



Transactions of the
South Indian Branch of the
Association
December 1901

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TRANSACTIONS OF THE SOUTH INDIAN BRANCH

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ASSOCIATION.

The following clinical cases were

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1901.

OCTOBER MEETING.

The usual Monthly Meeting of the Branch, was held in the Government Museum, Egmore, on 25th October 1901.

LIEUT.-COLONEL BROWNE, I.M.S., IN THE CHAIR.

The minutes of the previous meeting were read and confirmed. A letter from Mrs. Walker, thanking the Branch for the resolution of sympathy sent her, was then read.

The following clinical cases were shown.—

1. Lieut.-Colonel Maitland, I.M.S., showed a patient on whom he had successfully performed interscapulo-thoracic amputation for sarcoma of the scapula (the second case in which the operation had been performed for sarcoma in the General Hospital during the year), and read notes of the case.

He also showed a patient suffering from advanced Mycetoma of the right inguinal and lower iliac regions, and commented on the extreme rarity of cases reported in which the disease had attacked the abdomen. The limbs in this case were not affected.

2. Captain Niblock, I.M.S., showed three patients who had been treated for tubercular knee-joint by injections of Iodoform Emulsion. All three were greatly benefited by the operation; pain had completely disappeared and swelling almost completely.

3. A paper contributed by Major Simpson, I.M.S., on "A case of Panther Wounds" was then read, and commented on by several members.

4. Lieut.-Colonel Maitland, I.M.S., then opened a discussion on the Treatment of Hepatic Abscess, in which Lieut. Colonel Maitland and Browne, Captains Molesworth and Niblock, and Assistant Surgeon C. B. Rama Row took part.

The meeting then terminated.

NOVEMBER MEETING.

The usual Monthly Meeting of the Branch was held in the Government Museum, Egmore, on Friday, 29th Nov. 1901 at 5-30 P.M.

LIEUT.-COLONEL LANCASTER, I.M.S., IN THE CHAIR.

The minutes of the previous meeting having been read and confirmed the Chairman read a letter of apology for non-attendance from Surg.-General Sinclair.

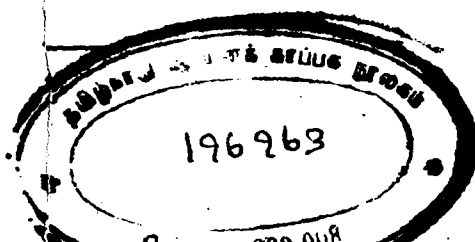
1. Lieut.-Colonel Maitland, I.M.S., then read notes on Nephrotomy for Renal Tension; and showed a patient who had just been benefited by the operation. He also showed a case of swelling of the lip of an obscure nature. The swelling was of several months' duration, soft in character, and ulcerated in places. There was nothing characteristic about the appearance of the ulcers. Some of the members present considered that the affection was due to mycosis.

2. Captain Niblock, I.M.S. showed a patient suffering from tubercular disease of the lungs on whom he had operated by excising a portion of the third rib and evacuating a large abscess situated at the apex of the right lung. The patient's condition improved remarkably after the operation. He also showed a case of secondary syphilis, with skin-eruptions closely resembling those met with in Framboesia. Also a patient suffering from very intractable cicatrizing granuloma affecting penis and scrotum. About eighteen months previously the granuloma had been excised in a Mofussil Hospital, and skin-grafts had been taken from the right thigh to graft the raw surface. The grafting was unsuccessful, the disease recurred in the old situation and also appeared on the place from which the grafts had been taken. At the time of his admission to the General Hospital the affected area on the thigh was as large as the palm of the hand.

3. Lieut.-Colonel Van Geyzel, then described an unusual case of Arsenical poisoning which had recently come under his notice. A short discussion followed, in which several members took part.

The meeting then terminated.

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DISCUSSION ON THE TREATMENT OF HEPATIC ABSCESS.

LIEUT.-COLONEL J. MAITLAND,—The subject that we have met to discuss this evening is not only one of perennial interest to us in Madras, where the disease is so common, but is also one of special interest at the present time, owing to the fact that somewhat radical changes in the treatment of this affection have lately been forced upon the attention of the profession. The first point to which I should like to draw attention concerns the use of the exploratory needle. There is a tendency amongst medical men of the present age to resort somewhat hastily to the use of such means as that of the exploratory needle: to the neglect of careful and systematic investigation by the more ordinary and often less hazardous methods of clinical examination. A tendency, in other words, to make short cuts to diagnosis. I am afraid that this is sometimes the case in regard to abscess of the liver. In the great majority of cases the diagnosis of hepatic abscess is quite simple, and the use of the exploratory needle quite unnecessary. It is extremely important to emphasise this point because there appears to be a wide spread idea that the use of the exploratory needle, in cases of disease of the liver, is a very simple procedure, and one unattended with any danger. So far is this from being the case that a very considerable number of deaths have been recorded, as having been due directly to this operation. For this reason alone it is important to insist that exploratory punctures for the purpose of diagnosis in cases of disease of the liver should be restricted to those cases in which it is absolutely necessary. There are a certain number of cases in which its use cannot be avoided, but they form a comparatively small proportion. What are the causes of the hæmorrhage which occurs in some of these cases? Mr. Cantlie, in a paper read at the recent meeting of the British Medical Association, stated his belief that the chief danger of hæmorrhage was from the inferior vena cava, and that this vessel could not be injured so long as the needle was not thrust in as far as four inches. Whether any of the recorded cases of hæmorrhage were due to injury of the vena cava, or not, I am not prepared to say, but I do know from practical experience that fatal hæmorrhage may occur from puncture of the liver tissue alone, when that tissue is in a condition of acute congestion. I speak

feelingly on this subject because I lost a patient myself from this cause. The case was one in which I was asked to explore the liver of a patient who was suffering from acute hepatic congestion and in which the presence of an abscess was suspected. Two hours later, when going round the wards, I found the patient dying from internal hæmorrhage. The vena cava, was not injured in this case; bleeding took place from the liver substance itself. Fatal hæmorrhage has also been known to occur from injury to the intercostal artery. Whenever it becomes necessary to perform an exploratory operation, arrangements should be made to open the abscess at once, should pus be discovered. By opening the abscess at once, not only is the patient saved the injurious consequences that may result from delay but he is also saved the anxiety involved in a second operation. Moreover, it sometimes happens that considerable difficulty is experienced in hitting off the abscess at the second operation, although it may have been found quite easily on the first occasion. Indeed I have known of a case, in the practice of a colleague, in which the abscess could not be found at all at the second operation. In performing the exploratory operation by means of a needle there is one precaution to which it is important to pay attention. There is always a temptation, in withdrawing the needle, when no pus has been found, to alter its direction before it has been completely withdrawn, and make another exploratory venture through the same orifice. As this manoeuvre tends to enlarge the orifice of entrance, it should always be avoided. If it is necessary to explore again, a fresh puncture should be made at another point. The fatality to which I have already alluded was due, I believe, in part to neglect of this precaution. The possibility of wounding the intercostal artery, if due precaution is not taken, must also be borne in mind.

I will now pass to the consideration of the operation for the evacuation of the abscess. If no exploratory puncture has previously been made a needle must first be inserted for the purpose of locating the pus. In the great majority of cases of single abscess the pus is found in the right lobe, and a trans-thoracic opening is required for its evacuation. The cases in which the abscess is situated in the lower part of the right lobe, which has been pushed far down below the margin of the ribs, are, in my experience, comparatively uncommon. I propose therefore to first describe the

trans-thoracic operation, as I am in the habit of performing it. If any point of special tenderness has been found the needle may be thrust in at that part. If no indication of that nature is present, it is best to explore through the eighth intercostal space. When the abscess has been found the needle should be left *in situ*, to serve as a guide. An incision is then made over the rib immediately beneath the level of the needle, and a portion of the bone, about two inches in length, is removed. The pleura is next incised, and, if there are no adhesions, the two layers are stitched together, the sutures being made to enclose as wide an area as possible. The diaphragm and peritoneum are next divided, and if no adhesions are present, the peritoneum is dealt with in the same manner as the pleura. A pair of sinus forceps is passed alongside of the aspirator needle into the abscess and an opening made by separating the blades. The opening is then enlarged to the necessary extent by incision. Having made a sufficiently large opening two glass drainage tubes are inserted and the pus allowed to flow away. When pus has ceased to flow freely the cavity is irrigated with weak boric acid lotion or sterilised water, in order to wash away as much as possible of the remaining purulent contents. Irrigation of the abscess cavity, although not an absolute essential, has the advantage of minimising the amount of discharge subsequent to operation. After the abscess has been emptied as far as possible, a finger is introduced into the cavity for the purpose of ascertaining its size, and necessity, or otherwise, of making a counter-opening. If the abscess is a large one and the opening has not been made at the most dependent point, a counter-opening should be made further down and more posteriorly. The arrangements for securing free drainage are the most important points in the whole operation, and it is for this reason chiefly, as I shall show later on, that I am opposed to the methods recommended by Mr. Cantlie, in the paper alluded to above. The main opening into the abscess should be sufficiently large to admit two drainage tubes of half an inch diameter easily. An opening of this size cannot be made in the chest wall without removing a piece of rib. I am in the habit usually of injecting Iodoform Emulsion into the cavity of the abscess, before inserting the drainage tubes. This is done with the view of checking septic decomposition should the discharges come to the surface and become contaminated, as they are not unlikely to do if the abscess

has been a large one. There is considerable difficulty in applying a sufficiently wide and thick dressing to this part of the body. In a climate like that of this country nothing is more distressing to a patient than to be swathed in an enormous mass of dressings.

When the abscess has to be opened below the ribs the operation is necessarily more simple. Here again I consider it best to operate by means of a free incision, and, if adhesions have not taken place, to stitch together the two peritoneal surfaces. If, as sometimes happens, difficulty is experienced in suturing the peritoneum, owing to the proximity of the pus, to the surface, or to the movements of the liver, the better plan is to pack the wound with gauze, and, having turned the patient on his side, to open the abscess by means of a knife. After the pus has been evacuated the edges of the wound in the liver are stitched to the edges of the wound in the abdominal wall.

I should now like to say a few words regarding the method of operation recommended originally by Dr. Manson and specially advocated by Mr. Cantlie at the recent meeting of the British Medical Association. It is necessary that this question should be fully discussed, not only because this method is so enthusiastically recommended by Mr. Cantlie, but also because he condemns, in equally forcible language, all other methods of operation. Is it possible that our methods here in India are so faulty as he proclaims them to be? For my own part I do not think so. Mr. Cantlie's method, speaking briefly, consists in puncturing the abscess with a trochar and emptying it by means of "syphon drainage." It is in fact an operation by means of limited incision, as opposed to operation by free incision; and is therefore opposed to the ordinary principles upon which abscesses in other parts of the body are treated. The main objection to this operation, as I have already stated, is that by such a method of dealing with an abscess of the liver we cannot ensure that drainage will be sufficiently free. This objection is forcibly illustrated by three out of the four cases cited by Mr. Cantlie in his paper. In the first case we are told that on the tenth day the drainage tube having slipped out, it was found necessary to administer an anæsthetic before the tube could be re-inserted. Again, in the same case, on the thirty-fifth day, it became necessary to make a counter-opening in order to establish free drainage. In the second

case we find that on the thirty-third day there was some difficulty in drainage, and it was contemplated to open the cavity further back, but the patient objected to be operated upon again. In the third case the drainage tube was pulled out by the patient on the night after the operation and "could not be satisfactorily replaced." Four days later a large drainage tube was introduced and twenty ounces of pus welled out of the wound. It is to be presumed that these four cases that have been selected by Mr. Cantlie, are taken by him to illustrate the benefits of his method of treating abscess of the liver, as compared with the results obtained by other methods. If that be so I can only say that in my experience such extraordinary difficulties in securing free drainage, as were met with in these three cases, are the rarest exception. It is impossible to avoid the conclusion that all these difficulties would have been obviated had the abscesses been opened by free incisions. The truth of the matter is that an opening so small as to tightly embrace a single tube does not suffice for the efficient drainage of most large abscesses of the liver. Moreover, if the tube becomes displaced by accident, its replacement into so small an opening is almost an impossibility. These difficulties are occasionally met with even in cases where a piece of rib has been excised and an opening made sufficiently large to admit two drainage tubes with ease. Another disadvantage of Mr. Cantlie's method of operation is that it does not admit of exploration of the cavity of the abscess with the finger, and therefore no estimate can be formed of its size, nor of the necessity, or otherwise, of making a counter-opening.

Before concluding I would like to draw attention briefly to the objections raised by Mr. Cantlie against the ordinary method of operation. In the first place, he states, that "the severity of the operation in many cases is such that the opening of the abscess is apt to be deferred until too late in the disease." That is a statement that is entirely without justification so far as India is concerned. The rule in this country is to operate at once. His second objection is that "the medical practitioner is willing to try every available resource before condemning his patient to so severe a line of treatment." It is hardly necessary for me to say, in this assembly, that such a statement is also without justification, at least so far as India is concerned. Indeed it would be curious to know what the "available resources" are, to which Mr. Cantlie alludes.

Lieut Colonel Sturmer,—I agree with what Col. Maitland has said for the most part. My experience is no doubt limited and I have not had to excise the rib so frequently, but then perhaps my cases have been further advanced and have contracted adhesions to the abdominal wall below the ribs. I cannot consider Mr. Cantlie's operation superior to that of incision and free drainage. My results from prospecting the liver have never resulted in any after bad effects, but Col. Maitland states he lost a case and Col. Hatch in the *Indian Medical Gazette* reports one or two deaths. That the liver can bleed when punctured there can be no doubt, and that too without puncturing any such large vessel as the vena cava. I certainly think it advisable to irrigate the abscess cavity after incision, and cannot understand why you should treat a case of hepatic abscess differently to that of an abscess elsewhere.

Captain Molesworth said he should like to ask Colonel Maitland whether it was not a fact that exploration in cases of congestion of the liver has not been followed by disappearance of the symptoms.

Lieut-Colonel Browne agreed with Colonel Maitland's remarks. He did not quite understand what Mr. Cantlie meant by "siphon drainage" and noticed that Dr. Manson said nothing about it in his latest book. It was very unusual for the tube to run "full," and therefore "siphon action" could not be obtained. He believed that the danger of damaging the pleura was just as great with the tube as with the incision method. He knew of three cases in which death occurred from hæmorrhage. In one of these, certainly, the bleeding did not come from the vena cava or any of the large veins but welled up from the whole of the interior of the wound.

Captain Niblock said that he agreed with everything Colonel Maitland had said. As to exploratory puncture with a needle he thought it should only be done in the operating theatre, when the operation could be proceeded with at once. Two cases he had seen impressed this strongly on his mind. The first case had been explored in the ward, and was a short time afterwards sent to the theatre. When the liver had been exposed by incision the pus was seen to be pouring into the peritoneal cavity through the puncture in the hepatic wall. In the second case also the patient had been punctured and then sent to the operating theatre with diagnosis of

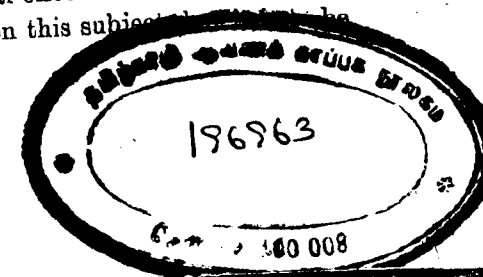
hepatic abscess. Under chloroform an exploring needle was introduced close to the former puncture wound, but immediately on entering the cavity of the peritoneum blood began to flow through the needle and several ounces came away. An incision was made alongside the needle at once when about ten ounces of dark blood were sponged out of the peritoneal cavity. The liver was found to be very congested and the capsule extremely tense. An irregular rupture about three-quarters of an inch in length was found in the latter, which opened immediately into a cavity the size of a walnut. In this case the oozing was general and did not come from any large vein. The damage to the liver substance was probably due to alterations made in the direction of the needle before it had been completely withdrawn. His experience therefore agreed with that of the previous speakers that bleeding was not in every case, at any rate, due to puncture of a large vein.

The operation performed by him was similar to that described by Colonel J. Maitland except that he did not inject iodoform emulsion. Later, if any unpleasant smell was noticed in the discharge he injected iodoform emulsion. He believed firmly in the use of two large tubes, one of which could be removed after a few days' time in the majority of cases. In one of his earliest cases in which the liver only projected a few inches below the costal margin he incised below the ribs, with the result that as the abscess began to empty and contract the liver was drawn up under the ribs and the utmost difficulty was experienced in getting, and keeping, the drainage tubes in. Ever since, unless there was very great enlargement below the costal margin he used the trans-thoracic method, generally with excision of a rib.

He had operated by the incision method in twelve cases of single abscess, with two deaths, and in four cases of multiple abscess, all of whom died. In no case was death due to the operation itself, and he did not think that any one of the fatal cases would have been saved by the "siphon drainage" method.

Lt.-Colonel J. Maitland in reply:—Capt. Molesworth has drawn attention to the fact that it is stated in some books that puncture of the liver with an exploring needle, even if no pus is found, is calculated to have a beneficial effect. It is unfortunately true that such has been the teaching on this subject.

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hoped that, in view of the fatalities that have resulted from the operation, the use of the needle will in future be more restricted than in the past. He was pleased to learn that evidently all the members present were in favour of the open method. As to mortality after operation, the great majority of our deaths were in cases of multiple abscesses of the liver.

NOTES ON A CASE OF ENCHONDROMA OF SUBMAXILLARY GLAND.

By MAJOR ROBERTSON, I.M.S.

Thoyammah, age 35. Growth began as a small hard swelling in the left submaxillary region. The growth of the tumour was slow during the first two years but for the last three it has been rapid. There has been no dysphagia, dyspnoea, or interference with the movements of the tongue. No pain. The only inconvenience is the increasing weight of the tumour which the patient supports by a sling going round the back and across the right shoulder. The tumour is a hard lobulated mass growing from the submaxillary gland, the base extends from behind the lobule of the left ear to the symphysis and downwards extends almost to the umbilicus. Large hard round nodules stand out prominently on the anterior and posterior aspects. A number of large veins are seen coursing over the surface. There was no difficulty in removing the growth, in fact it was shelled out by the fingers. On the posterior aspect there was smart venous bleeding for a few seconds from enlarged branches of the lingual vein. On section the tumour showed a simple character, no secondary changes were visible. The tumour was wholly encapsuled. The measurements from above downwards was 15 inches; round the tumour 27½ inches, round the long diameter 31 inches. I may mention that owing to the weight of the tumour the head was kept partly fixed and inclined to the left. The wound healed by first intention save for a small portion under the chin which was allowed to granulate owing to paucity of skin flaps. The tumour I think is a record one and is now exhibited in the Madras Medical College.



ENCHONDROMA OF SUBMAXILLARY GLAND.

INTERSCAPULO-THORACIC AMPUTATION FOR CHONDRO-SARCOMA OF HUMERUS AND SCAPULA.

By CAPT. W. J. NIBLOCK, I.M.S.

K. P. Malayali ryot from the West Coast, 38 years of age, Hindu, male, was admitted into the Surgical Wards of the General Hospital Madras, on 10th May 1901, with a large tumour affecting right upper arm.

From his statement it was understood that the tumour commenced about eight or ten years ago as a small painless swelling at the upper end of the humerus, and had continued to increase until it reached its present size. He was unable to say whether the increase in its growth had been more rapid recently, or not.

On admission patient was seen to be a small man, rather thin, but not cachectic. He stated that the tumour was painless, or almost so, and that his chief trouble was the annoyance caused by the large size, and weight, of the growth, which he supported by means of a large shawl slung from the opposite shoulder.

On examination the tumour was found to be roughly oval in shape, hard to the feel, with the skin over it healthy. Several large veins could be seen coursing over it in all directions.

The growth apparently involved the whole of the right humerus and was diagnosed as a probable chondro-sarcoma. It measured in its greatest circumference from above down, 3 feet 7 inches, and in its greatest circumference horizontally, 3 feet 2½ inches.

The right forearm was of the same size as the left. No œdema was present. No difference could be detected between the pulse of the right, and that of the left, side.

Operation.—As the scapula and clavicle did not appear to be involved in the growth, which seemed to merely *overlap* the joint, it was at first intended to do a disarticulation of the shoulder, and the operation was commenced with that end in view.

An attempt was first made to tie the subclavian artery, but this vessel was so much displaced and so flattened out as to render its ligature impossible without resection of the clavicle, which was not considered advisable. It was however found to be possible to

completely control the circulation in the limb by pressure with the finger on the artery, and the attempt to tie the vessel was abandoned, the wound being left open to enable direct pressure to be applied to the artery, should it be found necessary to do so at a later stage of the operation. An anterior skin flap was now marked out, several large veins requiring to be divided between ligatures. The axilla was opened, and the axillary artery and vein ligatured and divided, high up, with little difficulty. After the anterior flap had been cleared as much as possible, the posterior was partly made. It was then seen that the joint was hopelessly involved. The clavicle was therefore cut across just external to the junction of the outer and middle thirds, and as the scapula was found to be infiltrated with the growth it also was removed. A chain of enlarged axillary glands was excised. The skin flaps were brought together, two drainage tubes inserted, and the part firmly bandaged, over a large absorbent cotton-wool dressing.

Comparatively little blood was lost. During the operation the patient had two injections (7 minims each) of Liquor Strychnine and two hot saline enemata (one pint each).

The weight of the patient on the evening before operation was 137 pounds. The tumour after removal, weighed 48 pounds, i.e., more than one-third of his total weight.

Subsequent History of Case.—The patient was removed to the ward in a state of collapse, hot water bottles, &c., were applied.

At 10 A.M., (about 1½ hours after operation) a saline enema (one pint) was administered.

„ 11 A.M., Saline injection subcutaneously, 12 ozs.
„ 3 P.M., Liquor Strych. minims 6, hypodermically.
„ 5 P.M., Ether, minims 20, hypodermically.
„ 8 „ „ „ „ „
„ 10 „ „ „ „ „

16th. 12-30 A.M., Liquor Strych, minims 7, hypodermically.
4 A.M., Tr. Digitalis, minims 10 „

After this he was put on a mixture containing Liquor Strychnine and Tr. Digitalis, 5 minims of each thrice daily, until 29th when it was discontinued.

The subsequent progress of the case was uneventful. The wound healed without any difficulty, except at the lower part where the drainage tubes had been inserted, and the stitches were removed on the 13th day. The patient weighed a month after operation (just before discharge from hospital) 95½ lbs.

The bulk of the tumour on microscopical examination was found to consist of cartilage, the sarcomatous element consisting chiefly of the large spindle-celled variety. It was undergoing myxomatous degeneration in many places.

Remarks.—The points which strike me as of interest in this case are:—

1. The fact, that, although the tumour was of such an enormous size, (more than one-third the total weight of the patient) there was practically no pain, and no disturbance of circulation or nutrition of the forearm.

2. The most careful examination prior to operation failed to detect any disease of the scapula, or implication of the shoulder-joint, although during the operation both of these were found to be infiltrated with the growth.

3. The slight hæmorrhage was also a remarkable feature in the case considering that the subclavian artery had not been tied before the operation, and that so many large veins had to be cut through. The latter were however chiefly superficial and were, most of them, clamped before division. The total amount of blood lost did not appear to be more than ten ounces in all. The subsequent shock must therefore have been due chiefly to the nervous disturbance.

4. The resulting deformity, although necessarily very great, was, owing to so much clavicle having been left behind, much less than in a subsequent interscapulo-thoracic amputation performed during the year in the same hospital, in which the entire clavicle was removed. It appears to me therefore advisable to remove as little as possible of the clavicle in operations of this sort, unless the bone itself be actually involved, when of course complete removal is necessary.

CASE OF PANTHER WOUNDS.

By MAJOR D. SIMPSON, I.M.S.

Daniel, a native Badaga Christian, was brought to Coonoor Hospital about 11 A.M., on 29th November having been mauled the previous evening by a wounded panther. The wounds were extensive in character and of considerable depth—with great laceration of muscles. The most severe wounds being in the lumbar region of the back and extensor aspect of left forearm and also of arm immediately above the ulna. On admission the temperature was found to be 103°, F. patient being in a condition of great restlessness and suffering much pain. Absorption of septic matter or ptomaines had evidently already taken place for the mouth was parched, the tongue rough with intense thirst, and general constitutional disturbance was present. To cleanse the wounds I used the Perchloride of Mercury lotion, 1 in 1000 and kept irrigating the wounds freely for nearly an hour continuously and curetting the wounds at the same time and inserting the nozzle of the irrigator deep into the wounds. For five days the patient was in a feverish restless condition with rapid pulse. I administered Chloral in 15 grain doses three times a day which quieted to a great extent the restless condition. In a former case of this nature which I reported to the Branch in 1891, I administered Chloral per rectum with great benefit to the patient who, in that instance, was quite delirious—a longer interval having elapsed in that case from the time of receiving the wounds before admission to hospital, and absorption of poison to a greater degree in consequence having taken place, before treatment was undertaken. Chloral was given in that case per rectum owing to his refusal to take any medicine by the mouth. On the 7th day the temperature fell to 100° though it rose slightly again. The temperature reached normal in a few days and from the 12th day remained normal. Though a well built and well nourished man his condition at the termination of the fever on the 12th day was like that of a patient emaciated by a long attack of enteric fever and he was nearly four weeks in hospital before he was able to get up from his bed and stand up. The wounds threw off a small amount of slough attended with some amount of suppuration but not profuse and their edges were red and inflamed.

In the other case referred to by me, the wounds though small, sloughed extensively and large sloughs fell away leaving resulting cavities to fill up or granulate over at each point where the teeth had been inserted. The intensity of the septic poisoning would appear to be in proportion to the time elapsing before the wounds can be submitted to a thorough cleansing and for this purpose it is advisable to use an anæsthetic if it is to be carried out to the extent that is necessary—a proceeding which necessarily involves much pain. This view of the intensity of the septic poisoning being in proportion to the time allowed for absorption, *i.e.*, to the dosage is to place this case—and in my opinion the great majority of wounds from such animals in the category of a sapræmia rather than that of septicæmia. There is, however, no reason why septicæmia should not occur in this way inasmuch as it is possible that the carcass which the animal may have previously been devouring before inflicting the wounds might perhaps have been the subject of septic disease, or the micro-organisms of septicæmia might have gained ingress into the wound, and in that case the patient will suffer from septicæmia whether the injuries have been in themselves extensive or trifling—though of course if extensive, the case would be rendered still graver by shock or other complications being superadded. It is, however, I think, more likely that any case of wounds from these carnivora will, as a rule, be of the nature of a sapræmia varying in degree directly with the extent of the wounds and especially with the length of the time that elapses before they have been submitted to thorough local treatment—though general treatment is also important afterwards. The sapræmia will, however, also vary in its intensity according to the nature of the ptomaine that has been formed and with which the wounds have been impregnated at the time of their infliction, for these alkaloidal poisons will necessarily vary in chemical composition with the nature of the albuminous matter undergoing putrefactive changes, and experience shows that some cases of ptomaine poisoning are of an intensely acute character. The mouth of a carnivorous animal like the cheetah, panther or tiger could hardly escape being a nidus of putrefactive alkaloids derived from the albuminous substances of carcasses upon which they live and which are necessarily in all stages of putrefaction. The fact that poisoned wounds from such animals are almost cer-

tainly likely to be of the nature of a sapræmia is much more hopeful for treatment than if it were to be regularly regarded of a septicæmic character—*provided* local treatment can be insured within a reasonable time of the receipt of the injury and the patient has not been exhausted by shock and the extent of the wounds, for the symptoms will diminish in proportion as the poison can be cleared from the wound.

In the discussion which followed Capt. Cornwall, I. M. S. said that he did not agree with Major Simpson, that the mouths of carnivorous animals were dirty. On the contrary, in all the cases he had examined, the teeth and mouths were quite clean.

NEPHROTOMY FOR RENAL TENSION.

Lieut.-Colonel J. Maitland showed a patient upon whom the operation of nephrotomy had been performed, and made the following remarks:—The patient is a Hindoo, a barber by occupation, and 24 years of age. Three years ago he was suddenly attacked with acute pain in the left loin, shooting down towards the thigh, and accompanied by vomiting. The attack lasted about five or six hours. Ever since then he has been subject to attacks of a similar character, coming on once a month or once in two months. Latterly the attacks had been becoming more frequent. He had one attack two days before admission and another three days after his entry into hospital. He was thin, but his general health appeared to be good. The urine contained albumen. A diagnosis was made of renal calculus, and as the attacks were becoming more frequent and were of a very severe character it was considered advisable to operate without delay. An incision was made down upon the kidney on the left side and the organ was thoroughly explored, first by palpation, and then by means of a needle. No stone having been detected by these means an incision was made into the lower part of the posterior border of the kidney and a sound passed into the pelvis, which was thoroughly searched, as also the calices, but no stone could be detected. A drainage tube was inserted and the ends of the incision closed by sutures. The case progressed without the appearance of any unfavourable symptoms, and the wound has healed with the exception of a small granulating surface. As only five weeks have elapsed since the operation it is too early to pronounce the patient as cured, yet the experience of other surgeons, in similar cases, has been so favourable, that I think we are justified in expecting that this patient will be permanently cured. Many of those present this evening have doubtless read the paper on the subject of renal tension by Mr. Reginald Harrison, which was brought forward at the last meeting of the British Medical Association. In that paper Mr. Harrison reported four or five cases identical with this one, in which a renal calculus was suspected but not found at the time of operation, and yet a permanent cure resulted. Owing to the fact that the symptoms of renal calculus may be simulated by other diseases, the practice in the

past been rather in the direction of delay in such cases. The patient is often kept under observation, with the view of trying to eliminate all other possible causes, before resorting to operation. In view of the experience gained in the treatment of such cases as this one, there can be little doubt that the older practice will be abandoned, and that in future surgeons will operate at once.

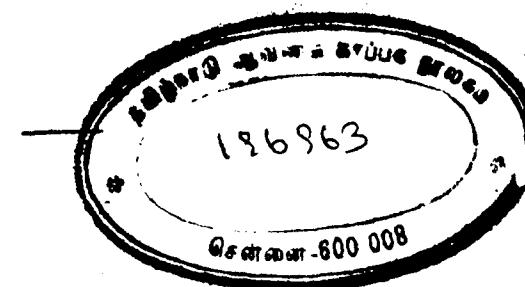
Mr. E. H. Harnack has shown (British Medical Association meeting 1901) that renal calculi of the smallest size can now be detected with absolute certainty by means of a radiograph. But the moral of such cases as the one before us this evening, is that in all instances where repeated attacks of renal colic are present, the operation of nephrotomy is called for even if the absence of a stone has been proved by the aid of a skiagraph.

AN UNUSUAL CASE OF ARSENICAL POISONING.

BY LIEUTENANT-COLONEL VAN GEYZEL, I.M.S.

Previous history good; patient aged 50; slight piles for thirty years; three years ago hæmorrhoids got worse and has had "attacks of piles" frequently. Six months ago a quack from Tanjore famous for treatment of piles was sent for and visited him at Anantapur. The quack applied a paste to the protruded masses for seventeen days, when seven lumps fell off. Three days after first application of paste he suffered from severe diarrhœa which was stopped by astringents; in a few days he began to feel numbness of right fingers, then of left fingers, followed by numbness of both arms and of the feet and legs and pricking pains in the fingers and toes followed. Subsequently he found difficulty in walking, his gait being jerky, and he then found he could not stand without support. When seen in Madras on the 10th November there were muscular tremors in legs and hands with rigidity of fingers, the hands being claw-like, and marked hyperæsthesia. There was no improvement of motor power, but there was ataxia and complete loss of knee-jerks. He was subject to hallucinations: attempting to scrub away dirt which he said was falling all round him and sometimes attempting to unravel imaginary cotton wool which he said was wrapped round his hands. I am indebted to my Assistant (Mr. Nanjunda Row) for the notes of this case, and I have myself not seen the patient. From the history of the case, and the way in which the symptoms began, there seemed to be some resemblance to recently reported cases of arsenical neuritis. On examining his urine on 12th November, distinct traces of it were detected. On being asked for a plan of treatment I advised alkalies because alkaline activity and also soluble compounds afforded the best chance of elimination. He was given 20 grains of Citrate of Potash, Spirits of Nitrous Ether with 20 grains Bromide of Potassium. In two days, the pains and muscular rigidity subsided; but the hallucinations increased. His urine was unfortunately not tested again until 19th, when all traces of arsenic had disappeared from it. Iron substituted, and the improvement has continued although the bromide has been omitted.

My impression is that the quack applied a paste of White Arsenic to the piles; and that the neurotic symptoms were due to arsenical absorption. I must add that I examined one of the lumps of piles which is said to have fallen off, and found in it only trace of Mercury but no Arsenic,—the paste possibly was a combined arsenical and mercurial paste; but the man never exhibited any signs of mercurialism. I do not say that this is positively a case of arsenical neuritis,—there are many points in favour of regarding it as such. I bring it to the notice of the Branch in order that any suspicious cases which may come under the observation of members might be more carefully investigated than has been possible in the present case.



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NOTICE.

Members are requested to notify changes of address to the Honorary Secretary, at the earliest possible opportunity. The attention of members is invited to the following by-law of the Branch:—

BY-LAW XII.

Members absent from Madras are invited to send papers of professional interest to the Secretary, by whom they will be read before the Meetings of the Society, and all matters of special value will be printed and circulated.