ART. XIV.—*Notes of some Rare Clinical Cases.*[a] By JAMES ALEX. LINDSAY, M.A., M.D., M.R.C.P.; Physician to the Royal Hospital, Belfast.

Case of Ulcer of Œsophagus, Mediastinal Abscess, and Superficial Emphysema.

CASE. I.—John C., traveller, aged fifty-nine, was admitted into the Royal Hospital upon Feb. 7, 1899. He had an attack of "blood-poisoning" twenty years ago, but otherwise had enjoyed excellent health. For some time past he had been suffering from pain in both lumbar regions, to which he did not pay much attention. During the first week of Feb. he had taken a good deal of drink; his appetite had been impaired, and the bowels rather relaxed. At eight o'clock a.m. on Feb. 7 he took 14 drops of laudanum; at ten o'clock a.m. he drank a bottle of stout, and was suddenly seized with severe pain in the epigastrium and vomited. He came to hospital at eleven o'clock and was admitted.

On admission the temperature was found to be 100°. The patient complained of pain in the epigastrium; the general condition was fairly good; the urine was found to contain a large quantity of sugar and a little albumen, and there were signs of effusion into the right pleura; the respirations were hurried; the abdomen was slightly distended and tender on palpation in the epigastric and in both lumbar regions.

The patient's condition throughout the day did not undergo any material alteration. Towards midnight his state began to change for the worse. For the first time a slight swelling was observed in the left eyelids, which proved to be subcutaneous emphysema. In a short time the eyelids became much distended, the eye completely closed, and the emphysema quickly invaded the left side of the face and neck and the upper part of the chest, extending slightly across the middle line to the right side. The pulse was 120, weak and irregular. The respirations were 56. Patient complained of pain in the abdomen and of feeling very weak.

The diagnosis presented great difficulties. We had to seek an explanation for sudden abdominal pain and vomiting, coming on after drinking a considerable quantity of fluid, followed after an interval of about fourteen hours by rapidly-developing superficial emphysema of the left side of the face, neck, and chest; and to compli-

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cate the case still further, we had sugar and albumen in the urine, and a large effusion into the right pleura. The possibility of a gastric ulcer rupturing through the diaphragm into the lung was considered. This rare accident is known to occur in cases of gastric ulcer in which adhesion has taken place between the stomach and the diaphragm. As this diagnosis seemed to leave several points unexplained, and as the patient's history did not point in any conclusive way to the presence of ulcer, no positive opinion was arrived at. The bowels were opened by enema; a sedative was administered, and it was decided to watch the case for the present. The indications seemed too obscure to justify operative interference.

The patient passed a restless night, and the following morning his condition was in most respects the same, but there was increasing weakness. He gradually sank during the day, and died at 11 o'clock p.m., thirty-seven hours after drinking the bottle of stout, and twenty-three hours after the first appearance of emphysema of the face and eyelids.

The autopsy was made by Dr. Lorrain Smith twenty-two hours after death. I am indebted to Dr. Smith for the following notes:—Emphysema was well marked in both mediastina, especially the left. The right pleural cavity contained 50 ozs. of fluid and the left 16 ozs. The fluid was flocculent serum, not purulent. Well-marked signs of acute pleurisy on both sides; lungs congested; no consolidation. Two inches above the cardiac orifice of the stomach there was an elongated ulcer, an inch and a half long, in the œsophageal wall. In the lower part of its extent it involved only the mucous membrane. The edges of the ulcer were thickened, but not indurated. There was no evidence of any malignant deposit around the ulcer or elsewhere in the œsophagus, and no secondary deposits in any of the viscera. A sinus connected the ulcer with an abscess in the posterior mediastinum between the œsophagus and the aorta. This abscess had ruptured into the lung at its root, and air had been extravasated along the deep fascia, and also along the superficial fascia of the neck. There was no communication between the abscess and the pleural cavity. A few patches of atheroma were found in the aorta. The kidneys were much congested, and the liver was fatty. In the brain there was chronic thickening of the pia and arachnoid. There were patches of atheroma in the arteries of the base, general congestion of the meninges, and œdema of the brain substance. The amount of fluid in the ventricles was increased, and the puncta cruenta were well marked. The pancreas was normal.

As to the cause of the ulceration of the œsophagus, it may have been syphilitic. There was no history of swallowing a foreign body or any corrosive fluid, but at the age of thirty-nine the patient had an attack of what he called "blood-poisoning." It seems probable that this was really syphilis, and that the ulcer had its origin in this way. There were no definitely syphilitic lesions found at the autopsy. The *post-mortem* evidence was decidedly against the hypothesis of malignant disease.

It is interesting to observe that the emphysema was first noticed in the eyelid.

Case of Probable Tubercular Meningitis, followed by Recovery.

Considerable doubt exists in the minds of many members of the medical profession regarding the possibility of recovery in tubercular meningitis. A long list of leading authorities—British, American, and foreign—might be quoted in support of the view that recovery never takes place, and that all cases of alleged recovery involve an error of diagnosis. On the other hand, Gowers says, "It is not open to question that cases do sometimes recover." Fagge and Bristowe held the same view, and although Osler has not himself seen a case of recovery, he admits that such cases have been reported by good authorities. While the subject remains in this doubtful state it is desirable to put on record every case in which recovery takes place after the diagnosis of tubercular meningitis had been made upon apparently adequate grounds.

CASE II.—Miss E. G., aged nineteen, was seen by Dr. King Kerr upon Nov. 20, 1898, when he found a considerable effusion into the right pleura. The family history was bad, there being tubercle on both sides of the house, and the mother and a younger sister being at the present time actual sufferers from phthisis. The patient had enjoyed fair health, but had suffered much from periodic headache. A few years ago some tuberculous glands were excised from the neck, the scars remaining, but perfectly healed. There was no reason to suspect the existence of any antecedent pulmonary disease, but the pleurisy had come on insidiously, and may have been tubercular in origin. The temperature upon Nov. 20 was 103°, and the pulse 96.

The case pursued a slow but not unfavourable course until Dec. 3,

when the patient first complained of headache. The previous night had been restless, and the temperature, which had fallen to 99°, now rose to 101°. On the following day, Dec. 4, the headache was exceedingly severe, and towards evening vomiting set in. The night was very bad, and on the following morning, Dec. 5, the headache was severe and continuous, vomiting frequent, the tongue thickly coated, the temperature 101·5°, pulse 96. At 4 30 o'clock p.m. on this day I first saw the patient in consultation with Dr. King Kerr. She was extremely restless, tossing about continuously in the bed, and apparently in great suffering. The pulse was frequent, regular, and of low tension. The pupils were very sluggish, but neither much contracted nor dilated. There was still some fluid in the right pleural cavity. On the following day, Dec. 6, the symptoms were still more severe. The patient was delirious, and was with difficulty held in the bed. The temperature was 101° in the morning, and rose to 102° in the evening. Tache cérébrale was well marked. The pupils were moderately dilated, and responded very feebly to light; vomiting still continued. An examination of the fundi oculi with the ophthalmoscope showed the presence of double optic neuritis, and the retinal vessels were dilated and tortuous. These signs were rather more marked on the left than on the right side. Late on the night of Dec. 6 the patient became comatose, and began to pass all evacuations involuntarily. On the following day, Dec. 7, the patient was comatose, but showed slight signs of consciousness if addressed in a loud voice. The temperature fell at night to 100°, the pulse remained frequent, regular, and weak. The pupils were much dilated and very sluggish. The patient continued able to swallow her milk. The evacuations continued to be passed involuntarily. This condition lasted from Tuesday, Dec. 6, to Friday, Dec. 9, without substantial change. The patient was seen several times daily by Dr. King Kerr, and each afternoon we met in consultation, only the slenderest hope of recovery being entertained. On Friday, Dec. 9, the coma showed signs of abating. The next day there was some further improvement, and upon Sunday, Dec. 11, the change for the better was marked. From this time forward the patient made an uninterrupted recovery, and in about three weeks had regained her ordinary health. During convalescence she complained of persistent vertical headache, which only disappeared slowly and by degrees. The fluid in the right pleural cavity gradually became absorbed.

The treatment adopted consisted in the continuous application of cold to the head by means of Leiter's tubes, the internal adminis-

tration of iodide and bromide of potassium, and the occasional employment of a mercurial purge.

It will, I think, be admitted that this was at least a case of meningitis, whether tubercular or not. The possibility of any alternative diagnosis, more especially of typhoid fever, was carefully considered, but was clearly inadmissible. The temperature was not in the least like typhoid; there was no rash, no enlargement of the spleen, no diarrhœa; the tongue was not typhoid in character.

In favour of the meningitis having been tubercular we have a quite unusual combination of evidence—the family history, the previous existence of tuberculous glands in the neck, the presence of a suspicious pleurisy all point in one direction. It is noteworthy that no slowing of the pulse and no paralysis of any of the cranial nerves appeared. The absence of any pressure symptoms justified a hope of recovery, which was never quite abandoned, and which was finally justified by the result.

Case of Non-febrile Pneumonia.

CASE III.—S. M'F., aged thirty-three, male. *Family History* good; both parents living. *Personal History*—No previous illness of any importance; habits very intemperate.

History of Case—On Thursday evening, Oct. 13, 1898, patient consulted Dr. M'Kisack. He complained of having suffered from headache, sickness, abdominal pain, and malaise for several days. The tongue was covered with a creamy white fur, the breath was foul; pulse 80, temperature 98·8°, respirations 20. No abnormal signs in chest or abdomen. The patient passed a fair night and next morning, Friday, Oct. 14, he was again sick and vomited after breakfast. Temperature normal, tongue still dirty. Dr. M'Kisack again examined the chest, but did not find anything abnormal. On Friday afternoon the patient felt better and sat for some time in the dining-room and talked with several visitors. At 9 p.m. it was noticed that his breathing was hurried, and he had some difficulty in going upstairs to bed. He passed a restless night. Dr. M'Kisack saw him again at 9 o'clock a.m. on the following morning, Saturday, Oct. 15, when a marked change in the general condition was manifest. The respirations were now 36 per minute, the pulse 100, temperature in the mouth and in the groin 96·5°. Signs of consolidation of the base of the right lung were now manifest—viz., dulness on percussion, bronchial breathing, and increased vocal fremitus. I saw him in consultation with Dr. M'Kisack at 4 o'clock p.m. on this day. In addition to the above

signs there was some crepitus audible over portions of the lower lobe of the right lung. The pulse was 106 in the minute and very weak; temperature in the groin 98°, in the rectum 99°; respirations 36. The patient was much collapsed, but quite conscious. The condition being evidently one of the utmost gravity the relatives were telegraphed for and arrived in a few hours. The patient got rapidly worse. At 8 o'clock p.m. the temperature for the first time began to rise, and reached 101°. The patient quickly sank and expired at 9 30 o'clock.

The points worthy of note in this case are the following:—(1) The obscure onset, the symptoms at first being purely gastro-intestinal and probably connected with the patient's alcoholic habits. (2) The absence of pyrexia until within a very short time of death, in spite of the presence of a considerable amount of consolidation of the right lung. (3) The absence of any reaction, the patient rapidly sinking under the pneumonic attack. In this collapse no doubt alcoholism was a chief factor. (4) The fact that death ensued within twenty-four hours of the definite onset of pulmonary symptoms.

The treatment included the administration of carbonate of ammonia, digitalis, strychnin, and alcohol, together with inhalations of oxygen, but proved wholly ineffective.

The immediate cause of death in the above case may admit of some doubt. The signs were more those of general collapse than specially those of heart failure, which is, I believe, the usual cause of death in pneumonia. In many cases death is preceded by evident signs of failing heart, but is very sudden at the end. In these cases the right ventricle is often found full of soft whitish clot. Possibly plugging of the pulmonary artery may sometimes be the determining cause of death.

Into the general treatment of pneumonia it is unnecessary for me to enter. I rely chiefly on strychnin, alcohol, and inhalations of oxygen. My early experience of oxygen was disappointing, and at one time I was disposed to take a low view of the value of this remedy. Recently I have been more fortunate, and believe I have seen substantial benefit from its administration. No doubt the benefit is often transient, but in an acute self-limited disease like pneumonia every moment gained is a substantial advantage to our patients.