TWO UNUSUAL CASES OF LEAD POISONING.

By ROBERT M. SIMON, M.D.CANTAB., F.R.C.P.,
Physician to the General Hospital, Birmingham.

THE causes of lead poisoning are so numerous, and often so mysterious, that it becomes almost a duty to put on record any cases of the disease in which the causation has been inexplicable without the closest inquiry. Of such a nature were the two cases I have to report. Both were unusually severe cases; one patient, indeed, died, and the other (for the notes of whose condition I have to thank my friend Mr. Hutchinson, of Birmingham) had an epileptic fit as the result of the poison.

His patient was a Mr. P., a farmer in Worcestershire. He came to Mr. Hutchinson complaining that he had had a fit while out in the fields a fortnight before his visit. The fit had been attributed to sunstroke, and was followed by persistent giddiness. For some time previously he had suffered from pains in the abdomen, chest, and limbs. His appetite was poor, he felt sick and thirsty. His bowels acted irregularly, constipation being succeeded by diarrhoea. He looked pale, sallow, and anxious; his pulse was weak and irregular; his head ached and he complained of indigestion and giddiness. A deep blue line was found at the edge of the gums.

All possibility of being poisoned by lead was denied, but on inquiry it was found that he had been drinking cider for months out of a cask through a siphon tube. This was made of a piece of lead piping, and in order to cause the cider to start to flow he would draw a few mouthfuls and swallow them. Moreover, at the bottom of one large cask of cider there was a piece of lead piping three feet long, that had slipped into the cask one day when he was sucking up cider through the bung. The patient used to put the end of a leaden pipe into his mouth, and draw cider a dozen times a day in this manner.

This man made a good recovery, but my own patient died from paralysis of the diaphragm. He had, moreover, the most widely-distributed peripheral neuritis and general paresis of muscles I have ever seen. The way in which he became infected by lead was most remarkable. He was a chemist, and kept among his stores a jar of putty powder (stannic oxide), and next to it another similar jar containing pepper. He was greatly addicted to the use of pepper, and used it always in a small pepper mill when at meals. The assistant when sent for more pepper to fill up the mill, unfortunately went to the wrong jar, and brought back the pepper mill full of stannic oxide. This was freely taken, as the patient thought the pepper was very weak, so took more of the pepper-flavoured oxide to compensate for the lack of strength. The stannic oxide was largely adulterated with lead, and the patient became fatally ill under the influence of the poison before its source was suspected.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

A SIMPLE CURE OF HERNIA BY MEDICINE.

CRETINS commonly have umbilical herniæ, doubtless due to accumulations of myxodematous or of fatty material in the abdominal cavity, leaving insufficient accommodation for the bowels, just as there is also insufficient accommodation for the tongue in the buccal cavity. These herniæ vanish in a very few weeks or months under treatment by thyroid extract, doubtless because this causes the absorption of both myxodematous and fatty material, and so affords increased space in the abdominal cavity.

In all cases of hernia it may be presumed that the diminution of the contents of the abdominal cavity would diminish the likelihood of the bowels protruding. The administration of thyroid extract brings about the absorption of fatty material both effectually and rapidly, and might therefore be relied upon to reduce the fatty deposits in the omentum, appendices epiploicæ, etc. I therefore suggest that hernial

protrusions from any part of the abdomen be treated for some months by the administration of thyroid extract before resorting to surgical means. I have several cases under treatment at the present time, but prefer to throw out the suggestion without waiting to learn to what extent experience confirms theory in the matter.

Kendal.

WM. RUSHTON PARKER, M.A., M.D.Cantab.

FOREIGN BODIES IN THE LARYNX.

IN view of the recent discussion on foreign bodies in the upper air passages at the Laryngological Society of London the following appears to me of interest:

When House-Surgeon at the Radcliffe Infirmary I was called in haste to see a child, aged 6 months, who was suffocating. The child was fully dressed, and was being held by its feet in an inverted position; it was deeply cyanosed, and, except for an occasional convulsive effort at inspiration, was to all appearances lifeless.

I put my finger into the mouth, and at the root of the tongue could feel a smooth swelling not unlike an enlarged and hard tonsil. As inversion and "thumping" the back had proved ineffectual, the right treatment, whether the obstruction was due to a foreign body or not, was tracheotomy. This I immediately did after the child's clothes had been cut off.

The usual stimulus to respiration caused by the incision failed in this case to cause effort, and for a short time I did artificial respiration, the tracheal wound being held open on either side by a silk suture in place of the ordinary dilator. The child now gradually regained its normal colour and began moving its limbs, but there was no cry, showing that apparently there was something impacted in the larynx.

I decided to pass a probe from the wound into the larynx, and was obliged to let go the dilating sutures in order to do so, when the child made an expiratory effort and shot a jube from its mouth on to the floor and began yelling lustily. The tracheal wound was sewn up and the child put into a tent with a steam kettle. It made an uninterrupted recovery and left the hospital in a week.

The case is interesting owing to the nature and shape of the foreign body. To the touch a moistened half-softened jube is not unlike a swelling covered by mucous membrane. The shape in this case was that of a truncated cone. It had no doubt fitted into the larynx with its smaller end downwards, thus forming a valve which allowed air to pass out of the lungs but not to pass in.

I take it that for this reason the child was unable to expel it, there not being sufficient air in the lungs to form an efficient *vis a tergo*. This, however, became possible when air had got below the obstruction by means of the opening in the trachea, as is proved by the happy result recorded.

B. W. GOWRING, M.R.C.S., L.R.C.P.,
Late House-Surgeon, Radcliffe Infirmary, Oxford.

REPORTS

ON

MEDICAL & SURGICAL PRACTICE IN THE HOSPITALS
AND ASYLUMS OF GREAT BRITAIN, IRELAND,
AND THE COLONIES.

SUNDERLAND INFIRMARY.

PERFORATING ULCER OF STOMACH: ABDOMINAL SECTION:
SUTURE: RECOVERY.

(Under the care of G. B. MORGAN, L.R.C.S.I., Senior Surgeon to the Infirmary.)

A. H., aged 22, admitted February 20th, under Dr. Welford, complaining of severe pain in abdomen, which was somewhat swollen, rigid, and very tender, especially in the left epigastric region. Liver dullness defined, area of tympanitic resonance up to fourth space. Her expression was most anxious; pulse 130, respiration 40.

This girl had been a patient in the infirmary three years before, and had then the symptoms of gastric ulcer and had had free hæmatemesis. She had been fairly well in the interval, and had observed a careful diet, but had had occasional vomiting, though not of blood. The day before ad-