MEDICAL SOCIETIES.

SAN FRANCISCO POLYCLINIC GATHERING.

Concluded from p. 30, Vol. IV, No. I.

On the 25th a rose spot was seen on abdomen. Patient has the so-called typhoid odor. Pupils again equal and react. Patient resists examination; impossible to elicit knee jerks. No Babinski, no Kernig. During these days the temperature ranged from 100 to 102.5° F., the pulse from 84 to 110, respirations from 22 to 26. Lumbar puncture could not be performed owing to patient's resisting.

As matters now stood, I gave the patient the benefit of the doubt and treated him as a typhoid. We know that not infrequently typhoid fever gives us meningeal symptoms. It was yet too early to expect a Diazo or a Widal. Our leukocytes and the beginning with a chill seemed evidence against it being an uncomplicated enteric fever, and these, together with the right lung changes, as well as the report that herpes had been present on admission, caused our giving a possible pneumonia a few thoughts. But the absence of bronchial breathing, of cough, of expectoration, with slow respirations and fairly good heart action, led us to exclude pneumonia with certainty. The lung affair was considered as purely bronchial, with an old right-sided pleurisy, of probable bacillary origin, owing to its having run a fairly latent course, the boy never knowing of its existence. Again, the absence of cyanosis, dyspnea and presence of good pulse weighed against an acute miliary tuberculosis. There was no reason for suspecting the existence of a malignant endocarditis. Hysteria was out of the question. The absence of vomiting, convulsions, Kernig hydrocephalic cry, sufficient retraction of abdomen, hyperesthesia of skin and special senses did not as yet permit a positive conclusion as to the existence of a meningitis.

On the 26th the boy was quite clear mentally, and lumbar puncture was possible. Left pupil is definitely larger to-day. K. J. not elicited. Kernig questionable owing to resistance of patient. Voids urine in bed.

Monday, the 27th, the temperature was 99° at 4 a. m., a drop of 3 degrees in 4 hours, but it began to rise immediately. Tenderness under left costal margin, but spleen not palpable. The cerebro-spinal fluid obtained yesterday was examined now, a piece of work deferred from Sunday, owing to lack of time. Fluid was clear. Centrifugalized and sediment stained: Very great lymphocytosis, no tubercle bacilli but quite a few extracellular, uncapsulated diplococci. The slides used were unfortunately not new, and I could not swear whether or not they came from the fluid which seemed too clear for such a number of bacteria. And this very point now made it impossible to say whether a coccal meningitis existed. The restlessness of the patient (the presence of the boy's father) and having once seen a needle break under such conditions, as well as the lack of therapeutic justification, prohibited a second lumbar puncture. Examination of fundus was also impossible.

Tuesday, 28th, pupils equally dilated, react slowly to light. Neck rigid and patient cries with pain and fright when one tries to see if spine is rigid. Tache and cerebrale and Kernig definitely present. Urine and feces passed in bed.

Wednesday, twitching of muscles of upper extremities. Diagnosis positively meningitis, probably tubercular.

Thursday, right pupil dilated, left small, neither reacts. Does not shut left eyelid as firmly as right. Tongue protruded to left of median line. Kernig. No K. J. No Babinski. Twitching, especially of fingers of left hand. Delirious only at times. Has no headache. Rather cyanotic. Heart sounds weak. For first time patient raises a little sputum, which with difficulty he is made to expectorate. It is mucopurulent, contains many pneumococci and a few scattered cocci. No t. b. found. Right lung gives a tympanitic note over first space. Rales over both lungs. Trophic pressure, sore right hip.

Friday the boy died at 3:30 a. m. The autopsy was performed but a few hours later by Dr. Blumer. To give in short the pathological findings: The abdominal viscera were normal but for slight congestion of kidneys; one or two very small tubercles in spleen; few small tubercles upper surface of liver; caseous glands at hilus. The right lung was adherent to pericardium, diaphragm and chest wall. Occasional tubercle in apex, also slight congestion of upper lobe. Left lung, fresh adhesions at apex and few tubercles in apex. Patch of beginning broncho-pneumonia lower lobe. Heart normal. Early fatty atheroma of beginning of aorta, of coronaries; fatty patches in descending aorta. Tuberculosis of glands anterior mediastinum, bronchial and tracheal, latter caseous. Brain: dura normal, sinuses free from clots; slight increase of fluid in sub-dural space. At base and running up towards vertex, along larger vessels, a moderately extensive greenish yellow inflammatory exudate. An occasional tubercle to be made out along the vessels. Brain tissue soft and a little edematous, and adhesions between lobes. Vertex free of tubercles. All ventricles dilated and contain slightly cloudy fluid, smears of which show only lymphocytes. Single tubercle on right choroid plexus. Small mass of tubercular granulation tissue attached to free edge of left choroid plexus. Basal ganglia, cerebellum, pons and medulla normal. Cord not opened. Cultures taken from fluid at autopsy gave no growth.

Death from Antikamnia (?) by Dr. R. Bine: Miss W., age 22, becomes a nurse at the French Hospital. For a few days she has some headache, but only mentions it to other nurses as she wishes to remain on duty. Headache increases in severity and menstruation beginning, rest in bed is ordered her and antikamnia tablets prescribed. July 12th patient takes 40 grains of this drug; July 13th the same amount and July 14th, before 4 p. m., consumes 30 grains of antikamnia and some ammonia besides. I will add that nobody was aware of the amounts used until events caused an investigation. At 4 p.m. patient complains to a nurse that her headache is, if anything, worse. This nurse returns inside of fifteen minutes and to her horror finds her friend unconscious, not breathing at all, very blue. Doctors come in haste and artificial respiration is begun. Patient regains normal color. And from this time on until 11:30 a. m. of July 15th, artificial respiration is continued—a total of 19 hours of what proved to be very difficult work, all to no result. If for a few seconds the movements were discontinued, respiration ceased, cyanosis recurred, pulse became very rapid, weak and irregular. At first heart action was regular, not fast, strong. As the hours sped, it became gradually faster and weaker. At 11:30 a. m. cardiac sounds had become inaudible and the patient was declared dead. Needless to say that every known method for stimulating the respiration centers was tried in vain. From time to time the patient was catheterized and the urine examined. To the last it was practically normal; it never contained any blood cells or blood pigment in any form.

The absence of cyanosis as soon as artificial respiration was begun, the good cardiac action, the urine, as well as the history of headaches, made us think the drug alone was not responsible for the death.

From the patient's sister (who had been sent for) we learned that the dead girl had had diphtheria at 5 years of age and that during childhood she had frequently had severe headaches. The only pathological finding disclosed by a very carefully performed autopsy was a very marked internal hydrocephalus, with occlusion of the foramen of Magendie. The respiratory center, we judge from the chemical aspect of the case, was perhaps more vulnerable than the cardiac, and that it therefore suffered first from either the pressure of the fluid or from the toxic ac-

tion of the drug. The occlusion of the foramen, in our opinion, must have been caused by an old meningitis, and on this hypothesis do we exclude an otherwise possible diagnosis—the angioneurotic form of hydrocephalus—the so-called "meningitis serosa of Quincke."

Evidently intercranial pressure was increasing and causing the severe headache. Small amounts of acetanilid, even but one dose of 25 grains, has been known to cause respiratory paralysis and death; but in all cases reported of acute poisoning cyanosis persisted, urine findings were positive, and the pulse was weak and irregular. In this case we are therefore unable to say just how much we are to ascribe the respiratory paralysis to the drug, how much to the pressure.

We take this opportunity to thank the French Hospital staff, all of whom clinically saw more of the case than we did, for their kindness in permitting this report.

Dr. Levison: I would also call attention to the present terrific destruction in cases of poisoning. I have in mind a patient, I think it was about two years ago, in her eighth month of pregnancy. She took 90 grains of antikamnia, and when I saw her some hours after the taking of this large dose, she was extremely cyanotic, and an examination of the blood made within the 24 or 48 hours following the administration of this, showed a terrific destruction of the red corpuscles; the count was as low as a million, which gradually increased. She made a very good recovery, and a month later gave birth to a girl.

Some time ago, D. L. Brown wrote an article upon this subject, which was a very exhaustive one, and explained the matter very thoroughly.

Dr. Bine: The first thing I would like to ask is if the taking of this drug did not cause the patient's death. I didn't report the case as a case of antikamnia poisoning. I stated she was a hysteric patient, and took a big amount of the drug, which terminated in hematoporphyrinuria, which I believe was the cause of death; but the point which interested me particularly was if the taking of the drug could in any way have hastened the necessarily fatal attack. I don't know personally whether it could have, but the fact that it did come up at that time leads me to believe that the patient would have died eventually from the hematoporphyrinuria. She had had headaches right along before she took the drug, and it was only a natural sequence. I think her death would have resulted from it, but would like to hear from some one who will explain whether taking this drug could have caused a destruction of the blood, or in any other way could have hastened matters.

Dr. Smith: I would like to call the doctor's attention to the fact that in the year 1894 I reported a case and it was published in the *Virginia Medical Monthly*, of a patient who had a slight attack of grip. The patient was apparently well, had only been sick some few days prior to this time. I gave a few doses of calomel about 1 o'clock, and about 2 o'clock a cessation in breathing occurred, with the heart beating normal. There was no response to the steady process of artificial respiration, and we kept it up something like an hour or two, with respiration about forty-two. We had exhausted everything else in the community, and finally pressed into service a rather intelligent negro, and after explaining the situation came the answer: "I isn't in the resurrection business."

COOPER COLLEGE SCIENCE CLUB.

At the meeting of the Cooper College Science Club, held January 8th, Dr. Ophuls exhibited specimens of atheromatous aorta injected with paraffin at blood pressure. They showed that contrary to Thoma's contention in the beginning of this disease there is no evidence of primary weakness of the muscle. A paper by him on the subject will be shortly published in the *American Journal of Medical Sciences*.

Dr. Garrey discussed this paper, saying that he had done a little work on this subject and had arrived at the same conclusions with regard to the primary changes in the media.

Dr. M. Cosgrave read a paper on the "Report of Three Cases of Sporadic Cretinism."

In discussing these cases Dr. Hirschfelder said: I think the results in these cases are beautiful, especially in the case of the first child. I think hardly anyone would suspect cretinism at present, but the picture shows that the case is quite evident. At present the symptoms are by no means marked. This speaks well for the treatment, and also for the preparation used, for these preparations are not always fresh.

Report of a Case of Fracture of the Skull, with Demonstration of the Specimen, by Dr. Winterberg: This is not a very remarkable case, but is a very good specimen of a fracture of the skull. The man was about 35 years of age. He was injured by a blast in a quarry. His previous history has no bearing on the case. He was an English physician with the morphine habit, and had taken up this hard manual labor in order to break himself of the use of this drug. On the 28th of December, while coming from the quarry, a blast went off and struck him. He was found lying on the ground, conscious, bleeding from the nose and back of the head. His chest was riddled with holes, many of which were bleeding. Through one the air was blowing in and out. He was taken to San Rafael, and I saw him five hours after the accident. The temperature was 98, pulse 120, respiration 32. He had no headache, no dizziness, and no paralysis. Nothing referable to the head. He complained a great deal of pain on the left side. The next day I saw him again in consultation with a doctor in San Rafael and found his condition slightly improved. He felt stronger. The pulse, while still rapid, was somewhat better. The dressing was removed, the man walking to the table himself. A fracture was discovered just above the occipital protuberance. A depression was made out. It was cleaned and bandaged. His back was covered with a large number of wounds, mostly ragged, varying in size from a pin point to quarter of a dollar. Some 1½ inches in depth. On probing through the one through which the air had been coming in and out we found a fractured rib. The left side was solid and filled with blood up to the seventh rib behind. The wounds were dressed. Arrangements were made to bring him to San Francisco, but he refused to come over, and as his condition did not seem to warrant any operative interference, he was left there with his physician to watch him. The next morning he died. A post-mortem was performed. He evidently bled to death during the night through this wound in the chest wall, which had been closed while it had been examined. The clothes and bed and dressings were saturated with blood. There was nothing abnormal found, except this fracture in the head. The skull was removed, but no injury was found to the brain. The membranes were not ruptured. There was no blood clot further than that the inside of the bone was covered with a light layer of blood such as could have leaked in from the outside. The question was, what could we have done for the man under the circumstances? The indication, as far as fracture was concerned, was very simple. We could have trephined, but in view of the surroundings it seemed to me better to wait until the next day, especially as there were no symptoms referable to this fracture. Opposite this wound, 2 inches from the articulation with the seventh rib of the spine, the lung was torn. There were two large gashes. Some pieces of rock and shirt were extracted from this opening. Another question was what to do for the hemorrhage which he was so

evidently having in the pleural cavity. It was not possible to determine whether the hemorrhage came from the pleura or the lung. There was no cough, no blood. His pulse was fair. The amount of fluid pressing upon the heart interfered with the respiration considerably, but if that had been drawn off probably the hemorrhage which had stopped at that time would have begun again. We could have made a resection of the ribs, but it was so high up, more than one rib would have had to be resected. Suturing is not of much value. The cautery might have been tried.

Dr. Rixford said, in discussing the case: This case is interesting in that it has brought up a good many very interesting problems with regard to fractured skulls, as well as thorax conditions. This man was not unconscious at all after the injury; was able to talk within a few minutes. The fracture of this part of the skull, although it did not cause any symptoms and although it did not lacerate the dura, certainly would cause subsequent trouble, and I think that in cases where there is very much doubt of fracture, in a large proportion of cases, it is good surgery to make an exploratory incision. It so commonly occurs that the internal plates are broken much more extensively than the external plates and will lacerate the dura, and in a considerable number of cases you have no symptoms to determine the matter. With regard to the condition of the thorax, I think the indication is plain to suture the lung or to use the cautery, provided the diagnosis is made and the condition such as to warrant the operation, although suturing is not altogether successful. I had a case of a man shot through the abdomen and through the chest. I saw him some few hours afterwards. The physicians who had examined him had made up their minds that there was no indication for operation. Subsequently there developed symptoms which made it necessary to operate. Persistent pain in the abdomen particularly. We opened the abdomen and found a number of perforations which we sewed up. The wound in the chest did not receive the consideration it should have. It was a small wound and bled only a little. The skin covered it in such a way as to form a valve and prevented bleeding. At the same time the patient was able to bleed into the pleural cavity and bleed to death, and this is what happened. We did not know that this wound of the chest wall penetrated. I neglected to put in my finger and hunt for the hole. I knew that another surgeon had previously taken out a bullet immediately under the skin a few inches from this point. Had I found the hole and percussed the chest and determined that there was an increased dullness, I should have opened the chest and attempted a suturing of the lung. This case is similar to the one reported.

Dr. Clark: I had a case somewhat similar, where a man was injured, the lung being torn by a piece of rock. A rib was fractured at about the fourth rib. The interesting point was that while there was not much hemorrhage the air was rushing in and out. A dressing was put on and strapped and the man did very well, but later an abscess formed in the lung which broke into the bronchi and a piece of rock was spit out through the mouth. The man recovered.

Dr. Stillman: In regard to the lung condition in this case, I think that it might have been recognized sooner that there was a continuous hemorrhage. I do not think there is any indication for opening a thorax because of a penetrating wound or collection of blood. But persistent hemorrhage should have been an indication for interference. If it is necessary to take out two or three ribs, take them out. Macewen has stopped a number of hemorrhages in that way. There is a difference in the character of wounds made by gun shot and by pieces of rock. The rock is very apt to carry in foreign bodies, but not so with the bullet. With regard to the skull, I think it is better surgery to expose the fracture and to open the wound well enough to see the condition inside of the skull.

Dr. Winterberg, Sr.: It is easier to advise treatments in cases of this kind when you know the conditions that existed. But before you know it is much more difficult. In this case there were two conditions that required treatment. One was the fracture of the skull and the other the fracture of the ribs. If it could have been known that there was a foreign body in the lung tissue blown in there by the rock, I would have been of the opinion that interference would have been necessary, not so much on account of the hemorrhage as on account of the presence of the foreign body, which requires removal. These foreign bodies often carry infectious material into the lung tissue. As long as this condition was not known then I do not think there was indication for a resection of the ribs, on account of the two lesions which co-existed at that time, a big operation would have been a shock to the patient. I would have confined myself to the giving of medicines which stop hemorrhage. It would not have been advisable to attempt operation for the fracture of the skull so long as such a severe wound of the lung existed from which there was a considerable loss of blood and which was rapidly exhausting the patient. In the absence of any symptoms of irritation to the brain or compression, I would not have interfered. Without the symptoms of brain compression it was just as well to wait a little for the patient to interfere. I agree that trephine in these cases is the proper thing, and I recommend and do it at once if there is nothing else to complicate the case.

Dr. Winterberg, closing discussion: There was no question in my mind as to what course to take with reference to the fracture of the skull. But the question was whether the man would die of the condition in the thorax, whether it was not better to wait a few hours longer. We had no opportunity of knowing that there was progressive bleeding there. I saw the man only once and waited to make another examination the next morning, having no way to know that there was continuous bleeding there. The fault was really with the attendant who watched during the night.

Dr. Hewlett read a paper on "Herpes Zoster."

Dr. Lehmann demonstrated a Roentgen plate of a case of pododynia gonorrhea. A man of 30 years was sent for an X-ray examination of his right foot. He was complaining of severe pains on the plantar surface of the heel which were especially marked when standing or walking on the foot. The pains had been especially pronounced for several weeks, but had bothered him somewhat for a longer time, as he thinks for about twelve years, because he connects them with an accident which he had twelve years ago when he sprained that foot and was obliged to keep in bed for a month. Although these pains were localized to the right foot and the well-known sore heel due to gonorrhea is usually bilateral, I asked for gonorrheal infection and found that he had had gonorrhea twelve years ago, and several times since, the last time being about one year ago. I made plates, therefore, of both feet and found a faint exostosis on the plantar surface of the calcaneus corresponding to the insertion of the plantar aponeurosis, very much larger, rough and irregular on the right, the diseased side, and more rudimental and smaller on the left side.

These cases which have been looked upon as bursitis gonorrhetic before the Roentgen rays had been discovered are more common than usually presumed. Only lately in Johns Hopkins Bulletin seven cases have been reported. Five of the patients have been operated upon. In these the very satisfactory findings have been made of gonococci in pure culture; gonococci in sections in two more cases.