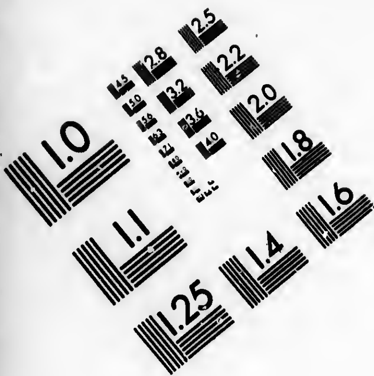
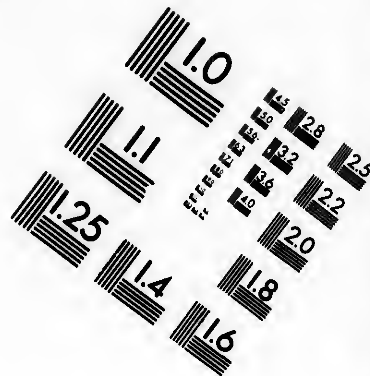

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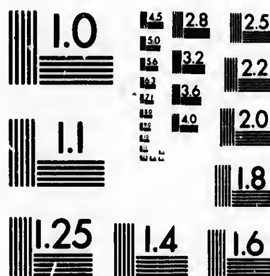
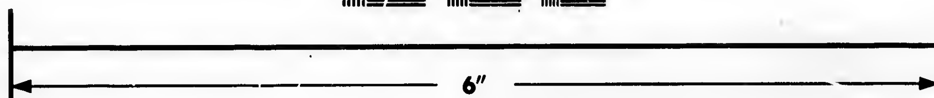

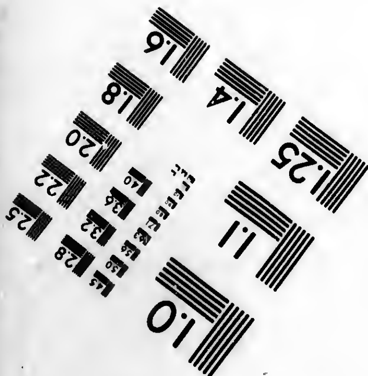
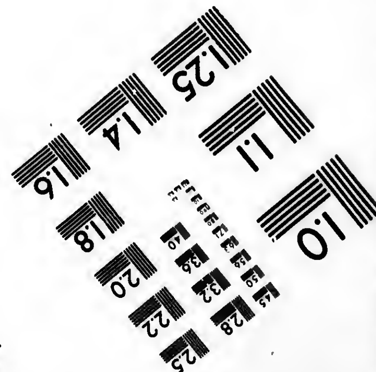

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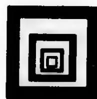

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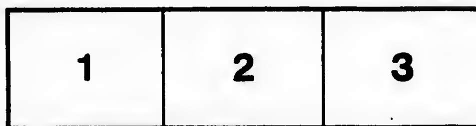

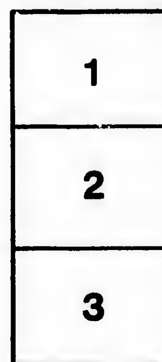

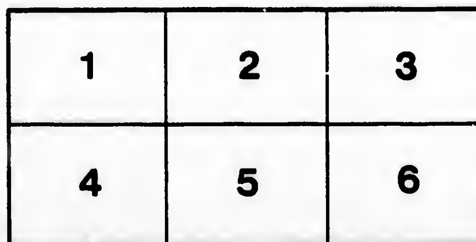

(*Reprinted from the* MONTREAL MEDICAL JOURNAL, *March*, 1890.)

MONTREAL GENERAL HOSPITAL.

CONDENSED REPORTS OF CASES IN DR. MACDONNELL'S WARDS.

Exophthalmic Goitre.—Two cases have been before the class. A girl, aged 21, for several years had suffered from palpitations on exertion, and six months ago the thyroid began to enlarge. The area of cardiac dulness was moderately increased. The pulse was rapid (120); the cardiac action hurried and violent. There was a systolic murmur, loudest at the 2nd right costal cartilage. The exophthalmos was not so well marked as the two other cardinal symptoms of the disease, but the eyes, though not actually prominent, had a staring appearance, which attracted attention. The remarkable feature in the case was the well-defined brown pigmentation on the upper and lower eyelids. This had made its appearance during the last six months, and seemed to have no tendency to spread. The natural complexion of the patient is fair, and the pigmented skin has the color of a huge freckle. Vitiligo, as I must call these patches, has been noted in cases of Graves' disease, and cases of universal bronzing of the skin have been recorded. The other eye symptoms (Graefe's and Stellwag's) were absent. There was a great deal of nervous excitement, and an inability to remain long in a state of quiet, the movements being almost choreic. There were no tremors. Decided improvement in all the symptoms followed a period of rest in bed without any medication. Subsequently the tincture of belladonna was given in increasing doses until the throat became dry and the pupils large.

The second case was that of a stout, married woman, aged 35, in whom the exophthalmos was remarkable. The cause of the disease was probably fright. Ten months ago labor came on suddenly when she was quite alone in the house, and it was two or three hours after delivery before assistance arrived. Almost immediately afterwards the prominence of the eyeball was noticed and the sight became defective. She presented

herself at the ophthalmic department, where the true nature of the disease was discovered. The pulse is not very rapid (100); the heart's action is not hurried. The thyroid is slightly enlarged, but there is no thrill; the exophthalmos is very prominent. When the pupil is directed towards the ground the upper lid remains perfectly fixed in its position, and it is in a constant state of retraction, so that the cornea is not covered.

Lead Poisoning; Chronic Interstitial Nephritis; Hemiplegia: Death.—(*Dec. 28th.*)—In the Hospital Reports of the October number of this JOURNAL, page 291, the reader will find the history of W. S., aged 58, who, since 1875, has suffered from symptoms of lead poisoning. On the 11th May of the present year it was recognized that he was the subject of chronic Bright's disease of the small kidney variety. He left the hospital on 31st August. On the 24th of December he was readmitted, this time profoundly unconscious. It appears that about a week before admission he had become suddenly unconscious, and had remained so until admission. He died after being two days in hospital. His condition was as follows: There was speechlessness without, apparently, unconsciousness, for although he gave no sign of comprehending the questions put to him, yet his eyes followed one about as if he partly understood his whereabouts. It would appear as if the whole body were powerless, but when the neck is irritated the right hand is raised, but the left arm is never moved. When the sole of the foot is pinched, the right leg is quickly drawn away, but this is not observed with the left leg. Knee reflex is absent in both legs. No evidence of paralysis of the facial nerve. Urine and fæces pass involuntarily. The former contains a very large proportion of albumen. The heart's action regular and the sounds natural. The evidences of hemiplegia were slight, and as he had had transient hemiplegia of the other side on the 18th May last, it was thought that possibly the condition might depend upon uræmia, though the extreme probability of hemorrhages into the brain was fully taken into account. The case is one of exceeding interest, as showing a succession of changes, all resulting the one from the other,—first the lead, then the granular kidneys, the arterial disease, the high tension pulse, and the final

catastrophe—the rupture first into one corpus striatum and eight months later into the other. The post-mortem appearances explained all the symptoms which were present. Both might with advantage be represented in tabular form.

Symptoms.	Post-mortem Appearances.
Left hemiplegia, with loss of consciousness.	Recent hemorrhage into the right external capsule.
On 18th May, 1889, transient right hemiplegia.	Spot of softening in left internal capsule and corpus striatum.
General mental enfeeblement.	Minute recent hemorrhagic softening in the white substance of the left hemisphere. The smaller arteries of the brain under the microscope show extensive fatty degeneration in the intima and media, with numerous aneurysmal dilatations.
Urine pale amber, sp. gr. 1017; small amount of albumen; quantity usually not much above normal. Hyaline casts.	Kidneys cirrhotic, greatly contracted; weight—left, 80 grammes; right, 70 grammes. Normal weight, 130 grammes.
Normal amount of urea.	
Apex beat displaced downwards and outwards. Increased area of cardiac dulness. High tension pulse.	Hypertrophy and dilatation of the left ventricle.
Ophthalmoscope shows albuminuric retinitis.	Retinitis on right side.
Physical signs of lungs negative when formerly in hospital.	Atrophic emphysema and healed tubercular nodule in left apex. Acute broncho-pneumonia (a late change).

Erythema Nodosum; Phlebitis of the axillary and femoral veins, and subsequently of the external jugular; epigastric pain and ascites; phlebitis in both legs; evidences of consolidation at the base of right lung; diarrhœa; subcutaneous nodules; aspiration of 110 ounces of serum; varicosity of the thoracic veins; rapid dilatation of right heart; death; autopsy.

Annie D., aged 43, was admitted into the surgical wards early in September last with erythema nodosum and stiffness of the muscles, especially of the neck. She was transferred to the medical wards almost immediately, and the following state on admission was noted. Slight swelling and tenderness of the left side of the neck and pain on movement. Physical signs of chest negative. Urine normal. No digestive disturbance. On the

fourth day after admission there was pain and swelling in left axilla, which was thought to be due to enlarged lymphatic glands. On the twelfth day there was severe epigastric pain, which was relieved by vomiting and passed gradually away. In the same evening there was pain and tenderness in left groin. Four days later there was evident phlebitis of the left internal jugular vein, which became distinctly cord-like and very tender. It was treated in the usual way, the pain and swelling gradually disappeared, and the patient feeling stronger, left the hospital on the 19th October.

On the 18th November she was re-admitted, this time complaining of severe epigastric pain, abdominal distension, and a painful swelling of the left leg. After leaving hospital she had been very well for a fortnight, when she began to menstruate and then to suffer from intense pain at the epigastrium. Temperature 100½°; pulse 96. Nausea and vomiting after food. Evidence of fluid in the peritoneum. Dulness on percussion, bronchial breathing, and crepitant râle at the right pulmonary base. Both legs are enlarged about the calves and very tender to the touch, especially the right. No affection of the joints. Sharp diarrhœal attacks from time to time. The thoracic veins of the left side were noticed to be varicosed. The patches on the legs for which she originally entered hospital never entirely disappeared, but remained as reddish indurations, and now they are inflamed and angry-looking. They are situated about the calves of the legs.

A week later similar physical signs, though not marked to the same extent, were found in the left base.

Nov 27th.—One hundred and ten ounces of a clear fluid were removed to-day by the aspirator; it contained no pus. The discomfort due to the abdominal distension was removed, but the symptoms were unchanged. The temperature is now generally about 100–101° at night and 99° in the morning. Considerable epigastric pain. As a result of a vaginal examination by Dr. Gardner it was found that the womb was fixed in the pelvis, probably by old inflammatory adhesions.

Dec. 10th.—The varicosity of the thoracic veins is becoming very marked.

Dec. 11th.—Death occurred to-day, the following symptoms preceding the event. In the early morning she complained of very severe pain in the abdomen, and she became much more feeble. The pulse became rapid (144) and very weak. The thoracic veins became as large as lead pencils, and the general surface of the upper part of the body on the left side was generally cyanotic. The heart's action became visibly turbulent, the cardiac area of dulness became increased, and the sounds became confused, so it was impossible to distinguish one from another.

At the autopsy thromboses were found in the right femoral and the popliteal, as well as in many of the smaller veins of the right leg. There was recent embolism of all the main branches of the right pulmonary artery. Old infarctions in both lungs, over one of which an adhesive pleurisy has occurred. The base of the right lung is collapsed. Pale, colorless clots dilate the right heart to an enormous size. There is chronic interstitial inflammation of tho pancreas, with the formation of some large cysts near the splenic end. Several small localized subcutaneous indurations containing pus are found in both legs and in the right arm. Fluid in abdomen and evidences of recent peritonitis.

The diagnosis of this case was very obscure. That some one cause was producing the stagnation of blood in so many different parts of the body was evident enough. There was no symptom present which could not be explained by the occurrence within the body of what we saw going on outside it. But to find a cause for this general tendency to thrombosis was a different matter. At one time it seemed as if the presence of tubercular peritonitis would account for the abdominal symptoms, but it would not explain the occurrences elsewhere. We must fall back on rheumatism to account for the thrombosis as well as for the erythematous nodules and the peritonitis.

Tubercular Meningitis in an Adult.

J. W., aged 23, had been in hospital two years ago with a tumor of the testis, which, on removal, was found to be tuberculous, and not very long after that he had an attack of pleurisy

of the left side, from which he apparently recovered, but soon an abscess formed in the centre of the sternum, from which there came a discharge which continued up to the last. On admission (Jan. 27th, 1890) the chief symptoms were intense headache, which was constantly present, though it was said to be worse at night, and with this headache delirium and noisiness. There was a continued high temperature and a rapid pulse. The expression was remarkably dull and stupid, and the gait staggering. He says that he has felt numbness in his right arm for the last two months. No history of tubercle in his family. The patellar reflex is lost in both legs. Cutaneous irritability is increased. Vision is very dim. Ophthalmoscopic examination reveals slight hyperæmia of the optic nerve and a tortuous condition of the retinal veins. The organs of hearing are unaffected. Physical signs of chest negative. The tongue is clean and flabby. He is not at present suffering from vomiting, but it has been present before admission. Coma put an end to the headache and delirium on the eleventh day after his admission to hospital.

At the autopsy gray granulations were found on the convexity, in the fissure of Sylvius, while large patches of lymph were seen at the base. In the left cerebellar hemisphere a large tubercular tumor was found. A few tubercles were found in the apices of the lungs.

Alleged "Fits" followed by profound Coma in a Young Girl after Mental Emotion; Death; General Thrombosis of the vessels of the Brain.

On 3rd February a servant maid, aged 25, was admitted under the following circumstances. She was said to have been in good health until the present attack. Though she had always been nervous and excitable, yet she had never been known to have had fits of any kind or to be at all subject to hysterical attacks. No family history of nervous disease. Five days before admission she complained of dizziness and of dimness of vision, but she continued at her housework for two days, and on the 1st February was said to have fallen in a fit in her kitchen, but recovered very soon, and was put to bed. On the following day

she was said to have had fits every half hour. There was gasping, sighing and rolling of the eyes, but no spasm of the arms or legs. These events were said to have followed some quarrel which she had with her mistress.

On admission she was almost completely insensible ; eyes half closed ; mouth slightly open ; pupils react to light. Pulse rapid and feeble. Tongue heavily coated and abdomen scaphoid. Incontinence of urine. Urine normal. The insensibility at the time of admission was not complete, for by an effort she could be roused to give her name and to say " yes" or " no," and she was able to take food offered to her, but immediately afterwards she lapsed into her previous state of insensibility. Reflexes normal. Sensation lost. On the day after admission the coma deepened.

Feb. 5th.—Breathing became rapid and swallowing was accomplished with difficulty.

Feb. 6th.—Condition much worse. Breathes more rapidly. Mouth continually open ; tongue dry ; mucous rattle in the trachea. Died on the following day.

The diagnosis of this case was a matter of considerable doubt and uncertainty. At the outset there were many symptoms pointing to hysteria. A young, healthy girl, never previously ill, quarrels with her mistress, is put thereby into a state of great mental excitement, is said to suffer from a succession of mild " fits," during which she does not bite her tongue or pass water involuntarily, and is finally brought to hospital in a semi-unconscious state. But subsequent observations soon dispelled that idea, for the patient presented no appearance of hysteria, but, on the contrary, there was profound stupor and no trace of clonic spasm. The incontinence of urine, which was present from first to last, added to the unlikelihood of hysteria. Though I could make no positive diagnosis, yet the possibility of the symptoms depending upon tubercular meningitis was before me, bearing in mind the case recorded by Gowers, where a young girl under circumstances somewhat similar developed symptoms which were at first regarded as hysterical, but which afterwards became serious, and after being a few days semi-comatose and passing

water involuntarily, died on the eighth day after the onset. The post-mortem in this case revealed general tuberculosis of the lungs, peritoneum and intestines, some small masses of yellow tubercle in the cerebral hemisphere, and meningitis of the base, the lymph being specially abundant about the pons and medulla, with opaque tubercular granulations.*

Having just read this case, I thought it possible that a similar condition might be found to exist in my patient. Dr. Johnston kindly furnished me with the following abstract of the post-mortem report, which speaks for itself:

" The vessels of the pia mater are very full, especially in the frontal region, where slight diffusion of blood has taken place into the tissues (post-mortem staining ?). Throughout the whole extent of the corpus callosum, fornix and internal capsule, the white substance is studded with innumerable punctiform capillary hemorrhages. A few similar hemorrhages are also found in the external and inferior part of both crura cerebri. The peripheral region of both optic thalami and the cortex at the spot of diffusion in the first frontal convolution are the only places where the condition extends to the gray matter. The hemorrhages throughout are perfectly symmetrically arranged. The only other lesion found was a moderate degree of broncho-pneumonia, chiefly in the lower lobes. The lungs and all other organs free from hemorrhages. Examination of the hemorrhagic spots showed them to be accompanied by, and probably caused by, thrombosis of the smaller vessels. The blood at these spots, as well as from other organs, was examined in the fresh condition and in stained preparations for bacteria with negative results."

* A Manual of Diseases of the Nervous System. London, 1888. Vol. I., p. 323.