Clinical Notes, Suggestions, and New Instruments

WOUND DIPHTHERIA COMPLICATED BY RHEUMATIC FEVER

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March 19, 1917, E. B., boy, aged 5 years, of German descent, was brought to my office with the history of a fall three weeks before, resulting in a wound of the ulnar side of the palm just below the wrist. This was said to have "healed up" and "opened again" one week before he was seen. He was pale and looked ill, but there was no elevation of temperature. The nose and throat did not show any acute lesion. Inspection of the hand revealed a wound 1½ inches long and from one-eighth to one-half inch wide, covered by a firm gray membrane. A culture revealed diphtheria bacilli. March 20, I called at his home and injected 5,000 units of antitoxin. The membrane disappeared from the wound in two days. March 27, the temperature rose to 103.6 F., and there were pains in both knees and the right ankle. The throat was reddened and next day the tonsils were covered with a loose exudate. A diagnosis of rheumatic fever was made. The temperature reached normal, March 31, when the patient was last seen. He still had a slight tenderness on pressure over the insertion of the left hamstrings.

On the day antitoxin was injected, a brother, C. B., aged 10 years, was found with a temperature of 103.5 F., evidence of inflammation of the mucous membrane of the nose, many punctate spots on the tonsils, and enlarged and very painful glands in the neck. Five thousand units of antitoxin were injected. A culture taken from the tonsils proved negative, but a diagnosis of diphtheria seemed safe. Recovery was prompt.

Another brother, G. B., aged 8 years, had excoriations at the edges of the nostrils, and evidence of inflammation of the mucous membrane of the nose. The mother stated his nose had been like that for a month. He received 1,000 units of antitoxin. The next day the temperature was 100.5 F. A culture was taken from the nose, and diphtheria bacilli found. Next day the temperature was normal and recovery good.

Two other boys were immunized.

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AN UNCOMMON FRACTURE OF THE PELVIS

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A man, aged 42, while walking in his sleep, Nov. 27, 1913, fell from the upper story of his dwelling, a distance of about 12 feet. It would appear that the fall was partly broken by the hands and that the main force of the impact was received on the left side of the chest and over the left trochanter major. These deductions are made from the external marks of violence, the patient not knowing anything of the circumstances. He did not awaken as a result of the fall, being still asleep when found.

On examination, no fractures were discovered. Palpation of the left leg, thigh and hip was negative. There was no shortening, eversion, inversion or other deformity. The patient, however, was unable to extend the leg on the thigh, and when this was passively done, a slight vibration (not a crepitation) was transmitted to the hand held over the thigh. This gave the impression as if the head of the bone were sliding out of the socket and returning with a jump, such as is experienced in contortionists with lax ligimentum teres and joint capsule. The patient felt this also but experienced practically no pain.

Roentgenoscopy revealed a fracture beginning just beneath the anterior inferior spine of the ilium and extending downward and inward on about the line of union between the ilium and ischium, passing through the acetabulum and continuing on through the body of the ischium, completely separating the os innominatum into two parts. There was considerable separation of the fragments at the beginning of the fracture line. Another fracture was noted in the ischium, a serrated fracture line extending transversely through the ramus of the bone.

The cause of the fracture was the blow transmitted from the great trochanter through the neck to the head of the femur. The rule is for the neck to give way.

The patient was treated in a Bradford frame with a lateral splint extending from under the arm to beyond the sole of the foot, with a cross piece, buckle straps and swathe being used to retain it in place. The frame was supported on an ordinary bed with mattress removed. Two cross pieces of heavy timber were placed across the bed, one at the head and the other at the foot, to receive the frame. Two planks, placed on this, outside the frame, served as a convenience for attending to the patient's wants.

Passive movement was begun on the tenth day, and the patient was allowed up on the forty-second day.

There was no shortening of the limb, no pain on movement, and the patient has complete use of the leg, the anatomic and functional results being perfect.

One year after the accident the patient was able to spend the entire day wading through rice paddies, shooting snipe, without pain or abnormal fatigue.

SIMPLIFIED TECHNIC FOR LOCAL ANESTHESIA OF TONSILS

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Some textbooks in describing injection of the tonsils for local anesthesia show six or seven points at which we are told to inject. Others use a curved needle and inject just under the mucous membrane. Both of these methods cause an edema of the tissue, causing so much distortion that often it is hard to find the tonsil, and after operation there is bound to be more or less reaction from the introduction of so much fluid into the tissues. Again, our anesthesia is often poor and unsatisfactory.

The middle and posterior palatine nerves (branches of Meckel's ganglion) join with the tonsillar branches of the glossopharyngeal nerve to form a plexus around the tonsils (circulus tonsillaris).

With the exception of the mesial free surface, the tonsil is surrounded by a distinct fibrous capsule, and external to this capsule is found the pharyngeal aponeurosis, which is rather loosely associated with the capsule. External to this is the superior constrictor muscle of the pharynx.

The circulus tonsillaris forms around the capsule in the loose pharyngeal aponeurosis, and then sends small branches into the tonsil proper, both anterior and posterior pillars.

First it is necessary to diminish the pharyngeal reflexes, by either spraying or swabbing the oropharynx with a 10 per cent. solution of cocain, the swabbing being a much safer method. Applications are made at two minute intervals, until the reflexes are under control and the patient does not gag easily. Two or three applications are usually sufficient, though some patients may need six or more. In nervous persons it is wise to give a hypodermic injection of one-fourth grain of morphin ten minutes before the patient comes to the operating room.

After the reflexes have been brought under control, the anesthetic fluid is injected. Novocain solution, 1 per cent., with 15 minims of epinephrin solution, 1:1,000, to one-half ounce of the novocain solution, is the most satisfactory anesthetic. Schleich's solution No. 1, with 15 minims of epinephrin solution works well. Instead of a small sharp needle or one of the hooked tonsil needles, a medium size, fairly blunt, short pointed, ordinary spinal puncture needle should be used. The needle is inserted through the center of the tonsil outward and backward, with the idea of placing the point of the needle as near as possible between the capsule and aponeurosis at its exact center, which procedure is easy. The needle is shoved through the nonresisting tonsil tissue until a slight resistance is felt, which is the fibrous capsule,