Original Communications.

Membranous Croup. — Tracheotomy. — Recovery.

By Wolfred Nelson, C.M., M.D., Member of the College of Physicians and Surgeons, Province of Quebec; late Assistant Demonstrator of Anatomy, Medical Faculty University of Bishop's College, Montreal; Physician Accoucheur to the Female Home; Attending Physician to the Montreal Dispensary. Read before the Medico-Chirurgical Society of Montreal, on the 3rd of May, 1878.

On Saturday, December 15th, 1877, saw patient, a little boy, aged two and a half years, for the first time. He is a well-nourished little fellow, very active and sharp. He was up and dressed. Breathing harsh; voice rough. Examined throat carefully, found tonsils enlarged; a number of small ulcers were to be seen on the right tonsil. Fauces and surroundings presented nothing abnormal to the eye. No fetor from breath. Face slightly flushed. Bowels have been regular. He has slept fairly. Ordered the following:

℞ Potass. chlor..... ʒ ss.
Syr. simp. ..... ʒ i.
Aq. ad..... ʒ viij.
M. ft. gargarisma.
Sig. The gargle.

A teaspoonful to a wineglass of water, and use as a gargle every hour.

Ordered slop diet. Saturday evening he was not so well. Ordered vin. ipecac. and a hot bath, as the child was decidedly croupy; no result followed. Repeated bath, and ordered mx of vin ipecac., which gave ease, the ipecac. to be repeated every two hours.

Sunday, Dec. 16th.—Made a single visit, found him somewhat better.

Monday, Dec. 17th.—Child the same. No anxiety of face. The repeated doses of vin. ipecac. act well.

Tuesday, Dec. 18th.—At morning visit found child worse. Breathing labored; pulse rapid; cheeks flushed. Had passed a very restless night. Will not allow throat to be examined.

Tuesday afternoon.—Child slightly better. He was sleeping during my second visit. Child's father came over at night, and said that he was worse. Used a gargle of liq. ferri, perch. and aq., as well as that first ordered. Pulse, 140; resp. 45.

Wednesday, Dec. 19th—Was called up at 5.30 a.m. Patient was markedly worse. He had been very ill from 1 a.m. Constant tossing about. High fever. Gave ten grains of calomel. Applied a solution of nitric acid, 1 to 20, to the throat, had a great deal of trouble in doing so; but succeeded fully. The child quieted down and went to sleep. Face flushed. Bowels moved at 5.45. Left at 6. Returned at 9: no change for the better. Dr. Reddy met me in consultation at 10.45. Had child removed to a room in the basement, where water was evaporated freely, filling the room with moisture. At 4.30 p.m. Dr. Reddy again met me. Child as before. We met at 6 p.m., when the child was worse. At 7 made another visit, when matters were very grave. During the day we had advised tracheotomy as a *dernier resort*. Dr. Reddy having agreed with me in my diagnosis of membranous croup. The child's parents consented. At this visit a powerful emetic, suggested by Dr. Reddy, of hydrarg. sulph. flova, was tried; it was followed by the vomiting of a small quantity of thick ropy mucus. At 7.30, as the child was worse, I sent for Drs. Reddy and Hayes for the operation. On their arrival the child's nails and lips were blue, and he was evidently sinking fast. Face pallid and cold. Child unconscious. All of the muscles of extraordinary respiration in play. Great sub-sternal depression on expiration. All being ready, the child was placed on a table, when, assisted by Drs. Reddy, Hayes and Mr. G. W. Nelson, operation commenced, Dr. Reddy administering the chloroform. A lamp was placed near the child's head to afford me a good light. The chloroform acted admirably. My outline incision was an inch and a half long, and then was enlarged on a director, thoroughly dividing the integument; fasciæ superficial and deep, were taken up and divided, layer by layer, on a director. The trachea was deeply placed. It was soon reached. Cut no vessels of any importance; there was scarcely any hemorrhage. The trachea was successfully hooked after a second attempt, and divided from below upwards with care. The child was sinking rapidly, some difficulty was experienced in introducing the tracheotomy tube, it having slipped into a small pouch to the right of the trachea. This was soon corrected, and the tube properly introduced; however, it would not work. The air rushing in and out of the wound around the sides of the tube, could be heard all over the room; the tube was choked with mucus. Here Dr. Reddy, with great courage, cleared the tube with his mouth, it was placed in situ. Pulse failing. For a few moments we all thought the child dead, as no respiration could be detected; nearly pulseless. He was turned on his side, and gently patted on the back.