A CASE OF FRACTURE-DISLOCATION OF THE ODONTOID PROCESS.

BY

H. C. WARDLEWORTH NUTTALL, F.R.C.S.,
HONORARY ASSISTANT SURGEON, LIVERPOOL ROYAL INFIRMARY.

THE increasing number of motor accidents, many occurring in country districts, creates a corresponding demand for a fuller knowledge of injuries, especially of bones and joints, from all practitioners.

Fractures or fracture-dislocations of the neck are more frequently seen nowadays, even allowing for more accurate diagnosis. On general grounds I fear they may be expected to occur more frequently in the future, and I submit the following record as an illustrative case.

On June 20th, 1928, the patient, a middle-aged woman, was sitting on the off side in the rear seat of a touring car. As the result of a collision at a cross-roads the car was turned over on to its near side, and the patient was thrown out, the left side of her head striking a wall which bordered the foot-path. Her husband, after extricating himself from the driving seat, found his wife lying in a "huddled-up" position. She did not lose consciousness, and complained immediately of pain in her neck. With the help of two other men she was carried into a neighbouring cottage, her husband lifting her head and shoulders. He says that her coat was rucked up about the neck, and thinks that it prevented any further displacement of the head.

Dr. L. Hutchinson of Huyton, who attended almost at once, diagnosed a fracture of the neck, fixed it temporarily, and sent her to the Royal Infirmary by ambulance.

On admission she was suffering from shock. There was a scalp wound in the left fronto-parietal region, but no signs of fracture of the skull. She complained of pain in the neck, and on examina-

tion marked prominence of the upper cervical vertebrae could be felt, with a depression above them. The head and neck were held rigidly on the trunk, and the neck appeared unusually short, probably the effect of the contracted muscles. Signs of injury to the spinal cord or cervical nerves were absent.

A temporary splint was applied; she was radiographed and treated for shock. The radiogram (Fig. 1) showed fracture of the odontoid process, with considerable displacement forwards of the atlas and odontoid fragment.

The next day the arm and leg reflexes were increased, and she had some retention of urine, otherwise there was nothing to report. The following day the reflexes were normal, and I reduced the dislocation under anaesthesia. Two assistants maintained steady traction on the head and neck by means of two traction loops, one beneath the chin and one behind and beneath the external occipital protuberance, crossing one another at the vertex of the skull. I then grasped the neck firmly from the front with my fingers on the vertebrae posteriorly and my thumbs and thenar eminences along either side of the mandible. With a steady pressure of the vertebrae forwards and a tilting of the head backwards I reduced the dislocation with a slight but quite definite click. While the extension was maintained a plaster-of-Paris bandage was applied to immobilize the head and neck. Except for a mild cystitis and a little respiratory discomfort on one occasion, due to the bandage, her convalescence was tranquil, and she was discharged from the hospital on June 30th under the care of Dr. Halton.

The plaster-of-Paris was removed on August 3rd, and a

wire collar support fitted. A radiogram taken the next day is shown in Fig. 2; it reveals slight over-reduction if anything, but this may be due partly to the position of extension of the cervical vertebrae in this radiogram as compared with the first.

Since September 1st the collar has been left off gradually, and the range of movement has steadily increased. At the present time (September 22nd) nodding movements are free, but twisting of the head from side to side is limited to 50 per cent. of the full range.

I am indebted to Dr. R. E. Roberts for the first radiogram, and to Dr. J. H. Mather for the second.

FIG. 1.

FIG. 2.

TREATMENT OF NON-SPECIFIC DIARRHOEA IN THE TROPICS.

BY

C. V. THORNTON, M.B., Ch.B.,
BOMBAY.

THE common occurrence of diarrhoea in children and adults in the tropics without any traceable cause is one of the many thorns in the flesh of the general practitioner. Very often his reputation will be made or marred by his success or failure to treat what is to the public a simple disease, but which in reality is a most complex condition.

In consequence of the innate conservatism of the profession the same old mixtures are copied religiously from textbook to textbook. Every mail brings pamphlets of new and futile proprietary drugs, drugs which are only equalled in their general inefficacy by their numbers. The four main types of tropical diarrhoeas are: (1) the dysenteries; (2) sprue; (3) tuberculous or syphilitic; (4) diarrhoea not caused by any of the above.

The patient's history will generally serve to allocate the diarrhoea to one of these groups. Thus, in the case of dysentery there will be a history of pain and tenesmus. Fever is a common accompaniment, and, of course, blood and mucus will be present in the stools. Here let me strike

a note of warning: never be satisfied with the patient's assertion that he has looked for these two phenomena—make sure for yourself.

Sprue is generally easy to diagnose. The patient seldom comes in the very early stages of the disease, and by the time the doctor sees him there are the typical signs of emaciation, putty-coloured stools, and most probably the tell-tale sores in the mouth. Moreover, if you inquire closely, you will elicit a story of long-continued "indigestion" and flatulence.

Tuberculous and syphilitic diarrhoea are more difficult to diagnose. The former frequently shows signs elsewhere, or there is a history of an old pleurisy or some other lung complaint. The physical findings in the abdomen often help. As regards syphilis, if the possibility of this disease in all obscure cases of diarrhoea is borne in mind, and a careful history taken together with a blood examination, a mistake ought not to be made.

It is the fourth group that we are specially concerned with, and here the history of the case is nearly always the same. There is no pain, no change in the colour of the stools, which are liquid but otherwise normal in appearance. The striking fact is that ingestion of food causes an immediate evacuation; or, as the patients express it, "the food runs through them." Examination of the stools reveals nothing of note. The presence of undigested food,