A NOTE ON THE PATHOLOGY OF A DOUBLE COLLES'S FRACTURE.

[WITH SKIAGRAPHS.]

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A MAN, aged 30, who had sustained a double Colles's fracture, was sent to me by Dr. Cresswell, House-Surgeon to the infirmary, to be skiagraphed, on September 9th. The deformity was of the usual character in both limbs, and the cause of the injuries was a fall from a height upon the palm of the extended hands.

It will be observed that the bone lesions of the radii of a clinical entity are dissimilar, but the point I would like to draw special attention to is to the fracture of the styloid processes of both ulnæ, with the hope that others who have the

Fig 1.

opportunities may assist in establishing as a fact whether this condition is as uncommon as we have hitherto been in the habit of thinking it to be.

Before the days of the Roentgen rays one may assume without fear that it was very difficult, if not often impossible, to diagnose the exact pathological condition of similar bone injuries, but now, thanks to the great physicist of Wurzburg, we are able to see the living bones without any worry to the patient.

In Treves's *System of Surgery* it is stated in connection with Colles's fracture that "the carpus moves outwards with the lower fragment, and sometimes carries the ulnar styloid process with it." Bearing on the same point, we find in Keen and White's *American System of Surgery* that "exceptionally the styloid process of the ulna may also be broken off." So far I have skiagraphed only five cases of Colles's fracture, and in four of them this "exceptional" (?) condition of the ulnar

styloid process was present, but whether these cases will prove "exceptional" or "sometimes" I would venture to ask that others who have frequent opportunities may assist in elucidating a point which by co-operation can now be satisfactorily settled in a few months.

Fig. 1 shows the ordinary fracture with outward displacement of the lower fragment in Colles's fracture, *plus* fracture of the styloid process of the ulna.

Fig. 2 shows very slight impaction of the radius about three-quarters of an inch from its lower end; it is to be observed by noticing the irregularity on the outer border of the bone, but the interesting, and I think a most unusual, condition to be noticed is a complete longitudinal single fracture of the lower end of the radius showing a detached portion of a triangular shape in its normal position attached to the radio-ulnar ligament.

In connection with the Roentgen rays I may be allowed to express the opinion that an apparatus for its development at

Fig 2.

a hospital is as essential in exploring living bones and embedded foreign bodies as an exploring needle is in connection with the chest, skull, and abdomen, and doubtfully fluctuating peripheral tumours.

DYSTOCIA FROM RELATIVE SHORTNESS OF THE FUNIS.

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S. F., aged 33, mother of two healthy girls, the younger 3 years old, was recently attended by me at full term. The labour was tedious compared with her previous confinements, the pains being of short duration and not strong. Presentation first cranial or left occiput anterior. When the head

was bearing upon the perineum evidence of the nature of the difficulty became manifest by great retraction between the pains, which were becoming shorter and less effectual, though not from exhaustion, as she continued cheerful with a good pulse. Pelvic examination showed no cause, there being ample space with yielding soft parts, and the nature of the presentation was further confirmed by feeling, with ease, the pinna of the left ear. Abdominal examination showed a single gestation, with the placenta at the fundus, where the rotundity became much less defined during uterine action. Though during the labour a firm binder had been applied round the abdomen, it became evident that Nature, unaided, could not effect delivery, which had appeared so imminent for over an hour. Forceps were therefore used, and the head delivered by carrying the occiput over the symphysis without injury to the perineum. There was no caput succedaneum or other indication of the head having been subjected to undue pressure. Hæmorrhage now began, and the diagnosis was verified by finding a strong rather thick cord passing over the thorax round the back of the neck. The tension was so great that it was impossible to slip it either over the head or shoulders, so I divided it between forceps, as it was uncertain which was the foetal end. The shoulders and arms were now freed, and a male child, weighing over 11 lbs. and 20 inches in length, delivered. As hæmorrhage continued rather free, and the placenta could not be expelled by Credé's method, ergot was given and the hand immediately introduced, when about a fifth of the placenta was found still attached to the fundus with a large clot.

I regret that the length and strength of the cord were not ascertained, but it was of an average length, probably more than 17 inches, and as a cord of medium strength will bear a weight of 8 lbs.,¹ this evidently would not have broken under a weight of 12 lbs. More frequently, when the cord is too short, and fully stretched, under the tensile force of labour, the placenta becomes detached from the uterus, as in this case; but the cord may be torn from either the placental or umbilical site, or when under the normal strength, snap through during labour, as related by Dr. Johnson.² It is not uncommon for the cord to encircle some part of the child, and, as a consequence, less marked degrees of relative shortening may be a cause of dystocia without being recognised, even after delivery.

During an experience of nearly 25 years I have no note of labour being impeded from absolute shortness, but have met with several where relative shortness has been a cause of the difficulty. This, however, is the only occasion in my practice where the symptoms and physical conditions were sufficiently obvious to enable a diagnosis to be, with reason, inferred before delivery.

A CASE OF ENTERIC FEVER, COMPLICATED BY PERFORATION, PERITONITIS, AND RELAPSE, AND FOLLOWED BY PERITYPHLITIC ABSCESS: RECOVERY.

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THE following case, as illustrative of a rather rare sequela of enteric fever, namely, perityphlitic abscess, may be of interest. This condition and its rarity as a sequela of enteric fever were noticed by Sir Dyce Duckworth in the interesting series of lectures on the "Sequelæ of Diseases" which were published a short time ago in the BRITISH MEDICAL JOURNAL.

On February 20th, 1896, I was called to see Mr. R. He had suddenly been attacked with severe abdominal pain, and when I first saw him was in great agony, lying on his back with both legs drawn up and rigid, tender abdomen. The temperature was 103.6°, the pulse 130, small, hard, and wiry. His expression was drawn and anxious, and his respirations shallow, rapid (38 to the minute), and entirely thoracic. He

complained of pain in the right iliac fossa, where tenderness was most marked; no dullness or tumour could be detected. The previous history of the case suggested a mild case of the so called "ambulatory typhoid."

The following day (February 21st) the abdomen was greatly distended and tympanitic, pain having become general. The other symptoms were proportionately intensified. For the next few days the patient continued to show all the symptoms of a very sharp attack of acute peritonitis.

Between 8 and 9 o'clock on the morning of February 23rd collapse suddenly occurred. The temperature fell from 104.3° to 96.4° with profuse perspiration, cold surface, an almost imperceptible pulse, and sighing respirations. The patient appeared to be in a moribund condition, but rallied surprisingly under judicious stimulation. The pain after revival was so agonising that 6 grains of opium administered within three hours failed to give relief, and recourse was had to hypodermic injection: 10 minims of the ordinary solution night and morning, and 5 minims in the middle of the day at last procured relief. Under the influence of morphine the patient progressed favourably, but the temperature remained fairly high and irregular, and the abdominal symptoms continued to give some trouble. For several days the case presented the symptoms of an ordinary case of peritonitis, but, suspecting enteric fever to have been present, I was not surprised when I found five well defined spots on February 29th. When the peritonitis abated the temperature fell by lysis in typical typhoid fashion. Characteristic stools followed with a period of moderate diarrhoea, considerable abdominal pain still necessitating the exhibition of morphine.

The patient now appeared on the fair road to recovery, when unfortunately on March 8th the temperature began to climb again, and there was no doubt that a relapse had to be dealt with. Fresh spots appeared, and all the symptoms returned, although in a much milder form. The patient was, indeed, in a very serious condition, and the chances of his recovery appeared to be reduced to a minimum. Still improvement took place, and all appeared to be going on well, when the patient again began to complain of pain in the right iliac fossa.

Towards the evening of April 4th this became more acute, with profuse sweating, and a temperature of 101.4°.

The following morning a well defined hard swelling was detected, and suppurative perityphlitis diagnosed. The case was now so serious that Dr. Goodhart, of Guy's Hospital, was called into consultation. He confirmed the diagnosis, and agreed that early operative interference was absolutely necessary.

On April 8th, chloroform having been administered, an incision was made about 2½ inches long, beginning 2 inches inside the crest of the ilium at its anterior extremity, and extending in a direction downwards and inwards. The peritoneum was opened, and about 4 ounces of pus evacuated; there was a fair amount of hæmorrhage. A drainage tube was inserted, and at 9 P.M. the temperature was normal, and the patient felt very comfortable.

The drainage tube was removed on April 22nd, and from this the patient made an uninterrupted recovery, being able to return to his home without discomfort on June 1st.

I have no doubt from the various symptoms presented that the case was primarily one of mild enteric fever resulting in perforation and consequent peritonitis; the abscess, I believe, occurred at the site of perforation, and was luckily cut off from the general peritoneal cavity by inflammatory adhesions. Such serious inflammatory action having occurred in the right iliac region, I consider it more than likely that subsequent abdominal trouble will occur, possibly requiring operative interference. The early stages of the case exemplified the necessity for the fearless exhibition of opium in such cases, the only criterion of the sufficiency of the dose of the narcotic being the relief of pain. Obstinate constipation is bound to follow and cause some trouble, but this is of little moment compared with the immediate beneficial action of the drug. I am indebted to Dr. Robinson, of Old Brompton, Chatham, for considerable assistance with the notes of the latter part of the case, as, owing to change of station, I was unable personally to conduct the case to complete convalescence.

¹ Matthews Duncan, *Obstetrical Transactions*, vol. xxiii, 1881; and *BRITISH MEDICAL JOURNAL*, 1881, ii, p. 857.

² *BRITISH MEDICAL JOURNAL*, 1882, ii, p. 132.