A Mirror of Hospital Practice.

CASES FROM PRACTICE,

By Surgeon-Major J. O'BRIEN, M.A., M.D., F.R. C. S. E.

In the *Indian Medical Gazette* for February last an interesting case of penetrating punctured wound of the skull caused by a bayonet thrust is reported by Assistant-Surgeon T. M. Shah. It is described as "a small triangular wound on left side of the head over the parietal bone. It was a penetrating wound communicating with the cavity of the skull; splinters of bone could be felt to have sank in also." The patient was admitted on 20th August. Fever due to imprisoned discharge, and, no doubt, decomposition of the discharge supervened in five or six days, and lasted for about fortnight, threatening life. On 4th September copious discharge from the wound is reported, This continued up to 31st October when the report is "wound still emitting matter, minute osseous spiculæ also discharged." On 22nd December, the date on which the case is reported, it is stated that matter was still discharging. The man survived, but the case was protracted for nearly five months. The local treatment appears to have consisted of carbolic oil and iodoform dressings with fomentations varied with cold lotions, and internally aconite; bromide of potass and at one time liquor hydrarg. perchloride were administered. It struck me in reading the case that if the latter, combined with removal of the fragments of the bone, had been assiduously employed externally, the result would have been more satisfactory. As a contrast to this case, I venture to report one of a somewhat similar nature in which treatment of this kind was adopted.

1. *Compound depressed fracture of the skull, trephining, recovery.*

A Mussulman female, aged 40, was brought to the Burdwan Municipal Hospital on 28th May last, with a contused wound of the head which she had received the previous evening in a quarrel with another woman. It appeared that her adversary had struck her on the top of the head with the corner of a brick bat. The hair was found matted with blood, and the wound itself was covered with a piece of dirty rag. The woman was conscious and pupils even, but the pulse was slow, and she complained of nausea and vertigo.

On shaving the scalp a linear contused wound two inches in length was found over the left parietal bone 1 inch to left of, and parallel with, the sagittal suture. Anteriorly it terminated close to the position of the coronal suture. On examining the wound with a probe the bone was found to be exposed, but as the probe glided smoothly over its surface, no fracture was detected. On exploring with the finger, however, a circular depressed fracture about one inch in diameter, of the "gutter" variety was readily discovered. The patient was placed at once on the operating table, the scalp and wound thoroughly cleansed with perchloride lotion (1 in 2000), chloroform administered and the longitudinal wound converted into a crucial one by an incision two inches in length down to the pericranium across the centre of the fracture. The original wound was also extended for half an inch backwards. The angular flaps thus formed were raised by retractors and the fracture exposed to view. An even circular depression of the bone was seen with a few cracks radiating from the centre. In some parts the depressed bone was still adherent at the edges. As elevation of the depressed bone appeared to be feasible, I applied the elevator and worked out a few pieces, but only the outer table came away. As the space was further cleared, it was seen that the inner table was much more extensively fractured than the outer table, and that a large detached piece lay on the surface of the dura mater. The dura mater itself was not torn, but there was slight hæmorrhage going on from a lacerated vessel on its surface. As it was found to be impossible to remove the fractured portion of the inner table, either with the elevator or with forceps, I cleared the pericranium from the bone round the anterior border of the fracture and removed a disc of bone forming about three-fourths of a circle—the remaining fourth being over the depression—with a three-quarter inch trephine. Even through the opening thus formed, so much difficulty was experienced in the attempt to extricate the fragment of the inner table entire that I had to split it carefully with bone forceps, after which the pieces were got out easily. The bleeding point which proved to be a small branch of the middle meningeal artery was then seized for a few minutes with compression forceps upon which the bleeding ceased. The wound was next douched with perchloride lotion, a tube inserted, the flaps brought into place with wire sutures, the incisions covered with Lister's protective, freely sprinkled with iodoform and dressed with a layer of Sal Alembroth wool covered with impermeable jacconet. The operation lasted about ½ an hour. The evening temperature was 100·4°. Next day it became normal, and never rose beyond this during the healing of the wound. The dressings were changed on the 5th day after the operation, that is, on 2nd June. The wound was found to be clean, not a drop of pus had formed. It was dressed again on 7th. Again on 12th when the tube was removed; again on 16th, and finally on 21st, by which time healing was almost complete. Thus only five dressings were applied altogether, and the later dressings were changed more through curiosity than necessity, as they were quite dry and free from discharge. No pus formed from first to last. The woman was dis-

charged with a firm cicatrix, slightly depressed where the bone had been removed on 25th June.

Case II.—Strangulated hernia with radical cure by excision of the sac.

This case affords an illustration of the advantage of early operation and strict antisepticism in cases of this kind.

At 8 p. m., 12th Nov. 1888.—I was called in to the bazar to see a man, aged 30, said to be suffering from an obstructed hernia. I found him in intense agony and practically trying to stand on his head to obtain ease from the pain. He had of his own accord assumed the genu, or rather pes-pectoral position to relieve the dragging pain of the hernia, *i. e.*, while standing with his feet on the ground he was leaning his head on his arms, which were resting on a pillow on the ground. Examination of the hernia showed that it was a tense and acutely strangulated right inguinal or rather scrotal hernia, the size of a cocoanut. As there had been no stercoraceous or other vomiting, the case had been diagnosed as "obstructed" hernia and taxis vigorously applied by the medical practitioner in charge. Profiting by the hint given by the patient's position, I placed him on his back and with the pelvis well raised and the thighs flexed, tried the taxis myself, but a brief trial convinced me that the attempt was futile, and that further persistence in it would be injurious. I had the patient accordingly sent to the municipal hospital for operation.

The history given was that he had had a reducible scrotal hernia for three years, which became painful and strangulated at 3 P. M., *i.e.*, 5 hours before I saw him. At 9 P. M. he was placed on the operating table, and the parts shaved and cleansed with perchloride lotion. It was then seen that there were two tumours in the sac, *viz.*, the old scrotal hernia and a very tense knuckle of gut close to the ring which had evidently descended recently and caused the strangulation. Chloroform having been administered, the usual incisions were made. The sac had to be opened, as the stricture was found to be in its neck which was dense and unyielding. The newly descended knuckle of gut at once slipped in, and the coils in the scrotum were got to follow it without trouble. The sac was them separated from the scrotum and pulled well down, the neck pierced with a stout catgut ligature and tied in two places about an inch apart, so as to form a firm plug for the canal. The body of the sac was then cut away, and the stump pushed within the pillars of the ring which were brought into opposition with a couple of gut sutures; two drainage tubes were introduced, *viz.*, a long one from the external ring to the bottom of the scrotal pouch and a shorter one for which an opening was made in the skin outwards towards the groin. The careful drainage of the site of the incision is a point of some importance, as the oozing which takes place from the cut surfaces cannot escape freely by the lower tube while the patient is in the recumbent position, hence it gravitates towards the flank and not infrequently gives rise to the formation of pus or otherwise delays the healing of the wound. A tube passing from the bottom of the incision in an outward direction obviates this tendency.

The wound was dressed as in the previous case, save that pads of sublimate wool were used instead of the Sal Alembroth wool.

The temperature next morning was 100·4°, evening temperature 100°. On the following morning it fell to 99·6°. For a few days there was an evening rise to 100·5°, owing, no doubt, to the condition of the intestines. The bowels were not moved for five days. On the 6th morning a caster oil enema was administered which produced a copious evacuation. The dressings were changed on the 4th day, when the small tube was removed, and the long one shortened by half. The incision was found to have united by first intention; there was not a trace of inflammatory action and no pus. Only two more dressings were applied, and they were removed altogether on the 12th day. If I had withdrawn the lower tube at the 2nd dressing, the healing would have been more rapid. The patient was kept lying down a few days longer and was discharged radically cured on 4th December. The part was supported with a belt of 'nawar' with a cotton pad attached after the fashion of a Lund's truss. I saw this man again three months later, *viz.*, at the end of February 1889. The hernia was completely cured, and there was no sign of any tendency to return. The 'nawar' truss caused an abrasion at first which obliged him to lie up for a few days, but he now wears it without discomfort, and as it affords a comfortable support to the part, I advised him to continue its use.

Case III.—A Hindu labourer, aged 45, came to the hospital on 19th November last on account of a large tumour in the scrotum which hindered his daily work. The scrotum was as big as a child's head. Examination of the tumour showed that it consisted of a right hernia of considerable size and of a large left hydrocele. As the patient was anxious to get rid of the encumbrance caused by the size of the scrotum, he consented to undergo the operation for radical cure of the hernia. After the usual preliminaries of clearing out the bowels and thoroughly cleansing the part, the operation was performed on morning of 20th November. The hydrocele was first tapped. In other respects the operation was practically identical with that described in the last case. The cremasteric and transversalis fascia surrounding the hernial sac were much thickened. The fundus of the sac was stiff and horny from incipient cal-

cification, and a small portion was so intimately blended with the adjacent tunica vaginalis of the testicle that it could not be separated. It was accordingly left, and the rest of the sac cut away. The patient made a quick recovery and left the hospital radically cured of his hernia on 8th December, that is, 18 days after the operation. The incision healed by first intention as in the previous case, but the track of the lower tube through the loose and baggy scrotum gave some trouble, as it was not easy to apply the antiseptic dressings efficiently to this part especially as the hydrocele fluid had begun to accumulate again. It was my intention to deal radically with the hydrocele when the hernia was cured, but the man got impatient and left the hospital before this could be done.

If a similar case came under my care, I should certainly excise the vaginal tunic of the hydrocele and clip away the redundant tissue of the scrotum when dealing with the hernia, and thus radically cure both hernia and hydrocele at the same time. In the last volume of Braithwaite, page 365, a paper by Mr. Henry Morris on the "Radical Cure of Hydrocele" is reproduced. In it he mentions a case upon which he had operated, in which a vaginal hydrocele was associated with an encysted hydrocele of the cord and a bubonocele. He excised the sacs of both the hydroceles and of the hernia at the same time, and closed the pillars of the ring in the usual fashion, thus ridding the patient of all his troubles by one operation. I have myself recently dealt with a case of enormous right hæmatocele and left hydrocele by excision of the hypertrophied tunica vaginalis on both sides, and pruning away the redundant tissues of the scrotum. The man left the hospital in about 20 days quite cured of his troublesome disease and with a scrotum of normal size.

3*rd April* 1889.

ASKA DISPENSARY.

POISONING BY STRYCHNOS NUX VOMICA.

By J. VENKATA SWAMY, L. M. S.

Lohakno, an adult male, was brought to the dispensary, Aska, at 7-30 A.M., on the 17th February 1889, with the following symptoms: Giddiness of head; a sensation of swimming of the whole body; feeling of numbness in the trunk and more markedly in the lower extremities; dryness of throat; slight injection of the ocular conjunctivæ; heaviness of head; occasional backward jerking of the head, sometimes developing into a flying fit of opisthotonos while or in the point of taking medicines; consciousness perfect; respirations 16 per minute and unaltered in quality; pulse slightly frequent; and weak articulation of speech confused as in a state of alcoholic inebriation, and facial features generally indicative of fear and despair.

The history of the case is that the patient had been for some time a victim to gonorrhœa, and was advised on consultation with a friend of his to take internally the root of Strychnos Nux Vomica well ground with equal parts of sugar and black pepper, and made into a mixture with water. He had taken the medicine at 7 A. M., and first observed the bad symptoms half an hour after. The spasms of the back were brought on by any exertion on the part of the patient to swallow any medicines, more powerful disturbances of his person in other directions being found ineffective and unrepresented. The muscles of the lower jaw and the pupils of both eyes were unaffected. The exact quantity of the root taken cannot be made out. The patient suffered severely from painful muscular cramps in his legs, so much so that they afterwards rendered the calf muscles as tender as a suppurating abscess, though the cramps only continued for not more than two hours.

Treatment.

℞

Sulphate of Zinc	℥ij.
Aqua	ℨij.
Ft. haust.	stat.

Followed by free drinks of warm water. Vomiting was excited only thrice.

℞

Acid Tannic	℥j.
Carbo Animalis	℥j.
Fiat pulv. iv.	
Sig: one every ½ hour.	

℞

Spt. Chloroform	℥ss.
Tinct. Aconiti	mviij.
Aqua ad.	℥viij.
Fiat Mist.	
Sig: one-eighth part every half hour.	

At 11 A.M. the patient showed signs of complete relief, and was discharged cured at 4 P.M. on the same day.

The opisthotonos being excited by bodily exertion in a particular direction is an interesting feature of the case, which is likely to arrest the attention of the reader. Just as in cases of hydrophobia, the mere idea of, or the act of swallowing medicines, induce spasms of the muscles of the lower jaw, so has the swallowing of medicines, nay, even the mere idea of medicine, in this case, excited spasms of the muscles of the back. The facts, that the patient often withdrew, as in a shock, from the medicine asserting that the sight of a glass of medicine simply made him recall to his memory the poisonous dose he had taken that morning, and that the spasms of the back muscles were excited by the act of swallowing only, go to charge his mind with instrumentality in causing spasms, the mental excitement caused by the sudden flashes of memory of the toxic medicine probably serving to produce spasms through the already irritated and unstable nervous centres of the spinal cord.

Aska,
February 1889.