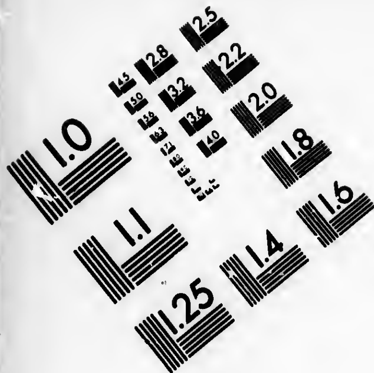
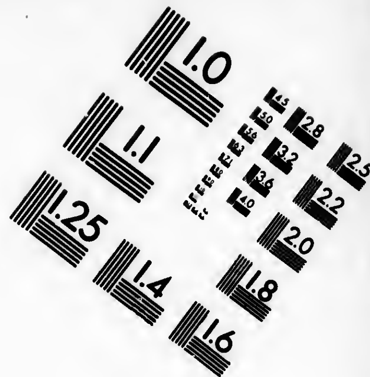

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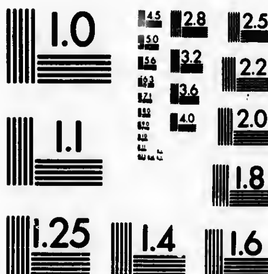
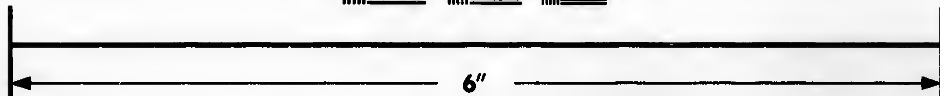
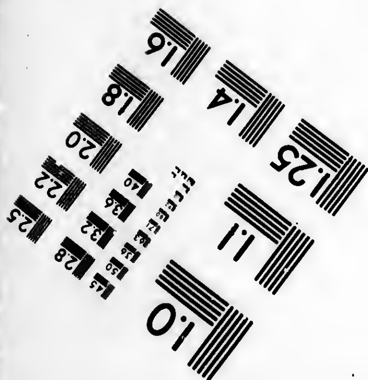

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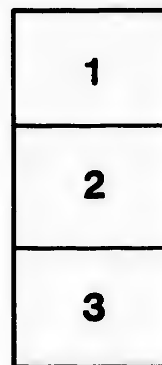

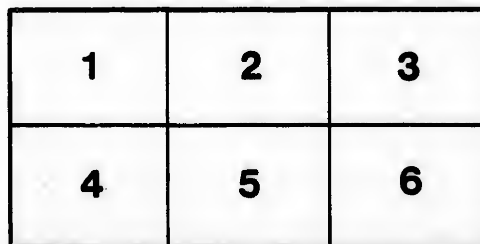

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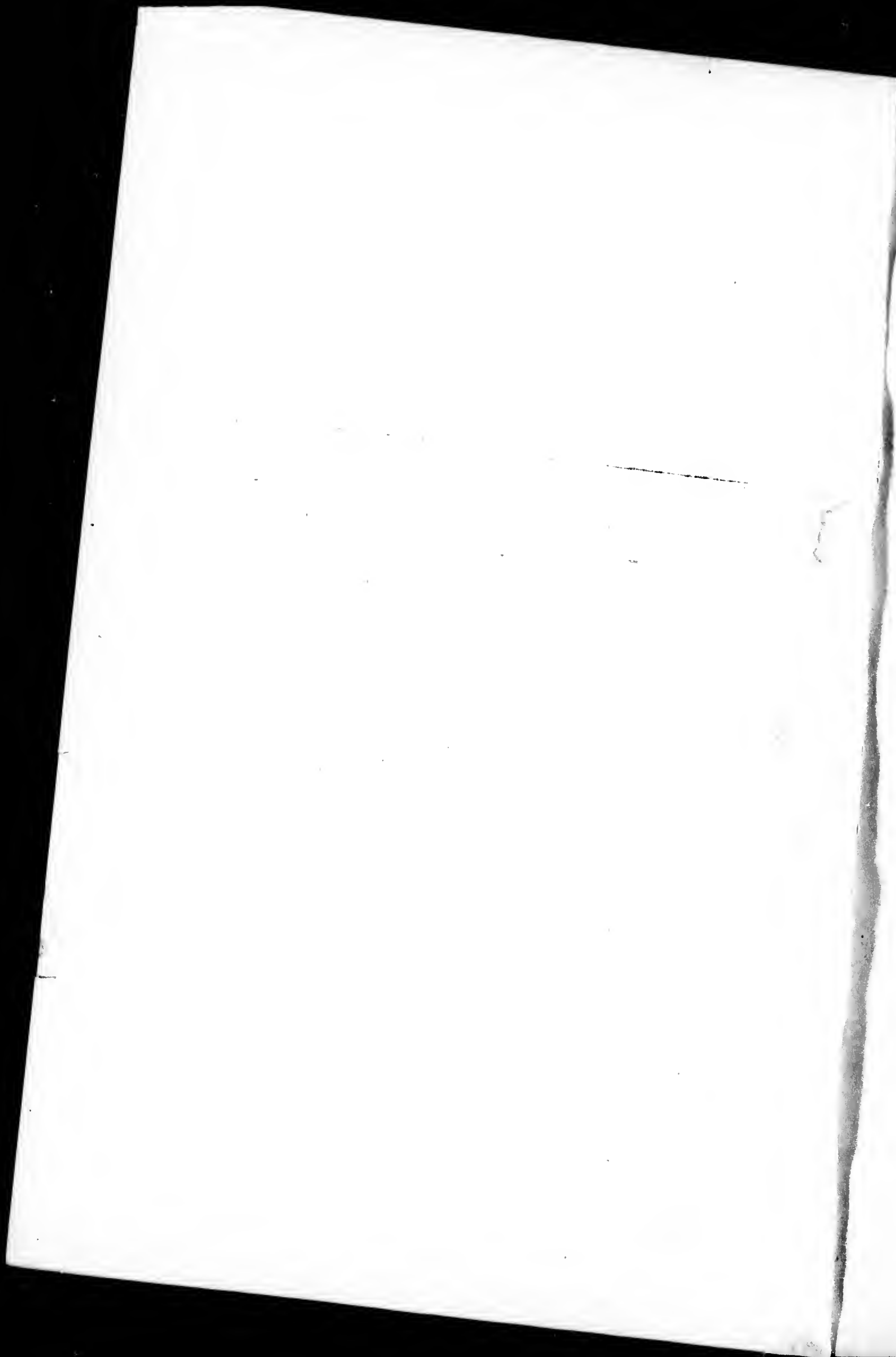
A LARGE MOUTH CONCRETION.—RENAL AND VESICAL CALCULI.—AN EXTREME DEGREE OF TALIPES EQUINUS.

BY

JAMES BELL, M.D.,

Surgeon to the Royal Victoria Hospital.

Reprinted from the Montreal Medical Journal, April, 1897.



A LARGE MOUTH CONCRETION.[1]

BY

JAMES BELL, M.D.,

Surgeon to the Royal Victoria Hospital.

Mrs. G., æt. 32, consulted me in September, 1896, for a large growth of long standing, which had filled up the right buccal cavity and had caused ulceration through the upper lip and great deformity of the face. The history was as follows: At the age of 12 years she had suffered from "fever," which had lasted a considerable time and had been followed by a slow convalescence, during which, she stated, that the teeth in the right side of the lower jaw had become loose and dropped out one by one, but without any pain or ulceration of the gums. The teeth had all dropped out in about six months, and then she began to notice a "shell-like" mass on the gums from which the teeth had fallen, apparently in the area occupied by the molar teeth. For ten years this growth was gradual and gave her practically no trouble. Then deformity of the face began to be noticeable and increased steadily. It was, however, only within the last year that marked increase in the size of the mass had been observed and troublesome symptoms had developed. On examination, the growth was found to fill the whole right cheek and to have produced great flattening of the right side of the face and the right nostril. It had ulcerated through the upper lip at one point, and the whole lip was greatly swollen. The point which presented at the angle of the mouth was evidently calcareous, but I mistook this for a simple coating of calcareous matter. The fetor was horrible and the mouth was so sensitive that no manipulation was possible. I looked upon it as a growth from the upper alveolar border, probably originally of the nature of epulis, but having recently (coincidently with the history of rapid increase in growth and symptoms), became malignant, and advised removal of the upper jaw. She went home, but returned and was admitted to the hospital on October 12th and prepared for operation on the 19th. When she was fully anæsthetized, I was able, for the first time, to make an examination of the mouth. I then found, to my surprise, that the mass consisted simply of a large concretion the size of a large hen's egg, lying free in the mouth, having formed a cavity for itself by displacement of the soft parts and

[1] Shown at the meeting of the Montreal Medico-Chirurgical Society, October 16th 1896.

absorption of the alveolar border of the lower jaw. It was so large that I removed it with considerable difficulty. A couple of teeth were embedded in its lower border, and it was clearly an enormous growth of "tartar" from the teeth. The ulceration of the mouth and lip healed rapidly, and the patient was discharged in a week quite well, except for the deformity which had occurred during the growth of the mass. The mass, which was oval in shape, measured 13½ cm. in its greatest circumference and 11 cm. in its smallest circumference.

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RENAL AND VESICAL CALCULI.[1]

BY

JAMES BELL, M.D.,

Surgeon to the Royal Victoria Hospital.

(1) A large branched calculus removed from the right kidney. The patient, 42 years of age, a strong, active and healthy man and a free liver, was attacked with fever and general malaise on the 28th of July, 1896, while on a fishing excursion. About the 11th of August he began to have severe chills and was seen by a physician, who found a large amount of pus in the urine and a tender mass in the right lumbar region. He was seen in consultation by Dr. Bell on the 24th of August, who confirmed the diagnosis of right pyonephrosis, probably calculous, and advised operation. The patient did not consent until the 8th of September, when he was admitted to the Royal Victoria Hospital. He was then in a condition of general septicæmia, with fluid in both pleural cavities, an exhausting diarrhœa, daily chills, followed by profuse perspiration and tremendous rises of temperature. His condition was so bad that nothing was done until the 18th of September, when the kidney was exposed in the loin in the ordinary way. It was very firmly adhered posteriorly, and, when isolated, was very large and œdematous. The pelvis was distended and contained a quantity of pus, which was evacuated, as well as a large abscess, which was situated above and in front of the kidney. The most careful exploration failed to discover any stone. The organ was palpated between the fingers from end to end, needles were introduced into its substance at several points and a short beaked stone searcher was introduced into the pelvis and directed up towards the calyces, with the fingers of the other hand upon the convexity of the kidney. The conclusion was therefore arrived at that the suppuration could not be due to a calculus. The wound was left open and a drainage tube was carried up into the perirenal abcess cavity. The patient's condition improved very markedly, but the urine still contained pus; there was always some fever and there was a free discharge of pus from the wound. On the 27th of November the wound was reopened for exploratory purposes and with the intention of removing the kidney if necessary, when the calculus now exhibited was found imbedded in the substance of the kidney at its lower

[1] Exhibited at the meeting of the Montreal Medico-Chirurgical Society, January 1[illegible].

extremity, the point of the stone being directed down towards the pelvis of the kidney.

From this time pus disappeared from the urine, except in microscopic quantities, and the patient's condition improved very much. The dullness in the lower part of the right chest persisted, however, and on the 22nd of December pus was discovered by an aspirating needle. On the following day the anterior two inches of the eleventh rib were excised and a large subphrenic abscess drained. The progress of the patient since that date has been uninterrupted. The original loin wound is now quite closed.

(2) Two medium sized phosphatic calculi, with the following history: The patient, S. M., æt. 76, was admitted to the Royal Victoria Hospital in April, 1896, in a toxæmic condition, with greatly enlarged prostate making catherisation extremely difficult, double (acute), orchitis and cystitis. One of the stones exhibited was removed then by supraputic route, and after a long illness the patient recovered and was discharged. In December he was readmitted on account of the suprapubic fistula, through which all the urine had been evacuated since the previous operation. His general health was excellent. On the 19th of December the prostate was removed by the combined suprapubic and perineal method and the second stone removed. The interest in these specimens lies in the fact that we have a definite observation upon the rate at which a phosphatic stone may develop in a bladder in which the urine is in a condition of alkaline fermentation,—the second stone, weighing 92·5 gr., having developed between the 11th of April and the 19th of December,—a few days over eight months.

(3) A large stone, phosphatic externally, removed by lateral lithotomy from a patient 26 years of age. There was a history of cystitis extending over a period of about five years with chills and fever following every attempt at intrumentation.

(4) Seven flattened, smooth, hard and light stones removed by suprapubic route. The patient 58 years of age had suffered from indifferent symptoms for about four years but only during the past year and a half had the symptoms became sufficiently troublesome to cause him to seek advice.

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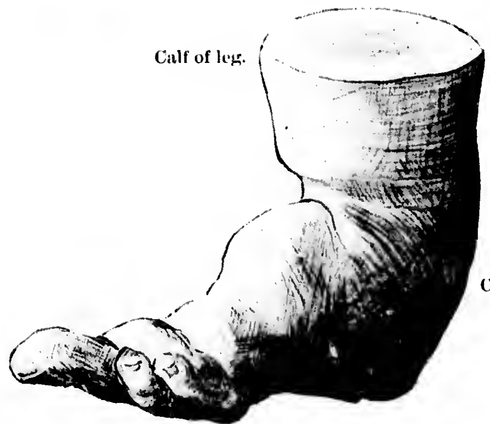
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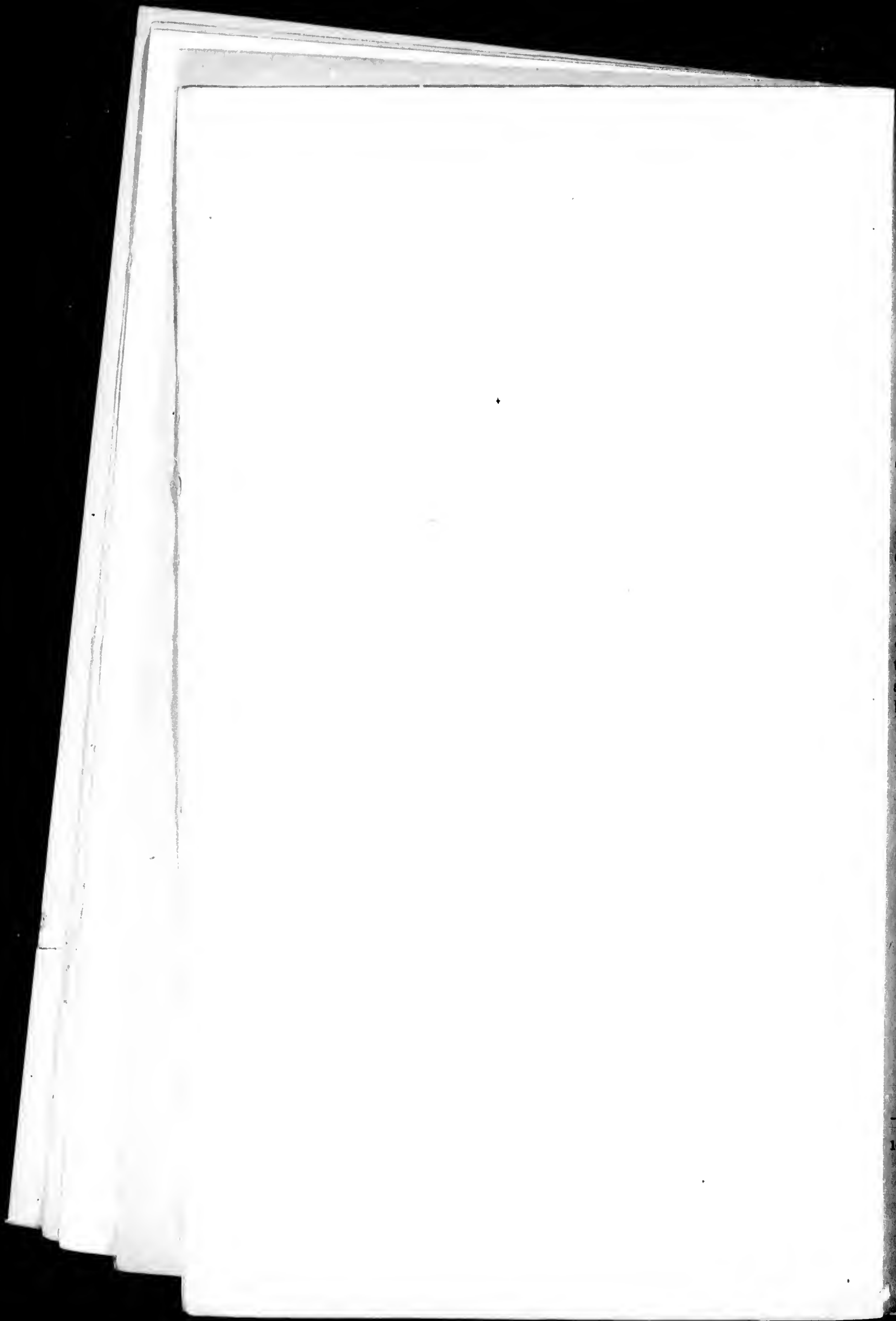
Crest of tibia.



AN EXTREME DEGREE OF TALIPES EQUINUS.[1]

BY

JAMES BELL, M.D.,

Surgeon to the Royal Victoria Hospital.

N. L., æt 31, French Canadian was admitted to the Royal Victoria Hospital in September, 1896, for cellulitis of the hand following a wound of the thumb received in opening a bottle some days previously. The interesting condition was the extreme degree of talipes equinus of the right foot which was bent back to such an extent that he walked on the instep and the lower part of the crest of the tibia corresponded to the os calcis, the toes being directed backwards and the foot at a right angle to the leg. He states that the condition was congenital but that in childhood the toes were in a straight line with the leg. The hyper-extension of the foot continued to increase gradually and when he was 13 years of age he was able to walk as at present on the dorsum of the foot. The foot is somewhat smaller than its fellow, there is absence of the fourth and fifth toes, and this leg is five inches shorter than the other. In walking he wears a metal frame on the boot which equalizes the length of the legs.

[1] Exhibited at the meeting of the Montreal Medico-Chirurgical Society, October 16th, 1896.