FULMINATING MYELOGENOUS LEUKAEMIA.

BY

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THE case here reported is remarkable chiefly for the uncommon commencement and history of such a case, and also on account of the extreme rapidity of its progress.

The patient was a young man of 28, who had previously enjoyed quite average health with no particular history except of influenza (which his wife and child also had) at Easter. When I saw him on June 11th he said that his friends told him he spoke so softly that they could hardly hear him, while it seemed to him that he was speaking loudly. At the same time he had found on testing that he was "rather" deaf. I found that he was almost equally deaf on both sides and could only hear my watch, which has a loud tick, two inches away. He could, however, hear on the telephone fairly well. He had some wax in the right ear, but the hearing was no better after its removal. The tonsils were large and flabby but not inflamed, and the pharynx was granular. He complained of having catarrh in the nasopharynx, but said that otherwise he felt as fit as ever. I prescribed nasal douching, and saw him again on June 16th. His hearing was the same, and he still said he was quite as fit as usual but annoyed at the deafness. As he thought he was a little better I told him to continue the douching and return in a week. On June 23rd he was rather more deaf but felt the same. I arranged then for him to see Mr. F. J. Cleminson, who told me that the whole of the lymphoid tissue of the nasopharynx was in a state of hyperplasia, that the deafness was mechanical, due to the blocking of the Eustachian tubes by this, and that vigorous local treatment was indicated. He asked me to see if any lymphatic glands elsewhere were swollen, as he suspected lymphadenoma or some general lymphatic condition.

I examined the patient on June 24th, but beyond a small gland in the left axilla could find nothing abnormal. The spleen was not palpable. I visited him on June 27th; he was thoroughly annoyed at being kept at home doing the nasal drill, etc., "as he felt so well." On June 30th he had a swollen submaxillary gland and the gums looked a little red. That evening for the first time his temperature was raised (99.6°). On July 1st the gums were more swollen and looked a little bluish, the submaxillary glands were larger, and he had some swelling beneath his tongue. The temperature was normal in the morning and 101° at night. On July 2nd the gums began to bleed and he also had some haematuria, and the temperature rose to 102.4° at night. I had ordered him arsenic that morning, and he had kept to his bed since the morning of July 1st, which was the first time he began to feel that he was "not well."

On July 3rd his condition was similar but he was weaker. The spleen was just palpable. A blood count showed 5,250,000 red cells and 200,000 whites; one-eleventh of these were polymorphs and there were numerous myelocytes. The condition now became rapidly worse. His deafness increased, he became pale and more swollen in the face, and the evening temperature was generally above 102°. On July 5th the spleen was two fingerbreadths below the costal margin. On this day he began to take capsules of benzol. The gums ceased to bleed on July 7th and the haematuria also stopped. The mouth was intensely uncomfortable; he rinsed it frequently day and night, but was unable to sleep for more than ten minutes at a time, chiefly on this account. He lost ground generally each day. A blood count on July 12th showed 1,900,000 red cells, 206,000 whites, 30 per cent. haemoglobin. Of the white cells 94 per cent. were myelocytes, 1 per cent. lymphocytes. On July 13th he was in a critical condition, but because his brother was arriving from America strenuous efforts were made to keep him alive with strychnine, camphor and ether, digitalis, and oxygen. He was delirious most of the day and died late that night. His spleen was never more than four fingerbreadths below the costal margin. The glands of his neck became larger each day. He certainly had the look more of a lymphatic leukaemia than a spleno-medullary. The two counts were done by different pathologists.

The only mouthwash which relieved him at all, among several which were tried, was carbolic and liquor potassae. He died thirty-four days after he was first seen, twenty days after he was last at business feeling quite fit, thirteen days after first going to bed—that is, after he first began to feel ill. I am much impressed by Mr. Cleminson's suspicions, which turned out to be quite near the mark, though at that time there was little enough to go on. I have not been able to hear of a similar commencement of this disease or a more rapid termination.

A METHOD OF FIXING HOOKS TO ADHESIVE STRAPPING.

BY

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ALEXIS CARREL, in his book on the treatment of infected wounds, described a method of closure of a granulating wound by elastic traction. To the edge of a piece of adhesive strapping he fastened a series of shoe hooks by the instrument commonly used by shoemakers. Around these hooks he passed in a criss-cross fashion an elastic ligature. When this was pulled tight the edges of the wound approximated. The great advantage of this method

FIG. 1.

over the usual "strapping" of a wound is that the adhesive material need not be removed each time the wound is dressed. The only disadvantage is that the shoemaker's hooks and the instrument for inserting them are rarely available.

Recently I have been using the hooks of the domestic hook-and-eye variety. To sew the hooks on to adhesive strapping is a laborious and annoying business, but by the method here figured any number of hooks may be firmly fastened in a few moments.

FIG. 2.

A strip of strapping is folded longitudinally but not quite in the middle line, leaving the sticky side out. A tiny nick with the scissors is made in the fold, but only just large enough to allow the hook, but not the flattened circles, to be pulled through. A second piece of strapping is placed over the first, as in Fig. 2, sticky side downwards. The dotted lines indicate the adhesive sides in both pieces of strapping.

When enough hooks have been inserted, the armed strapping is fixed to the skin parallel with, and about

FIG. 3.

one and a half inches from, the edges of the wound. The hooks are then laced, as in Fig. 3. It is not necessary to use an elastic ligature. A piece of silk serves admirably, and slides smoothly through the hooks.

It is possible that this handy method may have been described before, but I have not come across it in surgical literature.