

placed on the "Tufnell" diet. Iodide of potassium with various anodynes was given in gradually increasing doses until the patient was taking 70 grains three times daily and then, and not until then, a marked improvement began to be noticed. After three months he got up and a week later was walking quietly about with no pain and very little of the swelling in the suprasternal notch. He went to the seaside and two months later when he returned to his business in the city he was looking well, there was no swelling, and I could hear no bruit.

The second case was of a similar nature. The patient was a man who had engaged in violent physical training and presented on examination a painful pulsating tumour in just the same situation, though the bruit was not so easily heard; but evidently in this case, as in the former, the aneurysm was sacculated and was not an enlargement of the whole circumference of the aorta. He was kept in bed on the same strict diet and was given iodide of potassium in increasing doses with at times aperients and anodynes and on one occasion arsenic. When the doses of iodide of potassium had reached 75 grains three times daily a marked improvement commenced and this was kept up for 14 weeks. At the expiration of this period he got up and shortly afterwards went into the country. I saw him some months later and he expressed himself as feeling exceedingly well and thought that he could do a little "training" again, which, however, I strongly advised him against.

The third and last case which I propose to describe was the worst and looked for some time almost hopeless. The patient was a man, aged 23 years, who had undoubtedly been suffering for a considerable time and had received various kinds of treatment in accordance with the different diagnoses which had been made. He had been accustomed to play the cornet almost every evening and to this, as the immediate cause, I attributed his trouble. It was six years before I saw him that he first began to be troubled with pain on the left side of his chest which he stated was at times so severe as to produce actual vomiting; at other times it was of a dull, aching nature, and increased on taking a deep inspiration. After enduring these pains for four months he consulted a medical man who treated the condition as one of rheumatism. After continuing in this state for about a year, the pains troubling him on and off, he noticed a swelling on the left side of his chest near the clavicle. Becoming gradually worse, he consulted several other medical men, two of whom applied iodine externally, while the last said that nothing could be done for him. He first consulted me on March 6th, 1901, when I prescribed lead-and-opium lotion to be applied over the swelling which was situated in the second left intercostal space. On March 19th I placed him on iodide of potassium with some other ingredients of a simple nature. He seemed to have slightly improved, for I lost sight of him and he went on playing the cornet up to December, 1901. In January, 1902, he had, however, become so ill that when he sent for me on the 11th I found him in bed and in a most serious condition, the tumour protruding about an inch and a quarter from the anterior wall of the chest and pulsating strongly. It was expansile and a bruit was audible. I at once prescribed a restricted diet, aperients, and iodide of potassium with anodynes and depressants. Some weeks later Sir William Broadbent saw him in consultation with me and thought it best to continue with the same treatment. After he had been in bed for eight weeks Sir William J. Collins saw him with me and was of opinion that he had better try another eight weeks of the same treatment. Sir William Broadbent did not advise a larger dose of iodide of potassium than 60 grains. About the ninth week I increased the dose to 70 grains three times a day and one evening the patient became so ill that I was sent for hurriedly and Dr. F. Edridge-Green, who accompanied me on this visit, remarked that he would not give much for the patient's life. The thin part of the anterior wall where the skin was tightly stretched had given way slightly and a considerable quantity of blood had escaped, which, however, ceased as the pressure became lower. Up to then, be it noticed, there was little or no indication of any improvement and I thereupon increased the iodide of potassium to 80 grains three times daily, the low diet, absolute rest, and scarcely any drink at all being still maintained. After taking 240 grains daily for a few weeks the patient made very excellent progress; in about seven weeks from the date of the hæmorrhage he was out of bed and in about three weeks more he was at the seaside. I have seen him within the last few weeks and

he is looking exceedingly well; he goes to business and leads a quiet life without much inconvenience. Beyond a few spots on his legs and two on his forehead he betrayed no signs of iodism and I cannot help remembering the words of one of my old teachers, who is unfortunately no longer among us, that if iodism showed itself the proper course was to double the dose.

I think that most physicians hesitate to give iodide of potassium in doses of more than 60 grains, but the point which I wish to insist on is that little result is obtained in bad cases until the dose is over 60 grains. I have not as yet, however, given more than 240 grains per diem to any patient.

Haverstock-hill, N.W.

## BRADYCARDIA IN HEALTH.

By ROBERT J. BLACKHAM, L.R.C.P. EDIN.,  
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ON looking up the subject of bradycardia in standard works on cardiac diseases one is struck by two facts, the first being that some diversity of opinion obtains as to whether it is a comparatively common or a very rare affection and the second that great dissatisfaction exists with regard to the name itself, although it is blessed by the approval of the Joint Committee of the Royal College of Physicians of London, some preferring the term "brachycardia" and others insisting on a change of nomenclature to "araiocardia," "oligocardia," &c. Osler affirms that bradycardia "depending on individual peculiarity is extremely rare," whereas Professor Clifford Allbutt states: "Of normal slow pulse we see many examples." The former view is supported by Dr. Frederick Taylor who states: "As a purely functional disturbance it (bradycardia) is extremely rare," and in "The Twentieth Century System of Medicine" by the statement that "permanent bradycardia implies, as a rule, organic disease usually of the nervous system of the heart," the inference being that permanent bradycardia without organic disease is rare. In Osler's view I think most general practitioners will concur and the writers of the smaller books on medicine support this opinion by the fact that they dismiss the subject in a few lines. Osler treats of the syndrome under two heads and speaks of physiological and pathological bradycardia, giving ten causes of the latter which may be briefly summarised as follows: (1) convalescence from the acute fevers; (2) diseases of the digestive tract; (3) diseases of the respiratory system; (4) cardiac disease; (5) disease of the genito-urinary tract; (6) toxic agents such as lead, alcohol, tobacco, digitalis, &c.; (7) anæmia; (8) disease of the central nervous system; (9) certain diseases of the skin; and (10) asthenia. Professor Clifford Allbutt's epigrammatic summary of our knowledge of the condition is worth quoting. He says: "Bradycardia is a superfine name to denote slow pulse; it connotes nothing."

In military practice, whereas tachycardia, or, as the official nomenclature puts it, "273 Disordered Action of Heart (b)," is a very common disability amongst young soldiers, "Disordered Action of the Heart (a)"—to give bradycardia the name by which it is known in army medical statistics—is, in my experience, an extremely rare affection, so that a case which came under my care last year appears to be worthy of record, especially as it recalls the classical case of Napoleon, who is stated by Corvisart to have had a pulse of only 40 per minute.

The patient is a soldier, over 40 years of age, of medium height and exceptionally fine physique. He is a man who has led an extremely active life and has held many responsible positions. He is a good athlete and has lived carefully and abstemiously in a manner worthy of his military training. He came under my care complaining of præcordial pain of a transient character at long intervals. He was aware that his pulse was unusually slow as the fact had been commented on many years previously by a medical attendant. On examination I found the apex beat in the usual position and the areas of superficial and deep cardiac dulness perfectly normal. The cardiac sounds were absolutely clear over the various auscultatory points but the pulse was found to be only 45 per minute. Violent exercise sent the rate up to 50 or 55 per minute but it never exceeded the latter figure and rapidly fell to 50 or less after a brief rest. The

lungs, liver, kidneys, and spleen were normal and there was not the slightest trace of organic nervous disease. The patient is a man of iron nerves, as may be gathered from the fact that he is a rifle shot of the first order and has won many prizes for shooting. He had suffered from occasional attacks of flatulent dyspepsia and it was to one of these attacks with its concomitant cardiac pain from distension of the diaphragm that I was indebted for an opportunity of observing a case of what I believe to be absolutely physiological bradycardia. I placed the patient on a careful dietary and a course of stomachic bitters with pepsine and the præcordial distress rapidly disappeared and, so far as I am aware, has not returned. He was under my immediate supervision for upwards of six months and I have heard from him at intervals since. The last Indian mail brought me a letter from him informing me that at the time of writing he was in excellent health and free from the præcordial discomfort but that the pulse-rate remains unaltered, so as the patient came under my observation nearly 18 months ago the condition may be safely considered to be permanent.

The case is, of course, not unique, as in addition to the case of Napoleon mentioned above, Roux, Sir William Broadbent and other observers have recorded somewhat similar ones, but it is, I think, sufficiently uncommon, especially in military practice, to merit being placed on record.

## Clinical Notes:

### MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

#### CONCERNING THE NATURE OF THE GREEN PIGMENTATION OF THE TISSUES IN CHLOROMA.

BY EDGAR G. TREVITHICK, M.D. CANTAB.,  
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IN describing a case of chloroma in THE LANCET of July 18th, 1903, p. 158, I stated that the brilliant green pigmentation of the affected organs faded rapidly after their removal from the body and that I had been unable to find any reagent that would bring back the colour. I now wish to record the observation that when such organs are treated with a solution of peroxide of hydrogen the green colouration becomes quickly restored. When removed from the peroxide bath the colour again fades away, but if after the tissues have been thus a second time bleached by exposure to air they be once more immersed in the peroxide solution the green colouration reappears.

I send this additional note on the case in the hope that the facts herein stated may enable those who are well versed in the subject of pigmentations to form some opinion as to the nature of the substance responsible for the manifestations described.

The kidneys, the ovaries, the uterus, and certain other tissues from this case had rested in formalin solution for rather more than two months and had entirely lost their greenness. When, however, one of the kidneys was placed in the peroxide solution the distribution of the original green pigmentation became, in the course of a few minutes, most faithfully reproduced. The whole of the subcapsular layer quickly regained its green colour and, in addition, all the small green islands originally described as occurring in the medullary portion of the gland again came into evidence.

Cheltenham.

#### HERNIOTOMY UNDER LOCAL ANÆSTHESIA.

BY MARCUS MARWOOD BOWLAN, M.B., B.S. DURH.,  
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THE interesting lecture on Local Analgesia by Mr. A. E. J. Barker published in THE LANCET of July 25th, p. 203, leads me to submit the following brief note of a case of herniotomy under local anæsthesia.

The patient, who was a feeble woman, 77 years of age,

vomited on June 12th, 1903, and this continued until the next day (the 13th). When she came under my care I found her to be suffering from a right femoral hernia with absence of impulse on coughing. The vomit consisted of the contents of the upper intestine. The breath had a faecal smell. The specific gravity of the urine was 1023, it was acid, and contained a trace of albumin. On the same afternoon 40 minims of a 1 per cent. solution of beta-eucaine were injected under the skin of the area selected for incision and a quarter of an hour later the incision was made, the patient feeling no pain. About 20 minims more of the same solution were dropped into the wound during the dissection so that only one drachm of the 1 per cent. solution of eucaine was used. On opening the sac the gut exposed was found to be deeply congested and some blood-stained fluid escaped. However, on examining the crural ring with the finger the hernia slipped back through it so that the hernia knife had not to be used. The sac was separated and tied with catgut. The patient retched a little during the night and had occasional hiccough, feeble pulse, and dryish tongue, but these symptoms quickly yielded to whisky and strychnine. Flatus was passed per anum on the next day but the bowels were only moved by an aperient four days later. The wound was apparently healed on the fifth day when it was dressed and the sutures were removed, but when it was dressed again on the 24th a small subcutaneous abscess had formed and this was drained with gauze. Possibly the eucaine solution was not quite sterile, though her temperature was never above 98.8° F. By July 21st the wound was quite sound and a few days later the patient was up and about but, of course, wearing a truss.

Before, and for a few days after, the operation the condition of the patient was serious, the heart's action being feeble and irregular, and it is a question whether a general anæsthetic would not have added sufficient (drug) "shock" to have proved fatal.

St. George's-in-the-East Infirmary, E.

## A Mirror

OF

### HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

#### WESTMINSTER HOSPITAL.

A CASE OF ŒSOPHAGOTOMY FOR THE REMOVAL OF A PORTION OF AN UPPER TOOTH-PLATE.

(Under the care of Mr. WALTER G. SPENCER.)

FOR the notes of the case we are indebted to Mr. G. Brittan Gill, house surgeon.

A female, aged 37 years, broke her upper tooth-plate but continued to make use of the two portions. On June 12th last, whilst at breakfast, the smaller fragment containing a bicuspid and two molars was carried into the pharynx. In trying to remove it the patient pushed it downwards out of reach. She was then seen by Dr. M. Sharman of Rickmansworth who made repeated attempts to extract the plate, in which he was assisted by Dr. E. A. Peters. The plate was several times grasped by forceps but could not be drawn upwards. For some days the patient refused but ultimately consented to go to hospital. Meanwhile she had marked dysphagia and pain in flexing the head but no dyspnoea. A skiagram showed the plate to be situated about the level of the seventh cervical and first dorsal vertebræ, a short distance below the cricoid cartilage.

On June 16th—i.e., on the fifth day from the accident—the plate was removed by Mr. W. G. Spencer, assisted by Mr. E. P. Paton, Dr. Sharman and Dr. Peters being present. The patient was anæsthetised without difficulty and then a fulness could be detected in the neck low down on the left side, but there was also a considerable enlargement of the thyroid gland. A No. 18 bougie was passed without meeting with any marked obstruction. An incision was made along the inner border of the left sterno-mastoid from the level of the thyroid cartilage for an inch