4. Headache follows both; that of migraine being more severe.

5. The aura of migraine seldom affects a leg or the trunk.

6. Somnolence may occur in both.

As Gowers says, "it is curious that the most frequent relation between epilepsy and migraine is as a source of error between the two." Of course, one always has to remember that they are both comparatively common complaints, and there will be a natural overlapping, apart from any affinity.

The antecedents of migraine are migraine or gout, those of epilepsy being epilepsy or insanity. In migraine there is no deterioration of mind.

THE REMOVAL OF FOREIGN BODIES FROM THE AIR AND FOOD PASSAGES.

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AMONG the cases of foreign bodies in the air and food passages which came under my department during the last twelve months, two are of special interest, and appear to be worthy of record. While illustrating the ease with which such foreign bodies can be extracted even from deep-lying sites by means of the direct method, they show, at the same time, the importance in using it of having good illuminating power. They will also serve, I hope, again to call attention to this admirable mode of treatment, as it has hardly received in this country the attention it deserves.

Nutshell in the Left Bronchus—Extraction by Bronchoscopy.

A young sailor, 18 years old, was admitted to hospital in January, suffering from difficulty of breathing. He was eating nuts whilst playing "leap-frog," and aspirated part of a nutshell into his larynx. He had a severe suffocative attack lasting some time, during which he was partially cyanosed and in great distress. After a while the obstruction appeared to become displaced, and, while the breathing was relieved, discomfort was felt lower down in the chest. When seen, twelve hours later, he complained of a feeling of constriction of the chest and cough, and wheezing was audible. Beyond rhonchi heard over the larger air tubes there were no definite physical signs to be made out in auscultation. He was put under chloroform, which he took rather badly, there being much cough and cyanosis. After the upper part of the respiratory tract had been well cocaineized, a Killian tube 9 mm. in diameter was passed through the larynx into the trachea, which was injected and intensely red and contained much frothy mucus. This was rapidly removed by means of the saliva pump and cocaine applied to the lower air passages. The tube was passed down the right bronchus, which was explored as far as the second ramification and found empty. Its mucous membrane was much injected, probably explained by the fact that the patient had been suffering from a "bronchial cold" for some days. In searching the left bronchus a mass, reddish in colour, was found blocking it just below the commencement, but its relations were difficult to make out owing to the insufficient illumination given by a worn-out lamp. The examination was accordingly suspended, and on the following day the patient was again placed under the influence of chloroform, which he this time took very well. Using a new lamp giving a greatly-improved light, I passed the tube at once down to the left bronchus, and when the mucus was removed the reddish mass was made out to be the piece of nutshell lying inside the bronchus having a small hook-like process over the bifurcation. The convexity of the shell was uppermost, and from under it a constant stream of frothy mucus poured out of the bronchus. Its red colour closely resembled that of the adjacent mucous membrane, and it was the greyish tint of the part of the shell next the bifurcation which enabled its exact relations to be recognized. A Killian long forceps was passed down, the hooked end was seized and the nutshell drawn out along with the tube. The whole procedure did not last more than a quarter of an hour. The patient left hospital two days later.

The object removed was a fragment of a Spanish nutshell measuring 2 cm. by 1.6 cm. (Fig. 1). Its outer smooth convex surface was of a uniform red colour resembling that of the bronchial mucous membrane. Towards the apex, where it terminated in a hook-like process, it had more of a greyish tint, and this was the only point which stood out in contrast to its surroundings. Foreign bodies in the bronchi usually become covered with mucus and assume a grey appearance

which renders their identification from the adjacent structures easy; but in this case the polished surface of the shell afforded no hold to a mucous covering, and the entrance of the bronchus looked at first sight as if it were

Fig. 1.—Nutshell (a) impacted in left bronchus; (b) after removal.

filled by a smooth globular swelling. The use of a good light soon revealed, however, the condition of things; and, the exact relations having been ascertained by means of a probe, the extraction presented no special difficulty.

Plum Stone in the Oesophagus: Removal by Oesophagoscopy.

A Norwegian sailor, aged 16, was admitted in June, 1907, with difficulty in swallowing so complete that nothing had been passed for forty-eight hours. There was a complete block of the gullet, and this had come on after swallowing a plum stone. Attempts to dislodge it had been made in the hospital of another town but without success. On admission the resident medical officer passed soft bougies, and found that a small size could be got as far as the cardiac end of the oesophagus, where it stopped, and a large size was arrested about the middle of the chest. He wisely refrained from employing any force or using a coin-catcher. The patient was placed under chloroform, and an oesophagoscopic tube of 13 mm. diameter passed down until it was stopped about 8 in. from the teeth by a narrowing of the gullet, which was emphasized by spasm. But even abolition of the spasm under deep anaesthesia did not permit its passage. Accordingly a tube of 9 mm. diameter was introduced, and this went through the narrow part without difficulty. It was carried as far as a short distance above the cardiac orifice 12 in. from the teeth, where the plum stone was found lying transversely across the gullet. The mucus was wiped away, and the exact relations of the body ascertained by the probe. It was readily grasped by the forceps, and was being drawn up along with the tube, into which, on account of its size, it could not enter, when it stuck at the narrow part and the forceps slipped. This happened twice. By a little manipulation the plum stone was turned lengthwise and then grasped, after which it was manoeuvred through the constriction and brought out along with the tube. We subsequently learned that the patient when a child had swallowed some caustic alkali and was obliged to be very careful in eating. A few years ago he had trouble with food which remained in the oesophagus for several days.

The size of the fruit stone extracted (Fig. 2) was 2 cm.

Fig. 2.—Plum stone extracted from cardiac end of oesophagus.

by 1.2 cm. It had a sharp hook-like process at one end. This was embedded in the mucous membrane of the cardia and a forcible attempt to push down the stone would certainly have led to laceration. As a rule a foreign body is easily recognized, standing out, as it generally does, in sharp contrast to the pink tint of the mucous membrane. In this instance, again, the red colour of the foreign body gave no such distinction, and accordingly a good light giving brilliant illumination was indispensable.

The general technique of the method of removing foreign bodies by bronchoscopy and oesophagoscopy I have already

dealt with elsewhere,¹ and it is unnecessary to refer to it here. It is of interest to note that since Killian published his first cases of foreign bodies removed by bronchoscopy, nine years ago, more than 200 cases have already been recorded in medical literature. They all teach the importance of undertaking extraction at an early period, and more especially is this true of soft bodies, such as beans, etc., which swell and are prone to start septic trouble in the lung. The cases published in this country are still very few in number. We have the old methods still in practice. Articles in our journals continue to advocate tracheotomy as the proper treatment, in the hope that the foreign body may be coughed up, and failing that, to grope blindly with a forceps or wire loop. It seems to me that the direct method points the way that best carries out surgical principles, and is at once safe and practicable; and it behoves the profession to bring itself into line with the real progress which has taken place in this important branch of surgery.

REFERENCE.

¹ BRITISH MEDICAL JOURNAL, 1906, vol. ii, p. 353.

MEMORANDA: MEDICAL, SURGICAL, OBSTETRICAL.

A CASE OF PYREXIA IN MALIGNANT DISEASE SUGGESTIVE OF SUPPURATION.

DR. J. W. RUSSELL's instructive paper on temperature in malignant disease of the liver and bile passages¹ renders it desirable that similar cases should be placed on record. The patient in the present instance was a man of 64, who had always enjoyed good health until about two years ago, when he began to lose flesh and noticed increased frequency of micturition. In January, 1906, he had a severe attack of pain in the abdomen and right side stimulating biliary colic, and a similar attack occurred in November of the same year. He had never suffered from jaundice or from any dyspeptic symptoms.

State on Examination.—When I saw him in January, 1907, he was complaining of severe abdominal pain and tenderness, the latter being specially localized opposite the tip of the tenth rib. His temperature showed remarkable variations throughout the illness, but there were no rigors and no jaundice, and vomiting, though it occurred occasionally, was never an urgent symptom. The liver showed some general enlargement, but no nodules could be distinguished, and no enlargement of the gall bladder could be made out. The urine contained a considerable quantity of sugar (28 grains per ounce). Careful examination of the abdomen failed to reveal any evidence of tumour growth, nor could any enlarged glands be discovered. The faeces were of a pale greyish-white colour, and on more than one occasion were of the pulaceous character typical of pancreatic disease.

The temperature chart which I append is strongly suggestive

of suppuration, and it required most careful and repeated examination to convince myself that none existed; the leucocyte count, which was only 5,700, confirming this conclusion.

Autopsy.—The patient died on February 20th from acute haematemesis, and I was fortunate enough to obtain a *post-mortem* examination. This revealed cancer extending throughout the pancreas, involving the adjacent portions of the stomach, and with secondary growths in the liver, especially the right lobe. There were no gall stones, no cholecystitis, and no suppuration. There was a large mass of peritonitic adhesions between the diaphragm and the right lobe of the liver.

REMARKS.—This case forms a good illustration of Dr. Russell's contention that rise of temperature simulating suppuration may take place in malignant disease of the liver in cases where there is neither suppuration nor

BRITISH MEDICAL JOURNAL, 1907, vol. i, p. 311.

cholelithiasis. The resemblance was rendered all the closer in this particular case by the frequent occurrence of early morning perspiration. That this rise of temperature is due to some form of toxæmia can scarcely be doubted. Possibly it is of intestinal origin, and due to the entrance into the circulation of toxins which the liver, rendered *hors de combat* by cancerous infiltration, is no longer able to antagonize.

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A CASE OF TWINS WITH HYDRAMNIOS OF ONE SAC.

C. L., a 3-para, was brought in from the country. She was six months pregnant, and was distended to the ensiform cartilage. She presented all the features of a large hydramnios, and on the second day after my seeing her the os began to dilate, and the head of a child was felt distinctly without the intervention of a bag of membranes. As labour was very slow, when the os was well dilated I turned and delivered a dead female child; no liquor amnii came away, and the size of the uterus was not appreciably reduced. I then inserted my hand into the uterus and found an enormous bag of membranes quite intact, and with another child floating freely within it. Upon puncturing the membranes about 2 gallons of liquor amnii was evacuated, and I withdrew another dead female child. The uterus quickly contracted, and the single placenta was soon expressed.

The point of interest in the case was the absence of the fluid around the one child and its great abundance and entire limitation to the amniotic sac of the other.

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J. BRUCE-BAYS, M.D.Lond.

REPORTS

ON

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF THE BRITISH EMPIRE.

BRADFORD CHILDREN'S HOSPITAL,

CASE OF STRANGULATED INGUINAL HERNIA IN AN INFANT
29 DAYS OLD: OPERATION: RECOVERY.

(Reported by WILLIAM H. THOMPSON, M.R.C.S.,
Honorary Surgeon.)

J. B., aged 29 days, was admitted on January 7th suffering from a swelling in the right side of the scrotum.

History.—Up to January 6th the child had been quite well, but during the night he began to vomit. The vomiting continued until the morning, and the mother noticed the swelling in the right side of the scrotum about noon. So far as she is aware there had been no swelling there before. She took the child to Dr. Kee, who diagnosed strangulated inguinal hernia, with faecal vomiting, and ordered its removal to hospital.

On Admission.—The child was quiet, but looked extremely ill. In the right side of the scrotum was a large, tense swelling, which extended up through the inguinal canal. The skin over the swelling was red. The swelling was irreducible. The abdomen was only slightly swollen and tympanitic, and rigidity was not marked.

Operation.—An hour after admission (7 p.m.) the child was operated upon. The usual incision was made over the tumour, and the sac exposed; on this being opened blood-stained serum escaped. A coil of small intestine, quite black in colour, was found tightly strangled at the neck of the sac. The constriction was divided, and the bowel pulled down for a short distance and examined. The hernia was then easily returned, the sac removed, the internal abdominal ring closed with sutures, and the operation completed as usual.

After-progress.—Recovery was uneventful, with the exception of slight retention of urine for the first day after operation. At the end of fifteen days the child was completely well and was discharged from the hospital.

REMARKS.—I have thought the case worthy of record owing to the very early age of the patient and the extremely satisfactory result of the operation. I am indebted to the House-Surgeon (Dr. G. Young) for the notes of, and his careful attention to, the case.