

REPORTS

ON

MEDICAL & SURGICAL PRACTICE IN THE HOSPITALS
AND ASYLUMS OF GREAT BRITAIN, IRELAND,
AND THE COLONIES.THE FRENCH HOSPITAL AND DISPENSARY,
LONDON.SUBNORMAL TEMPERATURES IN THE CONVALESCENCE FROM
INFLUENZA.(Under the care of LOUIS VINTRAS, B.Sc. Paris, L.R.C.P.,
M.R.C.S. Eng., Resident Medical Officer.)

THE use of the thermometer in this disease has been generally limited to the registration of the fever during the attack, and the following circumstances have thus, I think, escaped observation.

If during the period of depression which follows the initial attack the mercury is shaken down below 95° F., it will be found that it does not rise to normal when the patient's temperature is taken, and that the greater the weakness the lower the mercury. This my father (Dr. Vintras) noticed repeatedly during the recent epidemic, and having remarked the fact, made a point of taking what may be termed the "minus" temperature during convalescence in all cases of influenza. He thus found that, as soon as the fever has subsided, when the well-known intense depression sets in, the thermometer is often below 96° F.; that gradually, as the strength of the patient returns, it rises until it finally attains normal.

One of the principal dangers of influenza lies in the liability to relapses and complications during the second stage, when the patient, feeling somewhat stronger, and having apparently recovered, resumes his ordinary mode of life, and gradually relinquishes all precautions. Still, if his temperature were taken, it would in many cases be found considerably below normal. If in this condition he catches a chill, it is not surprising that the result should often be serious, in some cases fatal.

This second stage is of variable duration, and in people advanced in years or with a weak constitution, may last for several weeks. It becomes then important to have some reliable guide as to the patient's progress and ultimate recovery. This we find in the subnormal scale of the thermometer. In assuming duty at the French Hospital, I took the morning temperature (February 24th) of eight in-patients, still suffering from the effects of influenza, and found in every case a subnormal temperature, varying from 96° to 97.4°. The lowest temperature (96°) was in a woman aged 67, suffering from chronic bronchitis, who had been admitted with influenza on January 2nd.

A man, aged 38 (under the care of Dr. Keser), who had had influenza three weeks previously, had a temperature of 97° (10 A.M.); in the afternoon of the same day, after dinner, the temperature was 97.3°, in the evening 98°. The next day his morning temperature was 97.3°, evening 98°. Six days later his temperature was normal, and he was discharged.

A man, aged 31, was admitted, under Dr. Keser, on February 8th, suffering from a severe attack of influenza; the debility following had been severe, and on February 24th the morning temperature was still only 97°, evening 97.4°. On March 1st, morning temperature 97.4°, evening 98°.

A man, aged 28, had a slight attack of influenza five days previous, which had not prevented him following his occupation; he was admitted on February 24th, complaining of great weakness, pains in the limbs, and feeling altogether unfit to continue his work. His temperature was 97.4°. After a few days' treatment in the hospital, with good diet and tonics, his temperature had gradually risen to normal, and he was discharged.

A woman, aged 60, was admitted under Mr. de Méric on January 11th, suffering from a severe attack of the malady, from the effects of which she has not yet entirely rallied. On the day in question the temperature was 97° in the morning, 98° an hour after dinner. On February 27th she complained of great pain in the abdomen, and vomited bile; this greatly increased her weakness, and the next day her

temperature had fallen to 96.4°. On March 2nd it had again risen to 98°.

It will be noticed that if the temperature is taken shortly after dinner it is higher than that taken in the morning, and that in some cases it may be as much as one degree above.

The practical result of these observations is that the thermometer is our only reliable guide as to the progress of the convalescence; that, so long as the temperature remains subnormal, the patient's condition is one that still requires the greatest care, and that his recovery is only complete when the mercury has risen to and remains normal. Further, the rise of the temperature after meals points in favour of the stimulating treatment of this disease.

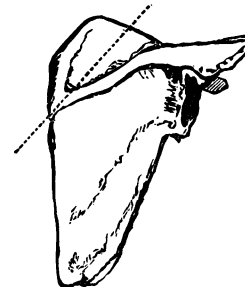
KING'S COLLEGE HOSPITAL.

CASE OF FRACTURE OF SCAPULA SEPARATING ITS UPPER AND
INTERNAL ANGLE.

[Reported by M. KNOX SOUTTER, M.R.C.S., L.R.C.P.]

THE patient, a Covent Garden porter, of fair muscular development, whilst carrying a box of fruit upon his head, slipped forwards, and the box at the same time falling backwards, its edge struck him on the back of the right shoulder. Upon recovering himself, he was unable to use his right arm and experienced considerable pain over the right scapula.

About half an hour, after infliction of the injury there was considerable pain and tenderness but not much swelling over the part. The superior and internal angle of the bone was to be felt displaced downwards and slightly inwards, an irregularity being felt in the vertebral border just below the level of the spine. This irregularity was caused by the projection inwards and slightly downwards of the inner and lower angle of the upper fragments. Between these separated parts of the vertebral border could be felt a small part of the roughened edge of the lower border of the upper fragment. On grasping the upper fragment between the thumb and forefinger of the left hand, and fixing the spine by those of the right, the upper fragment could be moved upon the lower, distinct bony crepitus could be elicited, and the line of fracture could be made out running across the supraspinous fossa, extending from a point on the upper border of the bone two inches from its inner extremity, to the vertebral border just including the triangular smooth surface at the inner extremity of the spine. Upon laying the left hand flat over the injured part and moving the shoulder, by means of the elbow grasped in the right hand, bony crepitus could also be made out.



Sketch showing approximately line of fracture in the bone.

The following treatment was adopted. Three pads were used; one was placed above the spine and one below it, whilst the third was placed between the vertebral border and the spinal column. The two former were thick pads, each about two and a-half inches long, and the latter extended the whole length of the vertebral border. The fragments being adapted as near as could be made out, and held there, the pads were applied and fixed in position by means of stout strapping. The spaces between them were filled up with wool, and over all roller bandages were applied, fixing and supporting the elbow, the arm, and shoulder. The whole was left undisturbed for three or four weeks, with the exception of the occasional application of a bandage. After which time the whole apparatus was removed and the following condition revealed. The fragments were found united but some

deformity persisted, the vertebral border projecting a little at the seat of fracture. The arm was kept in a sling for two weeks longer (being retained beneath the clothing for the first week) when at the end of this time all treatment was discontinued, and with the exception of some weakness of the arm the patient had regained entire use of the limb. I have been unable to find a report of any quite similar case in recent surgical literature.

REPORTS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

FRIDAY, MARCH 11TH, 1892.

Sir DYCE DUCKWORTH, M.D., LL.D., F.R.C.P., President, in the Chair.

Nerve Grafting.—Mr. DAMER HARRISSON, after recalling the excellent results that followed close apposition of the ends of divided nerves, observed that the only satisfactory method of dealing with nerves, the ends of which were too far apart to admit of their being sutured, was by nerve grafting. He referred in detail to the history of eight cases in which this operation had been performed at home and abroad, and then narrated a case under his own observation. A lad, aged 13, was admitted into the Liverpool Northern Hospital eleven weeks after a cut of the front of the right wrist had divided the median nerve and all the flexor tendons except the flexor carpi ulnaris. On admission the fingers were immovably fixed in the flexed position, paralysis of both motion and sensation being complete in the region supplied by the median nerve. Trophic changes were also present, the hand being blue and cold, the skin glossy, and the short muscles of the thumb much atrophied. The flexor tendons were found to be matted together; nearly 2 inches of the median nerve had been destroyed, leaving a gap between the ends. After dealing with the tendons, the nerve ends were freshened, thus increasing the separation to 2 inches, and a graft $2\frac{1}{2}$ inches in length, taken from the sciatic nerve of a recently killed kitten, was fixed in position by one fine catgut suture at each end passing through the substance of the nerve. The limb was then put in a splint, with the hand flexed and the fingers straight. The wound healed by first intention. Sensibility began to return in the palm at the end of forty-eight hours, and eventually extended to the fingers and the thumb, except to the tips of the fingers. There was also transference of sensation impressions, those from the index finger being referred to the middle finger. At the end of three months the nutrition of the hand showed great improvement. Motion did not return until the end of five months, and appeared first in the short muscles of the thumb. Now the patient could oppose the thumb to the index finger. Another operation of the same kind had still more recently been performed by Mr. Mitchell Banks, of Liverpool, upon the ulnar nerve at the elbow after excision of a neuromatous tumour, 4 inches being grafted from the sciatic nerve of a dog. Sensation returned within thirty-six hours. Of the ten cases quoted by Mr. Harrison, three were perfectly successful, six partially successful, and one failed. He attributed the difference in the success attending primary and secondary grafting to the trophic disturbances present when grafting was resorted to as a secondary operation. Restoration of function took place readily enough after long periods of time in respect of sensory nerves, but the degeneration which took place forthwith in the distal portion of motor nerves rendered repair slow and the return of function very gradual. —The PRESIDENT asked what medium had proved most suitable for nerve grafting.—Dr. SAVILL described a case in which $1\frac{1}{2}$ inch of the median nerve was wanting after two operations; he had sutured the ends together, and, although there was considerable delay, union was at last restored.—Mr. HARRISSON, in reply, said that segments of nerves of various animals had been tried, all with equal success. Whether the medium permitted the growth of nerve substance downwards was an interesting point.

Peritonitis from Hæmorrhage.—Mr. PAGE read a paper on three cases of abdominal injury without external wound, in which general peritonitis began within a few hours of the accidents, and was accompanied by large quantities of

extravasated blood in the peritoneal cavity. The abdomen was opened in a case of ruptured spleen 46 hours after the accident, and the complete washing out of blood from the peritoneum gave marked relief, lessened the evidences of peritonitis, and seemed to come very near indeed to saving the boy's life. The injury in a case of ruptured liver was more severe, several ribs being broken; but here also the peritonitis was unquestionably reduced by peritoneal flushing 27 hours after the accident. In a second case of ruptured liver the injury was complicated by slight laceration of one kidney, and the amount of hæmorrhage had been enormous. Operation, 29 hours after the accident, gave no relief. Notwithstanding the fatal results in these three cases the object of the writer in recording them was again to urge the advisability of early exploration, and especially whenever peritonitis followed and abdominal injury without external wound. The propriety of such a step had been well established in the case of ruptured intestine, but the surgeon might have to do with a lesion of one of the viscera, in itself of comparatively small moment. The real source of danger in such cases lay in the stagnant blood in the peritoneal cavity, and the abdominal exploration and peritoneal flushing were the means of averting death from the general peritonitis which was almost certain to ensue.—Mr. ARBUTHNOT LANE mentioned two cases of abdominal section for ruptured spleen, both eventually fatal from loss of blood; in another case of extensive laceration of the liver the hæmorrhage could not be arrested. He advised the more constant performance of exploratory operations for cases of abdominal injury.—Dr. M. HANDFIELD JONES mentioned a case of ruptured tubal gestation, in which the abdomen contained 40 or 50 ounces of blood for four days without sign of any peritonitis; in two other similar cases the presence of blood had not determined peritonitis. He thought the inflammation, when it occurred, was not due to the blood alone, but to the presence of impurities, such as bile or liquor amnii.—Dr. VOELCKER mentioned the case of a child run over by a cart, who had symptoms of abdominal hæmorrhage, and lived five days. After death $4\frac{1}{2}$ ounces of blood were found in the peritoneal cavity due to rupture of the liver; there was only one small patch of peritonitis.—Mr. BOWLBY said that peritonitis was not generally found, *post mortem*, after rupture of the spleen, but did usually follow rupture of the liver. Operation on every case of suspected abdominal injury would produce more unsuccessful than successful cases; and though something might be done for laceration of the spleen, he failed to see what benefit was anticipated from abdominal section in cases of ruptured liver.—Mr. SILCOCK thought that in cases of rupture of the intestine the escape of microbes caused the inflammation, and mentioned the case of a child with severe abdominal injury followed by peritonitis, in which very great relief was produced by emptying the lower bowel of its load of fæces.—Mr. HERBERT ALLINGHAM had performed abdominal section on a child run over by a heavy waggon. The abdominal cavity was full of blood, which was washed out. The child did well for four days, when peritonitis and death ensued. *Post mortem* injury at the back of liver was found, though at the operation there had been no sign of peritonitis.—Mr. PAGE, in reply, said the weight of evidence favoured the opinion that the presence of blood alone did not cause peritonitis. He was still of opinion, however, that it was desirable to get rid of all fluids from the peritoneal cavity which were foreign to it.

Mediastinal and Pulmonary Carcinoma.—Dr. PERCY KIDD described this case. The patient, a butcher aged 52, had suffered from cough, expectoration, dyspnoea, and wasting for three months. On admission there was retraction of the left side of the chest in front, with dullness over the whole lung, most marked at the upper lobe. The temperature maintained a remittent character throughout, varying from 101° at night to 99° in the morning. A troublesome cough, copious expectoration, and dyspnoea were the chief symptoms. Death occurred from exhaustion about eight weeks after admission. The case was regarded as one of chronic phthisis with thickening and adhesions of the pleura. The necropsy disclosed a large carcinomatous growth in the fork of the trachea, extending into and infiltrating the upper lobe of the left lung, which was firmly adherent to the ribs, the lower lobe was partially collapsed, and the bronchi were dilated and filled with pus. The whole was much reduced in size. There was no