

The general inquiry on the subject of appendicitis in Germany during the year 1907 set on foot by the Berlin Medical Society two and a half years ago is now complete, and the statistics collected were communicated by Professors Albu and Rotter to the society at its last meeting. The statistics deal with 4,800 carefully tabulated cases. Of the cases that came under medical treatment from the first day of illness, 4.1 per cent. ended fatally; of those medically treated from the second day, 4.9 per cent.; and of those not under medical care until at a later stage, 11.9 per cent.; 68 per cent. were first and 19 per cent. second attacks, the remaining 13 per cent. third (or more) attacks. Of the 4,800 cases, 1,344 came under operation, the majority being severe types. Of those operated within the first forty-eight hours, no more than 0.9 per cent. died; of those operated on the third day 7 per cent. died, the mortality figures rising considerably after longer intervals. As regards sex of the cases, males were in the majority by about 10 per cent. Children gave the highest proportion of fatal endings, probably because children in general fail to give a clear account of their symptoms.

In a paper on heating and ventilation of schools, read before the German Society for Public Hygiene, Dr. A. Marx gave an account of a real set of botanical experiments, which prove by analogy how all-important sunlight is for the development of the human organism: cultures of bean-plants were made, one in ground fully exposed to direct sunlight, and the other in ground lit by diffused light only. The descendants of both cultures were then cultivated in one and the same sunny situation—with the result that, after the second generation, no fertile seeds could be obtained from the second culture. From this Dr. Marx deduces that schoolrooms should not face north. A westerly aspect he thinks the best for morning-hour schoolrooms.

## Correspondence.

### SPIRITUAL HEALING.

SIR,—In the article which appeared in the last number of the JOURNAL on the above subject you allude to the difficulties which exist in attempting to verify the correctness of the diagnosis in cases of asserted cures. The following case, which occurred in my own practice, is an instance of how little credit many of these statements are worthy of.

Shortly after I retired from practice some ten years ago, a well-known clergyman wrote to me saying that members of his congregation were being much disturbed by the advent amongst them of a lady professing herself to be a faith healer, and saying that her conversion was due to the fact of my having told her that she was suffering from a dreadful disease and that her sole hope of cure lay in the performance of a very dangerous operation. She refused to submit to this, and instead placed herself in the hands of the "healers" and was cured. He concluded by asking me to give him particulars of her case.

I had no recollection of any such patient, but, as the name was given, traced her and found the following particulars recorded in my casebook:

I had only seen the lady once in my own house, when she had stated that she was well past middle life, and for more than a year had been weakened by the frequent recurrence of very profuse menstruations, the loss being sometimes quite alarming.

On my telling her I must examine her she had replied that she could not submit to it that day, as the discharge was then heavy, so I arranged that when it had ceased she would let me know, and I would call on her and examine her in bed. I made no diagnosis and gave no opinion as to the nature of her case. No doubt I may have told her that such symptoms often indicated serious disease, but to talk of performing an operation on a patient I had never examined, I never would have done, nor any other sane practitioner.

Instead of writing to me to call on her, she went to London. No doubt an examination would have revealed the fact that no disease existed.

It is impossible to deal with patients of this class. Their mental equilibrium is disturbed, they distort what

the doctor may say, and not infrequently invent and circulate statements he never made.—I am, etc.,

Dublin, May 24th.

LOMBE ATTHILL, M.D.

### MYASTHENIA AND HYPOPHYSIAL LESIONS.

SIR,—Your readers will be interested to hear that in the BRITISH MEDICAL JOURNAL, vol. i, 1867, pp. 597–600, a case was described, under the title of "Case of Paralysis of the Diaphragm, with Remarks," by the late Dr. P. Victor Bazire, that was almost certainly one of myasthenia. Bazire was on the staff of the National Hospital for the Paralyzed, London, and he died suddenly in August, 1867, three months after the case was published, but the sequel was never recorded apparently. That he was an exceptionally able man will be seen on reference to the obituary notices in (a) BRITISH MEDICAL JOURNAL, vol. ii, 1867, p. 141, and (b) *Lancet*, vol. ii, 1867.

It will be remembered that Dr. Leonard Guthrie mentioned in the *Lancet*, vol. i, 1903, p. 330, that the famous Dr. Willis had published a case in 1685 that seems to show that the disease was known to him then. Dr. Guthrie points out that Willis evidently regarded his case as functional. I shall show that Bazire did not fall into that error over his case.

*Bazire's Case of Myasthenia* (italics mine, unless otherwise stated).—"F., 41, married; tall, thin, bony, pale, sallow. Previous history good: nervous and excitable, easily moved, subject to depression of spirits: no history of hysterical fits, crying or sobbing; has been working hard and living poorly of late. Her son, aged 14, epileptic (under B.'s care). Present condition: Fifteen months ago gradual onset of epigastric discomfort (weight, not pain), and difficulty of breathing: kept gasping to take in more air. *These sensations came on towards evening, most marked when working hard, washing or ironing.* With the difficulty of breathing came loss of voice: *Frequently towards evening she would lose her voice completely, and speak in whisper.* If, however, she did during the day only sewing, etc., no dyspnoea occurred, and her voice was louder. *She was always better in the morning; if she had gone to bed voiceless overnight she would wake up after a good night's rest perfectly able to speak.* No cough: no pain in chest, no soreness, no abnormal sensations in throat to which she might refer her *occasional and intermittent aphonia.*"

Bazire goes on, p. 597, col. 2: "When I first saw her, the peculiar character of her voice attracted my attention at once." He compares her to a person out of breath from running, but notes that: "*Instead of her voice improving as she went on talking, it became weaker and weaker, occasionally squeaky, till at last it left her completely, and she could not for a while proceed even in a whisper.* This statement was confirmed by the nurse after the patient's admission to the hospital" (p. 598, col. 2).

Bazire found nothing in throat; cords came together perfectly on phonation. R. 32; breathing costal; on deep inspiration epigastrium was observed to *sink inwards* (italics in original); during expiration the parts that had sunken in during inspiration *bulged outwards* (italics in original); no lividity of lips or face; good entry of air in lungs; normal percussion. Heart regular; impulse somewhat feeble; sounds not very loud, but normal at apex and base. P. 65, regular. No enlarged glands at root of neck, nor any signs of aneurysm.

The paper is a very interesting one. As to diagnosis, Bazire held that the feebleness of the diaphragmatic action, on galvanization of the region of the phrenic in the neck, which he found "pointed to structural disorganization of the muscle." This proves that he rejected hysteria as a diagnosis. There is no mention of faradism; but we know that the myasthenic reaction is not always present in myasthenia.

Evidently Bazire recognized the intermittent aphonia brought on by exertion and relieved by rest as something quite new to him—and he was a very learned physician. The myasthenic nature is obvious.

Dr. E. B. Krumbhaar has recently mentioned (*Bull. Ayer. Clin. Labor., Pennsylv. Hosp.*, No. 5, December, 1908, pp. 32–45) that as far back as 1679 Theophilus Bonetus described what was evidently a serous cyst of the hypophysis (*Sepulchretum sive Anat. Practica*, Geneva, 1700, p. 24, obs. 24). Krumbhaar quotes thus:

§ 1. Capitis dolor ab abscessu seroso, natibus cerebri et infundibulo adhaerente. A girl, 12, phlegmatic and dull temperament, suffered for four months with a severe, continuous headache. When called to her case, I found her quite without fever, but rejecting all food. She lived for many days on sugared water only. She complained of pain over the coronal sutures. All remedies were vain; no swelling or redness was present; finally death put an end to her miseries and pains. On opening the head, everything was found beyond expectation well formed and without corruption. I had expected to find pus, as a little before death the right eye had

emitted some purulent fluid. But, when we despaired of ascertaining the cause, the surgeon, wishing to demonstrate to his pupils the rete mirabile and other parts, broke with his fingers an abscess which was adherent to the folds and infundibulum of the cerebrum, from which clear water flowed with force to the extent of 2 lb., as if gushing from a fountain.

Krumbhaar comments thus (page 41):

The enormous cyst, the modern equivalent of serous abscess, if attached to the infundibulum, evidently arose in the hypophysis. The dull phlegmatic temperament is interesting as a possible evidence of myxoedema, which has been found to have some connexion with lesions of the hypophysis.

In conclusion, Dr. F. Tilney has recorded a case of typical myasthenia<sup>1</sup> in which autopsy showed an adenoma of the hypophysis, originating in its anterior lobe and almost completely disintegrating its posterior lobe. I am told by a friend that he thinks one or two similar cases have been recorded, but at present I have failed to find them.

To sum up: Bazire's case is, with the single exception of Willis's, the most ancient case of myasthenia yet discovered; his description is far fuller than that of Willis's, and his greatness is shown by his rejection of the diagnosis of hysteria. It is of great interest after studying Bazire's case to refer to some excellent remarks on the differentiation between hysterical and myasthenic dyspnoea in a paper by Dr. Guthrie in the *Lancet*, vol. i, 1901, p. 395.—I am, etc.,

London, W., May 24th.

LEONARD J. KIDD.

#### FOREIGN BODY IN THE AIR PASSAGES.

SIR,—The letter by Dr. William Hill (p. 1268) with reference to the case published in the *JOURNAL* of May 15th, p. 1180, seems to me very opportune, and, like him, I desire to emphasize "the value of the bronchoscope in the investigation of cases of limited bronchiectasis of obscure non-tuberculous origin."

The details of the case published by Mr. Stroud-Hosford would suggest that, even had the foreign body been detected and removed when the patient was first admitted to the hospital, a fatal issue might only have been delayed. On the other hand, the history of such a case teaches two important lessons:

1. The value of skiagraphic examination in *each and every case* of limited bronchiectasis in children as well as in adults. Perhaps it would not be going too far to insist on the value of this mode of examination in any case presenting anomalous chest symptoms. In this particular instance the presence of the tintack would certainly have been revealed.

2. The great value of the bronchoscope in the examination and treatment of such cases. In this particular patient it is almost certain that the tack could have been removed by any one reasonably familiar with and skilled in the use of the instrument, although it is doubtful whether this would have saved this patient's life, because of the advanced stage of the lung mischief.

It has been my privilege to remove a large pin and the metal cap of a lead pencil from the larger bronchial tubes of two young patients, and during the past six years to make many examinations of the lower air passages by the direct method, and I do not think it an exaggeration to say that the method only needs a little skill, patience, and attention to technique.

Readers who are interested in the construction and uses of the bronchoscope will find an illustrated article dealing with the subject in the *Lancet*, November 7th, 1908, or in the *Laryngoscope*, December, 1906; and I am glad to think that since the publication of the first named the use of the bronchoscope has become much more general in this country than was hitherto the case.

It is only fair to state that for the perfection of the modern instruments we are indebted to Killian and Brüning of Freiburg and Chevalier Jackson of Pittsburg, Pa.—I am, etc.,

London, W., May 23rd.

HERBERT TILLEY.

SIR,—The question raised by Dr. Hill is worthy of serious consideration, and his plea for a more extended use of the bronchoscope in affections of the chest comes at an opportune time, and deserves support. To those who are accustomed to make use of it in their daily work it appears surprising that those who devote special study

to chest diseases should have hitherto failed to appreciate its advantages.

An endoscopic view of the interior of a bronchus affords much more information than an indirect examination however carefully carried out. In many conditions which are obscure and puzzling to the observer, a correct diagnosis is only possible with its aid. I have already drawn attention in the *JOURNAL*<sup>1</sup> to some of these, and subsequent experience has fully confirmed the views I have there expressed. I make regular use of bronchoscopy in the investigation of affections of the bronchi. It can be carried out with safety, and one might quote instances of the invaluable help which a direct view of the interior of the bronchus has given, were there space to do so. One will suffice, that of a patient who had been under treatment for some time for "bronchitis and asthma." It was only on making a bronchoscopic examination that a benign growth, quite unsuspected, was discovered just above the bifurcation of the trachea. Its removal led to entire disappearance of the symptoms.

To those who may be sceptical of the feasibility of applying direct methods to intrabronchial conditions a case recently recorded by Killian<sup>2</sup> is worth mentioning. A man had a carpet tack embedded, head downwards, in the right bronchus. Its presence had led to marked stenosis and bronchiectasis. After repeated attempts the stricture was dilated and the foreign body extracted. The constricted bronchus was afterwards intubated, the tube being changed from time to time, and this was followed by a corresponding improvement in the chest condition. Yet that patient had suffered from chest trouble for over five years, and had been treated in various sanatoriums until a skiagraph revealed the presence of the foreign body, which had never been suspected.—I am, etc.,

Cardiff, May 24th.

D. R. PATERSON.

SIR,—The sincere thanks of all clinicians are due to Dr. Murray Leslie for his public spirit in placing on record the above case which affords several lessons.

Rightly or wrongly, some of us think that no value whatever is to be placed on a negative history as to ingestion of a foreign body in a child of this age, and the result in this case confirms our view.

Further, many of us regard it as an axiom in physical diagnosis that in one-sided lung disease with copious foul expectoration (more especially if there are signs of a cavity), the presence of a foreign body in a bronchus or bronchiole should be suspected, and its presence or absence proved by every means available, that is, radio-scopy and bronchoscopy.

I have no doubt Dr. Murray Leslie used all the thoroughness and care for which he is so well known, and from the positive physical signs *plus* the negative history, was convinced that he could exclude the hypothesis of foreign body in favour of idiopathic disease. That he has had the courage to acknowledge that his conclusions in this case were incorrect, and to give full details of the ultimate result is likely to be of special interest and benefit to the profession now that the direct examination and treatment of the air passages, after having been a series of surgical triumphs on the Continent and America for some years, is at last becoming one of the burning medical questions of the day in these happy isles.

These cases are, after all, not very common, and since Killian's first case in 1897, there have been only about 200 recorded, according to the latest statistics in my possession (up to 1907).

Evacuation of the putrid contents of any accessible pulmonary cavity, and irrigation and perhaps drainage by pneumotomy, cutting down on the tube introduced into the cavity *per vias naturales*, is to be advised. Perhaps the utility of this letter will be increased if I just mention some of the chief conditions in which bronchoscopy has given the greatest assistance either in diagnosis or treatment: Tracheitis, tracheal papillomata, tracheal and bronchial ulceration and stenosis, adherent diphtherial membranes, inspissated secretions and crusts in trachea and bronchi, and oesophageal growths, aneurysm, thyroid and thymus tumours as causes of dyspnoea from pressure on trachea. A recent case has been reported in which a diagnosis of dilatation of the aorta has been proved by

<sup>1</sup> BRITISH MEDICAL JOURNAL, 1906, vol. ii, p. 356.

<sup>2</sup> Zeitschrift für Ohrenheilkunde, Bd. 55.

<sup>1</sup> Neurographs, vol. i, No. 1, March, 1907.