the head of the index metacarpal was fixed to the stump of the thumb metacarpal. The skin flap was placed as a web across the newly made space.

The man can now use the thumb freely and grasp a stick.

In all plastic operations on the hand the chief difficulty is the skin covering. In my opinion the available skin should be used to cover the web and the points which will have to bear pressure; all other parts, such as the dorsal surface of the thumb, being, if necessary, left to heal over, or skin-grafted, as any excessive tension seriously risks the vitality of the web.

The subsequent use of plaster splints moulded to the part serves to ensure abduction and opposition of the new thumb. These may need to be worn at night until all danger of contraction is over.

THE construction of a model leper house for Brazil, equipped with all necessary provisions for the isolation and treatment of patients, has been begun near Santo Angelo.

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Memoranda: MEDICAL, SURGICAL, OBSTETRICAL.

ACUTE SUFFOCATIVE CATARRH.

SOME years ago I was called to a man, aged 42, who was in bed and in every detail presented the exact counterpart of the woman Dr. Robert Anderson describes in the JOURNAL of November 8th, p 597. The attack had come on suddenly a quarter of an hour before I arrived. The patient's complexion was leaden and his skin clammy. He had eaten a large meal of steak and kidney pudding about an hour and a half before. I gave him a capsule of amyl nitrite to inhale, and he died suddenly whilst doing so. Feeling convinced that the condition was due to reflex nervous action, and seeing the parallel between such an attack and those cases of asthma which follow the ingestion of certain indigestible foods, I decided that if ever I saw another case I would at once inject morphine hypodermically.

I did not expect ever to see another case, but two weeks later I was called to a man aged between 50 and 60. He was standing up fully dressed, bending over a bucket and bringing up quantities of frothy watery fluid of a mucous character, faintly tinged pink. He spoke with difficulty owing to dyspnoea and because he was entirely engaged in expectorating the fluid in gulps (I can find no other descriptive word). His pulse was full, rapid, and bounding. I at once gave him a hypodermic dose of one-third of a grain of morphine. The effect was magical. His breathing was much easier in two minutes, and he was apparently quite well within ten minutes. I then learnt from him that he had enjoyed a good dinner of liver and bacon two hours previous to the attack, and that it came on suddenly with no previous indigestion or warning. I put him to bed and he slept well, and was perfectly recovered the next day.

Both men were healthy, and had had no previous illness for some years before the attacks.

I have had no opportunity of trying morphine in another similar case. To my mind there is no alternative cause of the condition but a nervous one, and it is probably started in every case by gastric irritation. The cases are rare, but I hope morphine will soon have another and successful trial.

Kingston Hill.

ARTHUR GALE.

DYSTOCIA DUE TO ANAL FISSURE.

I WAS recently sent for by a midwife on account of a "vaginal obstruction" in a somewhat delicate multipara whose previous confinements had been easy. On examining during a pain I was surprised to feel what seemed to be a horseshoe magnet of large size, with the arch backwards, obstructing the head. When the pain passed off the "obstruction" disappeared, and there seemed no obstacle to delivery; the "obstruction" reappeared with the next pain, and I realized the condition was due to a tonic spasm of part of the anterior levator ani muscle. On further examination I found two small haemorrhoids with an irritable fissure between them. Happening to have a bottle of codrenine* with me I applied some, undiluted, to the fissure, and the effect was almost instantaneous, for with the two following pains the head was born. Next day, on pressing the fissure, sharp reflex spasm of both the rectum and vagina resulted, also of the abdominal muscles, though there was no reappearance of the "magnet."

Bath.

F. C. FOSBERY.

EPITHELIOMA OF THE MOUTH IN A YOUNG PERSON.

EPITHELIOMA of the nasopharynx and contiguous parts is frequently seen between the ages of 30 and 50, but the following note records its occurrence in a lad not out of his teens.

On August 9th, 1918, M. C., aged 17 years and 11 months, consulted me regarding a swelling of the face, due, he thought, to

* Codrenine is a proprietary preparation stated (*Extra Pharmacopoeia*) to contain cocaine hydrochloride and adrenalin.