"Clinical Notes — Neurological and Surgical"

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Johnstone

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Table of Contents.

Introduction.

In the Thesis which follows, I have given only cases which have come under my own observation, as a General practitioner in Johnstone. They have all been cases in or near this district, and in connection with the surgical cases, the operations mentioned have been performed by me in the Cottage Hospital at Johnstone.

A glance at the Table of Contents on the preceding page, will shew that the cases are of two classes:- Medical and Surgical or to be more specific - Neurological and Surgical

Section I is that of the Neurological
Section II is that of the Surgical cases.

Section I Neurological.

Case (a) Ascending Myelitis in a lad of 13 years.

It is very rare to meet with a case of this fatal disease in a lad so young, and as a matter of fact, so far as my personal experience has gone, it is a disease seldom seen in general practice. The diagnosis being so difficult, & the differentiation so minute, between this disease & a few other neurotic affections.

As stated above, the lad was 13 years of age, with no history of nervous or specific disease, and the patient had up to this time enjoyed good health.

Present illness, had a history of

a

Section I Neurological.

Case (a). (Continued.)

a sprain at football two months previous to admission into Hospital.

He was sent to Hospital to be treated for Rheumatism, and when first seen, complained chiefly of pain along the six lower ribs on the left side. Some indefinite pains had been felt in legs for about two weeks before admission, and a thickness in his speech was noticed one week before admission. Both these symptoms had disappeared on admission.

On examination - pain was felt over lower six ribs; this was paroxysmal in character, and much worse during night, & it seemed to be very

Lect^re I. Neurological.

Case (a) Continued.

very great.

There was a tumour in the region of the Thyroid Gland, extending from the Cricoid Cartilage laterally to between 2½ and 4 inches, on either side. It was firm in consistency, yet some degree of fluctuation could be felt on each side. A great variation - daily - in the size of this tumour was noticed, & the effect of this on the breathing was remarkable. When large, it measured from 4 to 5 inches from side to side, respiration was difficult and stertorous, patient having to sit up with head thrown forward almost at right angles to the Sternum. When

Section I Neurological

Case (a) continued.

When small, it measured 4" and breathing became natural and easy.

Still another tumour was present, in the region of the right parotid gland, cystic in character, causing little or no pain, although it extended internally and could be plainly seen through mouth, behind the fauces.

Three days after admission, the intercostal pain having somewhat abated, it was found that he could not walk without aid, nor could he stand upright without suffering great pain in the back and legs.

Percussion of the spine caused distinct

Section I Neurological.

Case (a) Continued

distinct pain at the level of the 12th Dorsal and 1st Lumbar vertebrae. The pain thus emitted travelling down the legs as far as the knee in front, and the pot behind.

Reflexes. Deep. — Ankle Clonus was very decided, knee jerk greatly exaggerated, Superficial - Abdominal and Cremasteric very easily seen.

Four days later - 4 from admission - Voluntary power in legs was entirely lost. No thickness of speech had so far been noticed. Pain in legs had become less more severe. Pupil of left eye was much larger than right, and did not

Section I Neurological.

Case (a) continued.

not respond to light. Mouth and side of face was paralised on left side. Patient was very noisy and talkative during sleep. Next day. left pupil had diminished in size and was equal to that of right eye. Tongue deviated to right when protruded, an action that was performed very slowly; uvula pointed to same side (right); soft palate hung loosely over back of Tongue. Fluids run out of mouth on the left side; there was no great difficulty in speaking although articulation was less distinct; the lower lid of left eye drooped slightly, and

Section I Neurological.

Case (a) continued

and a choking sensation was felt after swallowing.

Two days later - 9 from admission - the arms began to show diminished voluntary power - paresis; Trembling and twitching all over body became common; ability to swallow disappeared; yet patient retained some voluntary power over hands & arms. He became unable to close his eyes, gradually getting weaker, with occurrence of coma, and died 14 days from admission

During illness temperature remained at or about normal, until the day before

Section I Neurological

Case (a) Continued.

before death, when it rose to 103, & remained between this & 101 until death took place.

Comments.

As already mentioned, this lad was very young, to be affected with this disease, as it is much more common according to records and statistics, over 20 years of age, and particularly between 20 and 30 years.

On searching for a cause, or rather more immediate cause, one is met with a great difficulty. There is no history of

Section I Neurological.

Case (a) continued.

of Syphilis in the family, nor had it been acquired by the patient; nor is there any trace of Neurotic disease in family.

The only circumstance that might be nominated as the probable cause, is the strain the boy got at football; and strain or overexertion are acknowledged to have originated the disease. I may be allowed to presume that the exertion or strain produced sufficient irritation in the Spinal Cord to set up inflammation.

On endeavouring to trace history of symptoms, it is noticed that the

Section I Neurological.

Case (a) continued..

the first, was pain along the 6 lower intercostal nerves, from the 4th to the 12th Dorsal — paroxysmal, & more severe during night, this had existed for 2 weeks before admission..

Some indefinite pain in legs and thickness of speech, appear to be the next in order, but both were at this time transient & slight. The pain in legs returned 3 days after admission, whilst the thickness in speech was again manifest 4 days after admission.

The above signs point to Inflammation in the Cord. left side - from the 6th

Section I Neurological

Case (a) continued

6th Dorsal & and including the Communicating branch - lower - of the 1st Lumbar nerve.

The next part of the nervous System to be affected, seems to have been the Lumbo-Sacral Cord and Sacral Plexus, as evidenced by the excessive pain over the 12th Dorsal and 1st Lumbar Vertebrae on percussion. The pain - shooting down front of leg to knee - points to implication of branches or fibres in the Anterior Crural and Obturator nerves, and shooting down behind to heel and foot, indicate involvement

Section I Neurological

Case (a) continued.

involvement of the Great Sciatic.. All of which nerves are connected with and form part of the Sacral Plexus.

The fact that the Deep Reflexes - Knee Jerk and Ankle Clonus, were greatly exaggerated during the greater part of the illness, suggests implication of the Cord above the arc of Reflex action - that of knee jerk being near the 2nd or 3rd Lumbar nerves. This is also supported by the pain in the legs mentioned above..

The pupil of left eye varied somewhat

Section I Neurological.

Case (a). Continued

somewhat - probably from irritation of the Sympathetic, or implication in the disease of the branch of the 3rd nerve (Cranial) going to the sphincter Iris.

Later slight Ptosis was apparent from implication of another 3rd nerve branch.

Paralysis of the Mouth, Face, Tongue, lips, uvula - point to implication of the Medulla Oblongata - Bulb - with destruction of the nuclei to the Facial Hypoglossal, Spinal Accessory, Vagus nerves, thus constituting Bulbar Paralysis of the left side.

Section I Neurological

Case (a) continued.

What may be termed the last stage in this particular case, shewed ~~last~~ signs that the disease had attacked Brachial Plexus Causing Paresis & pain.
Incontinance of urine one of the last symptoms to appear, and the highest Temperature of this illness was found a day or so before death.

Section I Neurological.

(b) Case of Scriveners Palsy or Writers Cramp.

This is one of the diseases which affect the muscles used in particular occupations.
In this case - that of a Minister - the cause seems to have been unusually trivial, the occupation being the writing of sermons, papers, lectures &c; yet this did not occupy anything like the chief part of the patients time, still the disease followed.
The patient had complained for about 5 years, of a difficulty in properly adjusting the thumb and forefinger of the right hand.

Section I Neurological.

Case (b) Continued.

hand when going to write. He wrote in a very constrained position, grasping pen between the first finger and thumb, with the former bent almost at right-angles to the middle joint.

Pain and spasmodic contraction of the muscles connected with these fingers, seem to have been the initial symptoms, which were as usual disregarded until they became more and more pronounced. Writing was a serious operation at this stage, & gradually it became an impossibility, so much so that the practice had to be given up.

Section I. Neurological.

Case (b) continued

up altogether. Learning to write with the left hand, patient was granted a short respite, and all went well for about one year, when this hand also showed signs — pain and spasm — of becoming affected in the same way.

It was at this stage I saw him first, and the above is an accurate account of the history of the illness. There is no trace of nervous disorder of any kind in his family. Patient is married and has four children, but there is likewise no nervous disorder.

Section I. Neurological.

Case (b) continued.

disorder amongst them.

The spasm complained of is very noticeable in his writing, and can easily be seen. That of the left hand is not quite so apparent. It is only minutely observable in an upward and abductory direction. The pain is not so much actual pain, as a feeling of cramped or strongly contracted muscles, and this affects the thumb, forefinger, palm of hand, wrist and forearm.

Pencil writing was much easier on patient, and could be continued for a much longer time than pen.

Section I Neurological

Case (b) continued

pen-writing, but even it, through time produced the same symptoms.

The spasm or jerk is also noticed when raising a cup or tumbler to mouth, when the jerk is emitted just as the mouth is reached. Patient being unable to counteract it.

In writing - jerk is indicated by an upward jerky line - on many right hand.

There is no other alteration, either of motion or sensation, nor is the jerk apparent in any other movement or use to which the hand or arm may be put.

The

Section I Neurological

Case (b) continued

The muscles respond readily to Faradism - one pole being put over Brachial Plexus and the other searching out the individual muscles in the forearm, and as far as it is possible to make out - Electric Contractility is normal.

There is no wasting of muscles seen, nor Hypertrophy.

Right.

Ulnar nerve. Evinces no abnormal sensation. But usual sensory distribution felt over distributed area, on irritation with

2. Rheumer Battery — normal,

Median nerve. Same — normal,

Musculo-Cutaneous & other Cutaneous branches to arm and forearm appear

Section I Neurological

case (b). Continued.

appear to be normal with same strength of current.

Musculo-Spiral with 2nd Pole applied in the Musculo-Spiral Groove, is not so readily responsive, requiring 5-4 (Spaner) before sensation is felt in the thumb and forefinger, even slightly.

Left. nerves all practically same as right. excepting Musculo-Spiral which only required 3-5 (Spaner).

Section I Neurological

Case (b) Continued.

This disease is so common, particularly amongst clerks who do so much writing, that it requires little by way of comment; yet I have neither heard, seen, nor read that it is common in clergymen, as in this instance.

The sensory and motor symptoms, seemed to arise at the same time, and with the exception of occasional shoots into the shoulder, the sensory signs were co-existant as to situation and time, with the motor.

As has been mentioned, the left hand began to shew signs of the same disease about

Section I Neurological.

Case (b) Continued.

about one year after acquiring the ability to write with it.

Thereafter patient invested in a Typewriter, and has abstained from writing altogether, with the result that the spasm and pain do not trouble in the least, and when writing is used, it shows considerable improvement.

The Treatment in this particular case, followed the usual course.

First and most important, he gave his arms as much rest as possible, abstaining from writing with either hand, and latterly the typewriter gave him complete

Lectrat Neurological

Case (b) Continued.

complete rest; this has been rewarded by an almost entire absence of jerk when writing is done for comparative purposes

For medicine he was given Strychnia & Phosphorous. Electric current in the form of Faradism was used daily, with great benefit. I am loth to believe this is contrary to the usual experience, for here it undoubtedly proved beneficial.

Massage, used twice daily, was applied to muscles of the whole upper limb.

Section Neurological

Case - (c)

Neurasthenia

Three cases.

The following cases have occurred within the last six months in my general practice, and to avoid needless repetition of symptoms I, I am taking the liberty to class them as one; both the objective and subjective symptoms being very similar in each case.

The Family History in each instance indicated distinct nervous features, although not to the extent of a decided disorder of the Nervous system. Either a brother or a sister, or as in one of the cases the

Section I Neurological.

Case (C) continued.

the whole family was decidedly irritable or nervous.

The Personal History in all, was free from any infectious disease — excepting one of the patients who had suffered three months previously from Influenza — intemperance, Syphilis; although strain in another of the cases, was the only cause to which such a nervous breakdown could be attributed. In the third case, a common cold, seemed to have been the originating cause of the trouble.

On looking back I am now

Section I Neurological

Case (c). continued

now quite satisfied, that heredity played a most important part in all three cases, as each could trace in their family History a distinct line of nerve weakness, & this has to be added as determining causes — Influenza, Strain, and a common or Catarrhal cold.

All three, as before stated, had practically the same symptoms, so I will narrate them as one.

The present illness had begun from three to six weeks before I saw them; and when examined complaint was made principally of pain and spasm, in

Section I Neurological.

Case (C) continued.

in the region of the neck and back, down to the level of the first Lumbar Vertebra.

The mental state was apparent in the dressing, the clothes being put on very carelessly and slowly; depression and irritability were very marked. Facial expression was anxious and pinched. Loss of weight was complained of, also anaemia, lack of memory, loss of concentrative power, with general inability to perform ordinary mental work.

Insomnia was a most persistent symptom. Headache with these.

Section I Neurological.

Case (C) Continued.

sense of fullness + flushes of heat.

Hyperaesthesia, was one of the main characteristics, chiefly superable to the cervical region, and particularly over the 4th Cervical spine, radiating from this point round neck, over scalp, shoulder and arms, down to little finger on the right side (in two of the cases).

In the Dorsal region, pain was also very distinct, travelling along the Intercostal nerves, almost to middle line in front.

Dysthesia - numbness - was felt along

School Neurological.

Case (C) continued

along the region of the Ulnar nerve on the left side.

Special Cases - An aching and dearness was more or continuously felt in the eyeballs, after reading, particularly, been for a very short time; also frequent flashes of light.

Noises in ears very often.

The case of pressure in the head, was very marked, and in these cases, it was occipital & parietal in locality.

Pain of an aching character was complained of, down the back of the legs, this varied greatly, and sometimes was very

Section I Neurological

Case (C) continued

Very severe.

Reflexes. The Superficial reflexes were much exaggerated in the three cases. whilst the Deep, were exaggerated during the whole illness in two cases, ~~two~~ and in the third, which was if anything, the worst of the three. They were exaggerated during the first 3 months, and later could not be easily elicited, until at least recovery took place.

The Pupils were equal in all cases, and responded well to light

Muscular weakness was well mark-ed

Section I. Neurological

Case (c) continued

:ed, and in one, it amounted to Paresis of both arms, the power in those limbs being greatly reduced.

Fibrillar twitchings of the muscles were a common occurrence, and often strands of muscular fibres contracted and formed nodes or balls in the tissue of the muscle. These nodes could easily be felt in the muscles, with the fingers.

Vaso-motor disturbances were com-: mon e.g. Perspiration, Irregularity of Pulse, with throbbing of the Aorta, Palpitation, Loss of Appetite and Constipation.

Urine

Section I Nurological

Case (c) continued.

Urine,- the daily amount varied greatly, but neither albumen nor sugar was ever found, although a deposit of urates was common.

Diagnosis:- In this connection the chief difficulties lay in discriminating between Neurasthenia, Hysteria and Hypochondriacal diseases overlapping each other to some extent. In Neurasthenia we have indications of a general weakness in the nervous system, in addition to the local disturbances. Besides in the cases quoted we have the

Section I Neurological

Case (c) continued.

the distinguishing features of Neurasthenia as against Hysteria or Hypochondria e.g. Pain & Pressure in head, disturbances of sleep, Rachialgia and Spinal Hypercesthesia, Muscular weakness, nervous Dyspepsia, irritability, depression, anxiety, lack of concentration, incapacity of decision &c.

In Hypochondria the excessive distribution of the pathological conditions of which the patient complains, is always suspicious that he is the victim of actual delusions.

Hysteria is very frequently confounded and the distinction is not always

Section I Neurological

Case (C) continued.

always easy, but in the absence of hysterical paroxysms, crises, and of the emotional and intellectual characteristics of the hysterical individual. The diagnosis of Hysteria could not well be made.

Two diseases of the Nervous System very easily confounded are - Tabes Dorsalis & General Paralysis. Yet in Tabes consideration of the sensory disturbances, Areflexes, and of the action of the pupils, will be sufficient to distinguish.

In General Paralysis there is more difficulty

Section I Neurological.

Case (c) continued.

difficulty, unless there is a definite indication of Paresis of the facial muscles, or muscles of articulation, or of the pupils, which are characteristic enough alone with the history of the case, to establish General Paralysis.

Treatment.

Under this heading, I will only give the full details of one of the cases mentioned above. For some time - about two weeks - I was completely baffled with the case, so far as any apparent improvement could be

Section I Neurological.

Case (c) continued.

be detected.

The outstanding feature in the early stages was sleeplessness, and a number of drugs was tried to combat this with little effect.

Patient was confined to bed, but quickly grew so restless, that staying in bed became an impossibility to him, and often I got him walking about the room, and the house in a state of great nervousness and fear. The sleeplessness was most obstinate. Pot. Brom in 60 - 80 grs per dose every two hours, or in one particular night 240

Section I Neurological.

case (c) continued.

240 grs were taken in 4 hours, without producing any soporific effect. Then Morphia in large doses hypodermically, was tried but proved useless, and his condition thereafter was even worse than before. Lastly Paraldehyde was tried in moderate doses, with great benefit, also Zeitz Baths. The improvement, so far as sleep was concerned, was more or less continual, and from this time until within six weeks of cure, Paraldehyde was taken in doses that proved to be sufficient, each night or thereby

Lecture I Neurological.

Case (C) continued.

thereby.

The pain in neck, back and arms continued, with periods of comparative relief and others of racking pain. For this electricity and massage were tried for 3 - 4 weeks with a little benefit.

Patient was examined by the X rays for disease of the cervical vertebrae, with a negative result.

He was next sent to an Hydropathic for Electrical and Bath treatment, remained 3 - 4 weeks and returned little better, and in a most depressed

Lecture I Neurological

Case (c) continued.

depressed mental state.

Soon after this patient ayreed to rest completely, in bed, free from friends, relatives and business, and was removed to a suitable place.

During his stay, he was massaged, had electricity - continuous current.

Dry cupping was also employed down both sides of the spine from neck to Lumbar region.

His diet was carefully watched & was forced to take a certain quantity of nourishing food at certain hours, milk, soup, eggs, beefsea, and other digestible

Section I Neurological.

Case (C) continued.

digestible articles.

Medicinal treatment consisted of Hypodermic Injections of Arsenic and Iron twice a day.

After four weeks, patient was vastly improved, feeling a different man, took suspicious Careworn, anxious look from his face, shaved, and altogether healthy looking. Cure was finished or completed by a sea voyage, from which he has just returned feeling quite well and as strong Physically and mentally as ever.

Section II Surgical.

By way of introducing this section of my Thesis I desire to say a little on Surgery in the Provinces as I have found it.

It is obvious to all that Provincial Surgery has improved with immeasurable strides, since the use of Antiseptics became so General; and more especially since Students began to see so many operations performed with equal success, operations which at one time were thought to be impossible; and also since those Students benefited so much from the explicit and practical

Lecture II Surgical.

practical lectures given by Teachers in our Universities both Clinical and Theoretical. Notwithstanding this however, it is very surprising to see how slow some men are to take up and practise, those ideas received at College and Hospital; and what has been a serious hindrance to progress in Provincial Surgery, is the lack of interest shewn by the laity, and when one has a Committee composed wholly of such men — otherwise able and progressive — it becomes a matter of difficulty to get improvements carried out in

Section II Surgical.

in connection with our Qualler Hospitals; as a matter of fact it is only by continually repeating the same request for months, it may be years, an improvement is made, particularly if it is to cost any little money.

These remarks have a special bearing on the Surgical cases detailed hereafter. And I wish to mention that the operations were performed in the Cottage Hospital, Johannesburg, in a room not very well suited for the purpose. This room is used daily for all kinds of accidents, visitors &c in short is a general utility

Lecture II Surgical.

utility room. When an operation is to be done the room has to be cleared of furniture &c and have walls and ceiling washed with Antiseptics. To have surgical work in a place of this kind is a source of extra work, and greater risk to the patient.

Care (d) over.

Section II Surgical.

Case. (d) **Strangulated Inguinal Hernia** (right) in a female — Operation for Radical cure (Macewen's) Recovery.

Miss B.O., between 50 and 60 years of age, came under my care in the winter of 1899, for operative treatment of a strangulated right inguinal hernia. Family history was phthisical, although personally, patient had always enjoyed good and robust health, until within the last year, when she began to be troubled with constipation, and somewhat later, first noticed a "swelling" or "lump" over the lower part of the abdomen, which gradually grew larger

Section II Surgical.

Case (d) Inguinal Hernia (Female).

larger and seemed — as the patient expressed it — to be travelling upwards on the abdomen. The swelling caused her no pain or discomfort until two days before admission to hospital, when she was suddenly seized with acute pain over the tumour, accompanied by sickness and vomiting. An enema was at once ordered, and taxis resorted to, but without avail, before coming to hospital. On her arrival here, examination showed a large tumour, of a more or less cylindrical shape, extending from the body of the right

Section II Surgical

Case (A) continued.

right pubis upwards and outwards towards the anterior spine of the ilium, a distance of 4 or 5 inches. It was exceedingly hard and resistant to the touch. Percussion yielded a dull sound. There was a slight impulse felt, on coughing, at the pubic end of the tumour. Chloroform was administered and taxis again tried, but without making the slightest impression. The history of the tumour, with the sudden onset of acute pain, sickness and vomiting, led us to believe that the tumour was herneal, and most probably consisted

Section II Surgical

Case (d) Continued.

consisted of omentum with a small piece of bowel.

An incision was made over the prominence, when we found that the tissues external to the sac, were so very much attenuated and atrophied, that it was impossible to differentiate the structures - as well illustrated in text books — from the superficial and deep fascia.

The external wall of the sac was laid bare in its entirety, which necessitated prolonging the incision to 6 inches. The tumour now brought in sight was of a very dark brown or

Section II Surgical

Case (a) continued

or chocolate colour, hard and resonant, measuring 6 inches long, with a circumference of 1½ to 3 inches. The wall — which was of course, the parietal surface of the peritoneum or sac — was firmly adherent to the external tissues in some places, particularly at the neck of the sac close to the external abdominal ring. This part of the tumour — the neck — was extremely narrow, and very highly constricted by the ring, so much so that it was with difficulty the point of an hernia knife could be introduced when making

Section II Surgical

case (d) continued.

making small incisions. On opening the sac, the hernia was found to consist of omentum and a very small knuckle of bowel, the latter part being immediately outside the ring, and of a very dark colour, but with its lustre still preserved. The greater part of the hernia was omental, and this explained the hard and resistant characters found previously; this fact also was explanatory as regards the absence of pain during the early stage of the tumour. There was no fluid inside the sac. I presume the "swelling" noticed for so long by

Section II Surgical

Case (d) continued

by the parent, was chiefly if not wholly, an omental hernia, and that the pain and sickness only came on when the bowel was pressed through the ring and became strangulated. I had to make a good number of small incisions in the ring before the bowel could be returned into the abdominal cavity. The omentum was likewise replaced without excising any part of it. Macewen's operation for radical cure was performed, and the external wound sutured with chromicised catgut.

Patient

Section II Surgical

Case (d) continued

Patient was sorely troubled with sickness and retching after operation, for which she was given ¼ gr Morph suppositories, ice to suck, brandy and milk, and, later, dry champagne. Flatus was passed the day following operation, and, sickness abating, nourishment consisted of essence of beef, extract of beef, and peptonized milk, gradually given at stated intervals for fourteen days.

Pulse kept normal, and temperature never rose above 99°.

An enema was given on the eighth day, and a small quantity of

Section II Surgical.

Case (d) continued

of faeces discharged. On the fourteenth day an aperient moved the bowels easily and naturally.

Case E

Section II Surgical.

Double Oöphorectomy
for severe ovarian pain –
– Recovery.

Case (E.)

Miss A. C., 29 years of age consulted me towards the end of last year, regarding very severe and persistent pain in lumbar region of back, and in both the right and left hypogastric regions.
Family history is unimportant, except to show that two or three members were decidedly phthisical.
As a child patient suffered from the usual diseases of childhood, e.g. whooping Cough, Measles, Croup, Bronchitis and had three attacks of Scarlet Fever, the last

Section V Surgical

Case (E) Continued

last attack when she was 20 years of age. Present illness - i.e. pain began about eight years ago, shortly after the last attack of Scarlet Fever, and although not very troublesome at first, gradually increased in severity. The pain became more continuous, and latterly never disappeared. Menstruation came on at the age of 15, and has always been irregular as regards duration and quantity, three weeks as a rule, elapsing between two periods, and each lasting seven or eight days. The Catamenia greatly aggravated the pain. The right side only became painful

Section II Surgical

Case (E) Continued.

pain for two years ago. Six years after she left.

Five years ago, a London gynaecologist was consulted, who diagnosed Contraction of the cervix and Retroflexion, and sent patient to an Edinburgh Surgeon, who dilated and split the cervix (February 1898)

This operation was the means of allaying the pain for a short time only — two months - after which it returned more severe than formerly, causing sickness and fainting very often.

In December last, patient first came under my charge. At this time pain was intolerable. An external

Section II Surgical

Case (E) continued

external examination showed nothing except tenderness in each hypo-gastric region, but on making an examination per vaginam, I found the uterus slightly retro-flexed, the cervix (anterior and posterior lips) elongated to a great degree, and tenderness on pressing into Douglas' pouch. I could not make out the presence of any enlargement or growth.

Being unwilling to perform the major operation for excising the ovaries in an unmarried lady, I advised first of all, that dilatation should be tried, and

Lecture II Surgical

Case (E) Continued.

and this was done. Murdock Cameron's dilators being used.

As a result of this, the pain was slightly relieved, but in a short time - three months - it returned to much the same degree as before.

Considering the history of the case, and the number of times patient had submitted to dilatation without relief for any length of time, I was not surprised when the desire to have the major operation performed, was expressed by the patient. Accordingly it was decided to remove both ovaries, with

Section II. Surgical

Case (E). Continued

with the hope that the pain would be considerably, if not wholly allayed. Operation was performed in May, when the following condition was found. Left ovary, partially collapsed, congested, and cystic. Right collapsed to a greater degree than left, congested, and extremely cystic. Both ovaries were adherent to surrounding peritoneum, particularly the right one, which was very strongly attached to the upper part of Douglas' pouch, and this accounted, I think, for the tenderness felt on making a per vaginam examination.

Ligature

Section II Surgical

Case (E) continued.

Ligature of stout chromic catgut used, and external wound closed in usual way with same material. Operation was borne well, although sickness and retching were troublesome for a few days.

Pulse and Temperature remained normal, and patient made an excellent recovery.

Pain disappeared wholly in the third week, and has not returned since.

Section II Surgical.

Case (62)

Oophorectomy for Prolapsed Ovary.

Recovery.

In October, 1899, I was consulted by Mrs. B.C, for a severe continuous pain in the back and left hypogastric region, which had tortured her for three months previously.

Patient is aged 26, wife two children. Family history unimportant, and personal only interesting as a period two years before (1897), when patient suffered from two "fits", which were purely of an hysterical nature.

On

Section II Surgical

Case (62) Continued

On admission to hospital in November 1899, she complained of severe pain in the sacral region, also in front sometimes in both sides, but chiefly in the left. The pain, when more severe than usual, produced faintness, headache, and sickness, and was continuous although aggravated at the monthly periods, when it also assumed more of a bearing down character than at other times.

On external examination, little evidence could be got as to the cause of the pain, except when the uterus was pressed upon from the left hypogastric region.

But/

Section II Surgical

Case (E2) continued.

But on making a per vaginam examination, an oval shaped body could distinctly be felt, lying in the reflection of peritoneum, behind the uterus — Douglas' pouch — and this when touched, even gently, caused great pain and sickness. Uterus was also slightly retroflexed.

The oval body, felt so distinctly, and producing the sickening pain, suggested that the ovary had prolapsed into Douglas' pouch, and was more or less congested and adherent. I suspect the prolapse became most pronounced two years ago, when the hysterical fits came on.

Considering these facts, an operation was

Section II Surgical

Case (42) Continued.

was decided on, for the removal of the ovary, and the patient was kept three weeks in bed, for the purpose of building up her strength, which was very considerably reduced. During these three weeks the pain did not abate, although she was treated medicinally with that object, and was taking food fairly well. She improved in strength, but remained very hysterical.

On 3rd December operation was performed, and the condition found was as diagnosed. Left ovary prolapsed into Douglas' pouch, adherent to peritoneum, congested, and with twisted broad

Section II Surgical

Case (62) Continued

broad ligament. Adhesions were soft, and easily broken, without causing haemorrhage. Stout carbolised silk used for ligature, in the form of a Staffordshire knot.

On ovary being examined after removal, it was found to be cystic.

External wound closed in usual way with chromicised catgut.

Patient bore operation well, and made an excellent recovery.

Temperature and pulse, kept normal. Pain disappeared on the fifth day after operation, and patient is now able to go about her usual household duties

free

Section II Surgical

Case (E2). Continued.

free from that distressing
Symptom.

Section II Surgical.

Case (1).

Case of Pleurisy with effusion and aspiration of 14 pints of fluid.

I was called to see a man aged 28, three weeks after the onset of an attack of pleurisy, which so far as could be ascertained, had not been accompanied by much pain, but was very soon followed by difficulty in breathing and debility.

When first seen, his respirations numbered between 35 and 40 per minute, and his temperature varied between 101° and 102·5°. On physical examination, extreme dulness almost wooden

Section II Surgical

case (f) continued

wooden in pitch, was found over
very part of the right lung.
There was very little respiratory
movement on that side, no vocal
resonance or fremitus, and the
respiratory murmur could only
be heard, and that very indistinctly,
over the apex, and in the axilla
at its highest point. There was
great pressure on the Trachea,
and he was troubled with a
throaty cough, and a sense of
weight and pressure in that
region. Two days later, I aspir-
:ated below the angle of the scapula,
and drew off, 85 ozs of clear
straw-coloured fluid. This gave
considerable

Section II Surgical

Case (f) Continued.

considerable relief, the circumference of that half of the chest being reduced by 1 inch. The frequency of the respiration was reduced from 38 to 24 per minute, and the pulse rate from 130 to 116. The respiratory murmur was now heard somewhat more distinctly, over the back, but not in front. His temperature ranged between 100° and 101·5. Within seven days, the dullness seemed to increase along with other symptoms, and I accordingly aspirated again, but only drew off 6 ozs, as the operation had to be stopped on account of severe coughing, which came on with

Section I Surgical

Case (f) Continued

with aspiration. The patient was very little better after the second aspiration, and the dulness seemed gradually to increase, so that I had again to aspirate, with the result that 90 ℥ss were removed, at a point selected at the edge of the pectoralis major muscle. The temperature ranged at this time from 100° to 101.5°, the respiration from 28 to 32, and the pulse rate from 112 to 140.

For five days following this there was considerable improvement, but he later began to shew signs of increased secretion of fluid, and he be

Section II Surgical

Case (f) Continued

twelve days elapsing. 80 ozs of fluid were aspirated. The fluid being still straw coloured with no sign of suppuration. The respirations were reduced to 20, the temperature to 99°2, and the pulse rate to 98. But yet again, signs of re-collection of fluid, began to appear, and he was aspirated for the fifth time, 10 days after the last occasion, when 45 ozs were removed, and as a result the respirations were gradually reduced to 16, the pulse rate to 90, and the temperature fell to normal. From this point, he gradually but surely

Lecture II Surgical

Case (f) continued

surely improved, all symptoms disappearing, and the chest measurement becoming the same on each side.

The points worthy of note, seem to me to be (a) the total amount of fluid aspirated — practically 14 pints (b) the rapidity with which it re-collected and (c) the absence of suppurative changes after the repeated aspirations. (d) the complete recovery.