CASES SEEN IN THE WARDS,

OCT. 22nd, 1925.

BY

C. P. SYMONDS, M.D. OXF., F.R.C.P. LOND.

THE following three clinical cases are of interest:—

*Infective Endocarditis ; Cerebral Embolism ;
Aphasia.*

CASE 1.—A policeman, aged 28. Admitted because of abnormal mental condition said to have appeared suddenly seven weeks ago. He is said to have had rheumatic fever in childhood. Now talks incomprehensible jargon, though by intonation and gesture he often succeeds in conveying his meaning. Unable to write and in some ways apraxic—i.e., unable to handle familiar objects correctly—given cigarette and box of matches fumbles with them aimlessly. Obeys simple commands correctly, but comprehension both of the spoken and written word is imperfect. Slight weakness of right face in smiling. No other physical signs in nervous system. He is up and about and eating well, but runs an irregular evening temperature.

The Wassermann reaction has been found negative in blood and spinal fluid. The fluid, however, contains 251 cells per c.mm., half lymphocytes, half polymorphs, with slight rise of protein, normal chlorides. The heart is enlarged with signs of double mitral disease and aortic regurgitation. The spleen is palpable.

Here is a somewhat unusual example of sub-acute infective endocarditis, first brought to notice on account of cerebral embolism. The completeness of the aphasia and absence of other physical signs is significant of a cortical lesion—obstruction in a branch of the middle cerebral. The numerous polymorphs and lymphocytes in the spinal fluid are presumably derived from the inflammatory reaction at the site of the lesion. I have once seen an exactly similar fluid from a case which proved at autopsy to be a thrombosis in the brain stem immediately beneath the floor of the 4th ventricle.

Acute Otitis Media ; Cerebellar Abscess.

CASE 2.—A boy of 8 had right-sided earache for the first time one month ago, for which the drum was incised. A fortnight later he complained of headache, and was admitted a week ago unconscious. No discharge from the ear has been observed since admission. There has been no mastoid tenderness. The only physical signs noted on admission were extensor plantar responses from both feet. The spinal fluid was clear but contained an excess of cells (not counted), mainly lymphocytes.

Since admission he has regained consciousness and is now wideawake. During the past few days he has developed weakness of the right arm. The temperature has been subnormal, the pulse about 60. He now has unequivocal signs of a right-sided cerebellar lesion—spontaneous deviation of the eyes towards the left, with gross incoördination and hypotonia of right arm and leg. The plantar responses are both extensor. There are no signs of meningitis. The optic discs are normal.

The increase of the lymphocytes in the spinal fluid is a point of great importance indicating an inflammatory lesion impinging upon the meninges. An acute otitis media may, as in this

case, lead to a cerebellar abscess without signs of mastoiditis, and the abscess may continue to increase in size after the primary focus in the ear has apparently healed. The episode of unconsciousness with subsequent improvement has probably been due to a bout of internal hydrocephalus from temporary obstruction of the outflow from the ventricles. This would also account for the extensor plantar responses. Swelling of the discs is not infrequently absent in these cases of cerebral abscess, especially in the early stage.

The plan of treatment I have advocated is first exploration of the mastoid antrum. If no track is discovered here leading towards the brain, this wound to be closed, and the cerebellum explored from behind by cutting away the suboccipital bone.

*Infective Endocarditis ; Embolism ; Intracranial
Aneurysm.*

CASE 3.—This man, aged 39, was seized suddenly with severe headache ten days ago. He rapidly became stuporose, and when admitted to hospital six days after the onset of his illness presented the classical signs of meningeal irritation—neck rigidity and a positive Kernig's sign. Lumbar puncture was performed and a uniformly blood-stained fluid obtained. In the test-tube this separated into a sediment of red cells and a yellow supernatant fluid without clot. Since the puncture the signs of meningeal irritation have almost disappeared. He has an evening temperature of 102° F. The heart is large with a to-and-fro aortic bruit, and he has a Corrigan's pulse. It has been observed that the left radial pulse is distinctly weaker than the right.

The important point here is that the spinal fluid was uniformly blood-stained, and did not clot in the tube as it would have done if the bleeding had occurred at the time of puncture. This, together with the meningeal irritation, had been rightly interpreted as evidence of subarachnoid hæmorrhage, probably from an intracranial aneurysm. To account for the complete clinical picture it had been suggested that the cause of the presumed aneurysm was syphilis, and that this had also produced disease of the aortic valves and an aneurysm of the arch of the aorta (unequal pulses). But syphilis is a rare cause of aneurysm in the smaller arteries—e.g., the cerebral vessels. The W.R. in the blood proved negative. There were no physical signs of aortic aneurysm.

Further inquiry showed that for five months the patient had suffered from malaise and night-sweats. Three months ago he had a sudden pain in his left arm, which subsequently was for a few days swollen up to the elbow. About the same time the patient had noticed a sore spot at the tip of the left thumb and a spontaneous hæmorrhage beneath the nail. The discovery of a large soft spleen completed the diagnosis of infective endocarditis. He has presumably had an embolism of one of the arteries of the left arm, though it is difficult to understand how the radial pulse has been diminished without being obliterated. On inquiry he confesses to having had severe headaches for five weeks before the sudden onset

of cerebral symptoms. Presumably a small embolus had lodged in one of his cerebral vessels without causing symptoms, the preliminary headaches were due to the gradual formation of an aneurysm and the sudden seizure to partial rupture. It is known that after such leakage from an intracranial aneurysm, the patient may recover and live for months or even years.

SURGICAL OUT-PATIENTS

AT

PRINCE OF WALES'S GENERAL HOSPITAL.

BY

HERBERT W. CARSON, F.R.C.S. ENG.,

SENIOR SURGEON TO THE HOSPITAL.

THE following five surgical cases appear to be worthy of record :—

CASE 1.—A. B., male, aged 34. Gave a history of severe melæna 20 years ago. Since then he has had many attacks of "indigestion." The present attack has lasted two months. An average day is as follows: Wakes up free from pain, has light breakfast, pain in epigastrium follows and lasts about one hour. After his midday meal pain recurs and is generally felt both in epigastrium and between the scapulae. He has very bad nights indeed, pain in the back being very marked. He does not vomit, but is losing weight rapidly. Appetite good but he dare not take much food. X ray examination shows hyperperistalsis, but no deformity of stomach or duodenum.

Diagnosis: probably lesser curvature ulcer adherent to pancreas near œsophageal opening.

CASE 2.—J. B., male, aged 71. Noticed three swellings on the abdominal wall two months ago. They have increased in size and are threatening to break down. He has no other complaints except that he has slight epigastric pain, relieved by sipping hot water. Three hard and typically malignant tumours are present, one in the left hypochondrium, one to left of umbilicus, and one just above left Poupart's ligament. They are superficially situated in the subcutaneous tissues. There is free fluid in the abdomen, a hard, irregular, slightly mobile abdominal mass in the epigastrium, and a hard fixed gland just behind the left cleido-mastoid above the clavicle.

The case is one of advanced cancer of the stomach with very unusual metastases in the skin. It illustrates the insidious onset of cancer of the stomach which has reached an advanced state of development without the patient being aware that he has anything but a slight and easily remedied "indigestion." The gland above the clavicle is an accepted metastasis in cancer of the stomach, but is not often found. The more common metastases in the liver and in Douglas's pouch are not found in this case, though the free fluid is suggestive of a peritoneal carcinomatosis.

CASE 3.—G. O., a boy of $8\frac{1}{2}$ years, has had a lump under the chin for six months. It is steadily increasing in size and is painless. A smooth, semi-fluctuating spherical

tumour is present exactly in the middle line of the neck below the symphysis menti. It is not fixed, the skin moves freely over it, and there are no signs of inflammation.

Discussion turned on the alternative diagnosis of a caseating tuberculous gland and a dermoid cyst. The position of the tumour and its freedom from fixation in spite of its size (that of a good-sized grape) decided the diagnosis of a sequestration dermoid cyst.

CASE 4.—A. M., a married woman, aged 26, gave a five years' history of pain after food, very constant in character and accompanied of late by daily attacks of vomiting. She has lost a great deal of weight. The pain is epigastric but goes through to the back; it follows food very quickly and is very severe at night. She obtains relief by taking bicarbonate of soda. There has never been any hæmæmesis or melæna. A curious feature is that she can take bread and cheese with less discomfort than any other kind of food. The teeth are well cared for and the tongue clean. Examination of the abdomen shows nothing but marked wasting, but there is acute tenderness on even the lightest pressure high up in the epigastric angle.

A barium meal X ray examination has not yet been done, but a suggested diagnosis was made of an hour-glass stomach resulting from an active ulcer of the lesser curvature, probably eroding the pancreas. Epigastric pain going through to the back is very characteristic of lesser curvature ulcer, especially if the pancreas is involved, and the frequent vomiting is irritative rather than obstructive and points to an active ulcer and probably some narrowing of the gastric lumen.

CASE 5.—A. H., a married woman, aged 62, who has had several children, has noticed a lump in the left breast for one month. The lump is painful but not tender, and she has "rheumatic" pains in the left shoulder. The patient is stout and the breast large. The surface of the whole breast is puckered, the deepest pucker being at the upper and inner quadrant, where there is a hard, irregular mass intimately attached to the mammary gland, and apparently anchored somewhat to the pectoral sheath. The nipple is indrawn and there are several glands palpably enlarged in the axilla.

The case was obviously one of carcinoma of the breast, but it was pointed out that a new diagnostic problem had arisen with the discovery of what is called "fat necrosis of the breast." This condition is found only in women with large breasts, and one is generally able to obtain a history of some injury with bruising. The area of the breast affected is generally the lower half, where a lump is found moving with the mammary gland and causing puckering of the skin which resembles closely that seen in a late case of breast cancer. This condition is innocent and does not affect the mammary gland, but so difficult is it to differentiate it from cancer of the breast that the complete operation has been done in nearly all the few cases recorded and the true diagnosis has been made only on a microscopic examination.

Will Authors kindly note that any arrangements for the provision of reprints of their articles should be made direct with the Manager of the POST-GRADUATE MEDICAL JOURNAL, 1, Bedford-street, Strand, W.C.2.