A CASE OF TRAUMATIC PNEUMONIA.

BY

JOSEPH GEOGHEGAN, M.B., CH.B. EDIN.,
GOVERNMENT MEDICAL OFFICER, TURKS ISLANDS; LATE DISTRICT
COMMISSIONER AND GOVERNMENT MEDICAL OFFICER, CAICOS
ISLANDS; HOUSE-SURGEON, GENERAL HOSPITAL,
FARMOUTH, ETC.

INVOLVEMENT of the pleura as a result of injury of the chest wall, either by direct violence or by the indirect effect of a force, such as a strain, probably happens more often than is observed. The small area of the probable lesion and the slight constitutional disturbance minimize the importance of such a pathological process, but perhaps explain the occurrence of isolated fibrous bands between the pleurae, as seen in the *post-mortem* room. Involvement of the lung, as contusional or traumatic pneumonia, though well known to happen, is still less frequently noted. Parkes Weber¹ refers to haemorrhagic infiltration in this condition, and interesting speculations may be introduced as to lesions of small vessels, the latency of the organism, the frequency of the common pneumococcus in the mouth, and the atypical features possible.

The following notes on a case lately seen present certain well-marked points: (1) The definite injury, associated at the time, it may be, with a slight attack of influenza. (2) The acute pain, but total absence of any pleuritic signs, unless, as has been suggested, the minute crepitations first heard are not moist sibili, but a fine pleural friction. (3) The irregularities noted; the curiously low temperature and the fall by lysis, the slowness of the pulse, the area of lung involved, and the lateness of the sputum.

R. G., aged 27, a strongly-built coloured labourer, received on March 26th, 1916, a heavy fall while engaged in some horseplay. There is a trick practised in irregular combat which consists of suddenly catching hold of the loose lower front ends of the opponent's trousers and throwing him headlong. Done with a deft celerity, it results in a heavy fall. R. G. was treated in this fashion and suffered afterwards from some pain in the right side, but not to any marked extent. He further states that at the time he was troubled with a "cough and cold," probably an attack of mild influenza which had been epidemic.

Four days later, on March 30th, between 10 and 11 a.m., he was suddenly seized with severe pain in the right side just below and outside the nipple, and came first under my hands on the afternoon of the same day. Breathing was rather hurried, short, and restrained; the chest wall was rather rigid on the affected side; no abnormality could be detected on physical examination, the temperature was normal, and the pulse 78. Pleuritic possibility was kept in mind in prescribing the treatment.

Nothing more was heard of him for four days, when, on April 3rd, he returned obviously ill. He stated that he had had great pain in the right side at the same spot, with a short hacking cough, for the two preceding days, and had felt very ill. There was no history of rigor or vomiting. Respirations were 32, short and restrained; there was rigidity of the whole chest and inability to take a deep breath. Vocal resonance and fremitus appeared somewhat increased on the right side posteriorly. No change was noted in front, but on the back (right side) some impairment of note, the breath sounds having a blowing character over the same area with some fine crepitations at the end of inspiration and lengthened expiration in front. There were no friction sounds. The second sound of the heart was accentuated, with a tendency to reduplication of the first in the aortic region. There was no enlargement of the spleen, but some liver tenderness. Temperature 100.2°, pulse 78.

Next day an area of dullness was noted on the right side posteriorly extending along the base of the lung, the upper limit (rather indefinite this day but confirmed the next) starting from close to the mid-axillary line, rising to the scapular margin at the sixth rib, and thence passing transversely across the back. Respiratory sounds over this area were approximately equal in length, more particularly at the upper edge of the dullness. There was a short, dry, painful, and infrequent cough. There was no herpes on the lips at any time. There was yellow discoloration of the conjunctivae. Urine acid, specific gravity 1026, no sugar, faint trace of albumin, deeply stained with bile.

On April 5th the temperature was 101.2°, the pulse 98, and the respirations about 30. The following day the temperature fell to 100.3° and the pulse to 84. Some sputum now appeared, frothy and white, with no viscosity or green or rusty discoloration, in quantity small, and rather similar to the bronchitic type. On April 7th the temperature had risen to 102.8°, pulse 100; jaundice less and albumin absent from urine. On the 8th the temperature was 101.8°, pulse 88, and respirations 32; on the 9th, temperature 100.5°, pulse, 100, respirations 30. The next day the temperature had fallen to 99.3° and the pulse was 84; all over the affected area were crepitations of various degrees; dullness, fremitus and resonance were diminished, but there were still blowing bronchial sounds in the area.

On April 11th the temperature was 97.4°, pulse 78, and respirations 26. On this day a definite green colour suddenly appeared in the sputum, which was very viscid, almost nummular. The breathing was free and there was a frequent soft cough. There was a distinct movement of the chest wall. The subsequent progress to recovery was uneventful.

The patient's illness was treated in a small wooden hut about 20 ft. by 12 ft., with such nursing as his friends and relatives could give him. The temperatures, etc., recorded are those of the evening.

The ordinary treatment was given, with the use of calcium chloride, creosote, and potassium iodide, in suitable doses.

Little of the usual anxiety, as can be seen by the brief notes given, was aroused, owing to the full pulse, the generally easy, though nervous look, and the absence of the more serious signs or symptoms.

REFERENCE.

¹Parkes Weber, quoted in the *Medical Annual*, 1911, p. 517.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

RECURRENCE OR REDEPOSIT OF CANCER?

MR. TILLEY's question in the *JOURNAL* of March 31st (p. 424) sent me to my notes on the medical aspects of carcinoma of the breast, two series of cases of which I have already published (*American Medicine*, 1901, and *BRITISH MEDICAL JOURNAL*, 1906, i). The following statements seem warranted:

There is no time limit to the primary growth, which may persist from ten, fifteen, or twenty years before metastases occur; or the patient may die of some other malady.

Secondary growths, even multiple, may become quiescent or even disappear (Cases v and vi).

A primary mass with metastases may remain stationary for years.

Years after removal there may be local recurrence, as illustrated by Mr. Tilley's cases.

Years after removal of the original growth there may be extensive internal (without local) recurrence.

Though no time limit exists for recurrence the modern complete operation has been followed by good health for periods long enough to justify the use of the word "cure." Is there an instance of return twenty years after the complete operation?

Oxford.

WILLIAM OSLER.

BRILLIANT GREEN AS AN EPITHELIAL STIMULANT.

THE minor ailments of the soldier may not in themselves be dangerous either to life or to limb, but are sufficient to incapacitate a man, rendering him useless as a fighting force, a source, may be, of infection to his friends and an encumbrance to a medical unit where space and time are of paramount importance.

A casualty clearing station affords a unique opportunity of meeting these cases—impetigo, indolent ulcers of various kinds but principally of traumatic origin, superficial shell wounds involving only the skin, raw unhealthy areas due to the bursting or unscientific removal of the skin forming a blister, and such like. Apart from actual wounds caused by the enemy, cases of this description comprise from 40 to 50 per cent. of the total walking cases