Six cases from the
University Clinical Surgery
Wards.

for

"The Paterson Prize
1910.

John Cooper Booth.
List of Cases.

Case I  "Cystic Goitre"  Page 1.
Case II "Carcinoma of Cæcum" Page 9.
Case III "Gastric Ulcer" Page 15.
Case IV "A Bladder Case" Page 21.
Case V "Elephantiasis" Page 29.

Case VI "Concussion & Cerebral Irritation" Page 35
(Case 46).
Case I.

(A case of Cystic Gaitre)

Name - Walter Simpson        Age - 47.

He is married & has 5 children.

Occupation - Weaver

Birthplace - Durness, Caithness

Present Residence - Bonar Bridge, Sutherlandshire

Recommended by - Dr. A. Rae of Bonar Bridge

Date of Admission - 26th March 1910.

Date of Operation - 30th March 1910.

Result of Operation - Satisfactory

Date of Discharge - 20th April 1910.

On Admission:

Patient complained of "swelling in neck".

Duration - 7½ years.

History -

Seven and a half years ago the swelling began and for six and a half years it steadily and uniformly increased in size, giving him no pain or other discomfort.
A year ago, however, the rate of growth increased, and the swelling of the left lateral portion outstripped that of the right, until at present the left portion tends laterally to the limit of a line dropped perpendicularly through the lobe of the left ear.

He has not had to carry heavy weights on his head. While at his weaving (when hand-loomming) he has had to work fairly hard in a stooping position — this he has done for 32 years (since the age of 15). Since he has had the swelling, he has at intervals been troubled with Shortness of Breath — generally when exerting himself, but also when he quiet his down at night. He sleeps well — about 8 hours. He suffers at intervals from Hoarseness — in fact he thought that he was always catching cold. There is a history of Hoarseness, two years before the swelling began, in two separate attacks with 18 months interval between them. The second attack of Hoarseness was accompanied by pain in the right lateral thoracic wall. These attacks lasted for three months and one and a half
months respectively.

He is not troubled with giddiness, but at times he has "a full feeling in his head—as though his brain was too big." His memory during the last year has not been as good as it used to be, and at times he feels stupid. He has become very nervous since the trouble began and rather self-centered; when startled, he has some difficulty with his breathing and swallowing.

He has no tremors and his eyes are not prominent. The Stellwag, Moebius, and the von Graefe signs are absent. There is no Myasthenia and there are no attacks of vomiting. At intervals of 2 or 3 months he has attacks of diarrhea. The face and neck are not flushed, and he has had no palpitation or angina pectoris. He has had no previous treatment for the swelling. He has hardly lost any weight. The swelling is painless. There is no unilateral vocal chord paresis, there are no shooting pains in the neck or arm, and there is no contraction of
The pupil, or palpebral fissure.

Previous illnesses —

The two illnesses mentioned above (i.e. the two attacks of lassomeness before the swelling appeared). Twelve or thirteen years ago he had a piece of his index amputated — it having become long and swollen. His toesils have not troubled him. He has had no accidents.

Social condition —

Lives in a three roomed cottage and has open surroundings. He takes ordinary food, not much meat, and has a liking for sweet things. He has never smoked; takes "gin and egg" as a tonic in three monthly periods, otherwise he takes no alcohol. He takes hardly any exercise.

Soil — the soil is a "clay" one.

Water supply — not good. The water supply for the village is obtained from a small leach; this water is of a brownish colour, has a "soot" taste and leaves a brown deposit on standing. This water was not boiled or filtered for
drinking purposes.

**Family history** — Good. He belongs to a family of eight; his mother died of Typhoid fever at the age of 62, and his father at the age of about 70 died of "senile decay." — The rest of the family are all living and well. No history of "T.B.," gout or rheumatism. The only history of tumour growth is that of an uncle who had what appears to have been a large Lipoma in his side — this uncle lived to the age of 90. The patient's children are all living and well.

**State on admission:**

**Appearance** — Looks fairly healthy but has a large swelling (about the size of an adult heart) in the region of the Thyroid gland.

- Temperature 98.2
- Pulse 72
- Respiration 20

**Recent state of health** — He is feeling fairly well.

**Local appearance and condition:**

**Subjective** — Nothing just now.

**Objective** — There is a large swelling (about the size of an adult heart) on the
anterior and antero-lateral aspects of his neck, in the Thyroid gland region. The swelling on the left side is more extensive than that upon the right. On the left side it extends laterally to a line dropped perpendicularly through the lobe of the left ear. The mass as a whole is very firm, does not pulsate, has but a fractional transverse or vertical manual local movement, and is not attached to the trachea. The skin over the swelling is tight, but moveable; the trachea is displaced, to some considerable extent, to the right; the Thyroid cartilage being almost under the right angle of the lower jaw. The lymphatic glands are not to any extent enlarged. The right jugular vein has increased to about twice its original size, and the common carotid arteries are displaced backwards and outwards by the mass, the left common carotid being more displaced than the right common carotid. Diagnosis — Goitre probably of a cystic nature. The history of increased rate of growth during the last year.
is interesting, and brings into consideration
the possibility of the goitre having become
malignant in the left lobe.

Operation—

The patient was operated upon on 30th
March 1910. The greater part of the goitre was
removed by "Transverse Incision," a small
portion of the gland being left on the right
side for the maintenance of health. The divided
muscles were united with "catgut" and after
the platysma had been stitched, the skin was
closed by "skin clips." The operation was
performed by Professor Alexis Thomson, and lasted
for 55 minutes.

Anæsthesia—The patient was given a hypodermic
of Scopolamine and Morphine before the
operation, and anæsthetized with Ether. He
took the Ether rather badly at first, threatening
to pass into rinses, but upon the transverse
section of the skin and platysma, in the
preliminary steps of the operation, he gained
relief; and during the rest of the operation
behaved fairly well.

Type of Goitre—on section the goitre
was found to be of a cyclic nature with very
After treatment and general result—
In being removed to his bed after the operation, the patient was given a saline enema.

Temperature 99.5°F.
Pulse 116.
Respirations 28

The skin clips were removed on the third day. His recovery was uneventful, and occupied twenty days. He had some difficulty in speaking clearly after the operation—his voice resembling that of a person suffering from a "sore throat." On the day of his discharge this hoarseness had not disappeared.

Remarks.
In this case, the fact that the thyroid swelling was greater on the left side than upon the right, is interesting; most thyroid swellings are usually greater upon the right side than upon the left.

This case was prepared for operation by the "wet method"; although the "iodine method" of preparation is being used more extensively in surgery, its use is not acceptable for any thyroid cases.
Case II

(A case of Carcinoma of the Cæcum)

Ward 144. R. I. E.

Name: Janet P. Honeyman  Age 59.
She is a widow & has had 5 children
(one child is dead).

Occupation: Keeps a shop  Birthplace: 
Airth

Present Residence: 82 Dundas Street Grangemouth

Recommended by: Dr. Patterson of Grangemouth

Date of admission: 15th April 1910.
Date of operation: 19th April 1910.
Result of operation: Complications, and death.
Date of death: 25th April 1910
Cause of death: Acute general peritonitis following upon operation.

On Admission

Patient complained of "dull pain" in
right iliac region

Duration: The pain has been
present for about 1 year.
History

About a year ago she had a fall — since then she has had a more or less constant pain in the right iliac region. This pain became very severe about the beginning of this year, and she called in Dr. Patterson of Grangemouth, who informed her that she had an "inflamed appendix". She was given medicine and lay in bed for about two weeks, the painful area being poulticed. The severe pain then left her. Since this severe attack of pain, she has not been improving, but has been steadily losing weight, and in consequence feels very weak. During the severe pain at the beginning of the year (this year) she had attacks of vomiting at irregular periods — during these vomiting attacks she was troubled with diarrhoea, and after the attacks she would be constipated for two or three days. This vomiting ceased with the severe pain, after she had been treated for the period of two weeks mentioned above. The diarrhoea ceased when the vomiting ceased — the patient has found it necessary to make almost constant use of opening...
medicines since then.

Four weeks ago the vomiting started again,
accompanied by its train of attendant
symptoms. She again called her doctor
in, and he gave her medicine and applied
for her admission to this Infirmary.

Previous Illnesses

About thirty years ago she had a
bad attack of biliousness accompanied
by indigestion — these two complaints
have, in moderate form, occurred off
and on, up to date. For the last twelve
years she has had an intermittent
pain, shooting down the right leg; nine
years ago this leg became very hot —
swollen, "cold and hard" and at the
same time she was anaemic. The shooting
pain in the leg appears to be on the
outer side and back of the leg. She
had done nothing for this habit.

The patient has no sense of smell —
she cannot remember ever being possessed
of smelling powers. She had measles
when young.
Social Condition:
She lives in a low lying, damp,
quarmer. She and her two daughters
occupy two rooms. She does not take
alcohol, drinks little tea, and since
the beginning of this year has been on
a "white diet". The conditions are on
the whole not good.

Family History:
Her father suffered from Rheumatism
and also from what the patient calls
"a painful leg". One of her brothers
also suffered in a like manner.
No history of any other diseases in the
family. It appears to have been
a healthy family.

State on Admission:
- Pulse 72
- Temperature 96.0°F
- Respiration 18

Present state of health—She feels
a little better than she did two weeks
ago, except with regard to loss of
Local appearance and condition:—

Subjective.
She feels a dull pain in the right iliac region.

Objective.
In the right iliac region a tumour can be felt over the region of the Caecum. The "apparent" size of the tumour is that of a "Turkey-egg" and the shape is that of a sausage roll. The region of the mass is painful upon deep palpation but not upon superficial. The abdominal wall shows no marked signs of wasting. The tumour appears firmly fixed.

Operation.
On 13th April 1910 her abdomen was opened by an incision in the region of the tumour. The tumour (which was judged to be of the nature of a carcinoma) was found firmly fixed and so no attempt was
made to remove it. A lateral anastomosis (ileo-coloanastomosis) was performed and the patient, who took the chloroform badly, was returned as rapidly as possible to her bed.

On the night of the day of her operation, her temperature was 99.5°F and her pulse 104. On the night of the 21st (two days after the operation) her temperature rose to 100.5°, and from the night of the 21st to the night of the 22nd there was an almost clear drop to 97.5°, her pulse being 120 and her respirations 36. On the morning of the 25th (six days after the operation) her temperature was 98°, her pulse 112 and her respirations 30; — upon this day she died.

Cause of death.

Death was due to a complication of acute general peritonitis following upon a palliative operation for carcinoma of the ovary.
Case III.
(A case of Gastric Ulcer).

Ward 14, R.I.E.

Name: Mary Newlands       Age: 28

Single

Occupation: Servant

Birthplace: Morayshire

Present Residence: 10 Vearsfield Street, Stirling.

Recommended by: Dr. Skinner of Stirling.

Date of admission: 26th April 1910.

Date of operation: 29th April 1910.

Result of operation: Satisfactory.

Date of discharge: 14th May 1910.

On Admission:

Patient complained of "pain in the stomach, and vomiting."

Duration - about 5 years.

History:

About five years ago she was seized with a sudden sharp pain in the epigastric region, and she vomited. She does not remember
what this vomit was like. She called in a doctor and after medical treatment for about a year she "became well again". Even after this "recovery" she became ill again, with the same symptoms. Within the past five years she has had about five separate attacks and "recoveries"—each attack lasting for from one to two months. During these attacks (i.e., during these periods of 1–2 months), a sudden sharp pain comes on in the epigastric region about one to two hours after meals—shortly after the pain starts, she vomits, and the pain is then relieved. She can gain relief from the pain before vomiting, by lying on her face. The vomit sometimes contained "coffee grounds"—her last vomit was not of a "coffee grounds" nature. She ended her last attack 5 weeks ago—the period of attack having lasted for two months. She has had a doctor for all her attacks and he gave her medicine. She is rather constipated and so she takes "Epsom salts" regularly. During her attacks her stools are blackish in colour. She has had no "hunger pain" and is not awakened from sleep by pain.
She did not alter her diet at all during the five years, but—however for the last five weeks (i.e. since her last attack ended) she has been on milk, food, eggs and fish—this latter diet has agreed with her very well.

Six months ago she was very anaemic and had an accelerated heart—on account of this she was admitted to Stirling Infirmary where she remained for two months. Two weeks ago she was re-admitted to Stirling Infirmary on account of severe pain in the epigastric region—this time she remained in for a week. The last statement is peculiar, for she distinctly stated that her last attack ended five weeks ago and yet she says that she was taken to Stirling two weeks ago on account of pain in the epigastric region—she persist in this statement. So far treatment has in no way "cured" her complaint. Just now she is in the slue between attacks and is feeling fairly well.

Previous illnesses:

Measles when young. Diptheria seven years ago.
Social condition

She has been in service, with heavy work. She took ordinary food until five weeks ago.

Family history.

She is an only child. The family seems to be healthy and there is no history of disease.

State on Admission.

She looks rather anaemic and thin.

Temperature 97.1 F

Pulse 96.

Respirations 24.

Local appearance and condition —

Subjective — She is feeling "quite well" just now.

Objective — Some tenderness in the midline in the epigastrium region. Below the left angle of the jaw there is a slight swelling remaining from her attack of "ulcerated throat" of six months ago.

Operation —

On 23rd April 1910, under an anaesthetic of chloroform (induced) and ether (continued), an incision, about 3½" long, was made
in the middle line between the umbilicus and the epipharynx cartilage and the anterior wall of the stomach was examined; no sign of an ulcer or any induration was found on this aspect of the organ. The lesser sac was then opened and the posterior wall of the stomach examined—the wall of the lesser sac was found to be adherent on this aspect of the organ, close to the pyloric opening. This pathological attachment was then broken down, but no ulcer was found. A gastro-enterostomy was then performed (posterior) and the patient, who bore the operation well, was returned to bed. The operation was performed by Dr. Peter Alexis Thomson.

After treatment of special result—

The patient was kept in the Fowler position and made a satisfactory and uneventful recovery. She was discharged 15 days after the operation (i.e. 14th May 1910) feeling much better than she had felt for the last five years.

Remarks.

The gaining of relief from pain by lying...
on her face indicated a posterior ulcer.

Less of free HCl was found in a test meal. As contrasted with duodenal ulcer the following are respectively for and against:

<table>
<thead>
<tr>
<th>In favour of Duodenal Ulcer</th>
<th>In favour of Gastric Ulcer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ferroferric HCl</td>
<td>Ferroferric HCl</td>
</tr>
<tr>
<td>Time (1-2 hours)</td>
<td></td>
</tr>
<tr>
<td>Melena &amp; Haematemesis</td>
<td>Haematemesis</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>Pain in mid line</td>
</tr>
<tr>
<td>Pain relieved by vomiting</td>
<td></td>
</tr>
</tbody>
</table>

From the above it will be seen that the facts are in the majority for Gastric ulcer although the case might have been one of "pseudo-gastric-ulcer" or in other words "Gastriatosis". The demonstration of the "attachment" in the operation leaves no doubt that it was a case of chronic inflammation of some part, and that it was a stomach, and not a duodenal, complaint. But does it justify the statement that the case was one of "Gastric ulcer"?
Case IV

"A Bladder Case"

Ward 13 R.I.E.

Name: James Morris  Age: 21

Occupation: Coachmaker  Birthplace: Ladyemist, Aboyne

Present Residence: 1042 Loanburn Street, Dumfries

Recommended by: Dr. Ferguson (Dumfries)

Date of Admission: 14th May 1910

Date of Operation: 27th May 1910

Result of Operation: Satisfactory

Date of Discharge: 13th June 1910

On Admission:

Patient complained of "bladder trouble", pain at the point of his penis and pain in his lumbar region.

Duration: 4 or 5 years

History:

Four or five years ago he had a slight...
pain at the point of his penis when the making of water was finishing; this pain grew gradually worse and the inclination to micturate in short intervals grew in proportion to the pain. A year ago he was making water every 3/4 of an hour — the amount of urine expelled at each micturation being about enough to fill a wine glass; at this time (i.e. a year ago) he noticed that this flow of urine generally ended with a drop of "blood".

For the last two years he has been unable to sleep on his right or his left side on account of pain which comes to the point of his penis, when in either of these positions. He has no pain however when he lies upon his back.

He states that every time he micturated he gave a shudder when the urine began to flow.

Four months ago he began to be irregular in going to "stool", and when he had a motion it was generally a very painful act. He found it almost impossible to walk after having defecated, unless
he had rested for about an hour — sometimes he even had to go to bed.
For the last year and a half he has had little sleep.
He has been a masturbator for about 4 or 5 years — masturbating on an average of twice a week. Two or three years ago he attempted copulation.

Family history —
His father died of "Consumption," otherwise the family appears healthy.

Social condition —
Bad. He has been in bad company for several years. I also suspect the use of drugs.

Previous illnesses —
Measles, mumps, and influenza.

Previous treatment —
Within the past 12 years he has been treated by four doctors — we will call these doctors N°1, N°2, N°3, and N°4.

One and a half years ago the patient got a severe wetting while bicycling in the rain; after this wetting, a jolt on the bicycle would cause a sharp pain to shoot down
to the point of his penis — so he went to see Dr. No. 1. The patient told the Dr. nothing about masturbation or his other habits; in fact he denied having bad habits — so Dr. No. 1 diagnosed Bright's disease, treated the patient wine every fortnight, told him to stop work, and gave him medicine. So the patient took a holiday for four months and went to Devonshire. Here he went to Dr. No. 2 who treated him and said that it wasn't Bright's disease. He returned from his holiday feeling a little better and started work again. He worked for two months gradually getting worse — so he went to see Dr. No. 3 who sent him to Dumfries Infirmary. Here they also said that it wasn't Bright's disease. He remained in Dumfries Infirmary for 16 weeks; when he came out he was feeling much better — so he went back to work. After working for two months he again became "knocked up" and so he went back to Dr. No. 3, who again sent him to Dumfries Infirmary — here he remained for 3 weeks. He left the
Dumfries: Insipid pains feeling no better than when he was admitted. He returned to work, and worked for a fortnight—then he gave up work and called in Dr. W., who put him to bed and treated him for two months. This doctor tested the patients urine and found a good deal of sugar in it—so he thought it was diabetes. Under medicine and diet the sugar disappeared in four weeks' time. The last act of Dr. W. was to send the patient to the Royal Infirmary, Edinburgh, where he came under the observation of Professor Alexis Thomson.

His temperature on admission was 97°.

"pulse " " 104.

General appearance — He is a greyhound, weak, gaunt youth, and he is a nervous wreck. His hands are very unsteady and his lips droop and tremble. His eyes are wearying and not candied. He is pale and thin and appears to be tired out. He is very morbid.

Subjective appearance and condition —

Subjective — He feels pain at the point of his penis, pain in his back and feels "done up".
Objective —

On rectum the right lobe of the prostate appeared to be enlarged — the examination was painful. An X-ray photo was taken and a Janet mass about the size of an egg was seen on the right side near the Symphysis pubis, in the pelvis. An operation was then decided upon.

Operation —

On 27th May 1910, Mr. George Chien performed a suprapubic Cystotomy and explored the bladder and prostate gland. He found — nothing abnormal. The prostate was in good condition and nothing was in or growing from, the walls of the bladder. The wound was then partially closed and suprapubic drainage established by means of a glass tube. The patient was returned to bed, and the bladder was drained by a siphonage pump. On 1st June the glass tube was removed but the siphonage was continued. His temperature after the operation was 99.5° and his pulse 120. When the glass tube was removed the temperature was 98°, and the pulse 96. He was
given
1. 9H Hystopar 30 X c.i.d.
2. Contraceptive Water.

General result:
He had good sleep after this operation, and improved generally. He made an uneventful recovery and was discharged on 13th June.

Remarks.
The X-ray result is a puzzle.

With regard to the history given by the patient I consider that something is still wanting. This urine when examined at the infirmary contained a faint trace of pus and microscopically blood. He had never passed a stone. The masturbation may account for some of the symptoms — the "genital centre" having been educated to a state of abnormal activity. Fear may account for something else, for the patient was frightened that he was going to die and had been worrying over the fact for about three years; in fact for the last year the seems to have thought of nothing else. Even allowing that excessive masturbation and fear had caused...
some of the above symptoms, something is keen that wanting. The use of drugs, added to the above two causes might account for the symptoms. With regard to the "drug supposition," these two facts are worthy of note: 1. "D. W. No. 3" gave the patient laconism, and he gained relief. 2. When the patient woke up after chloroform he complained of great pain and asked for "a needle."

No marks however could be found on his wrists or arms, and he denied ever having used drugs — seeing however that he denied masturbation or loose habits, to two or more doctors and held to the same story on admission here until he was forced to admit the fact, his denial of the use of drugs carries no weight.
Case V
(A case of Elephantiasis)

Name - Robert Dickson  Age 51
Married

Occupation - Tractor engine driver

Present Residence - Barnard, Beal Northumberland

Recommended by - Dr. Crawford

Date of Admission - 28th May 1910

Previous Residence - He has not been out of the British Isles.

Removed to Ward 26 on 18th June 1910

On Admission

Patient complains of painless swelling of both lower limbs, scrotum and penis.

Duration (from first gland signs) 2 years

History -

Two years ago a small "elastic feeling" swelling, about the size of a pea appeared in the left groin. For two years this swelling increased in size until it became as large
as the "head of a common clay pipe." Then the left leg began to swell (4 months ago); some days it was bigger than on others. He worked on in this condition for three months. The swelling then went across to the right side, attacking the scrotum and penis on its way, and the right leg became affected. He stopped work; the right leg got worse. He was then admitted to the Edinburgh Royal Infirmary and came under notice of Professor Alfred Thomson. Since his admission the limbs have decreased in size and the left is the larger of the two.

**Temperature** 96.5°
**Pulse** 72.
**Respirations** 20.

**Previous illness**

None that he can remember. 21 years ago he had an accident to the thigh of the right leg, in the shape of a cut about 2" long.

**Social condition** - Satisfactory
**Family history** - Nothing of importance
State on admission: –

Subjective – he feels no pain

Objective –

The lower limbs, scrotum, and penis are enlarged. The left lower limb is larger than the right. A number of small “reddish-brown pimples” are to be seen on the left limb, just above the ankle – there are none on the right leg. He does not know when these appeared. The skin on the right limb is fairly soft (almost normal) while the skin on the left limb is thick and “hide-like,” with irregular lines running in it. In the left groin there is a hard “beacon” swelling, about the size of a “bath bean.”

– This is the primary gland swelling.

Measurements

Normal part of body:

Neck 14”

Waist 39”

Forearm 10”

Upper arm 10”
Affected parts of body.
Circumference of penis 7"
Scrotum 1. From junction with penis to central point of perineum 3"
2. From groin to groin cutting mid point of above measurement 10"
Lower limbs:
Measurements as follows: 1. Mid poupart point to mid patella point, halve the line and take circumference round the thigh at the mid point; 2. Circumference over mid patella point; 3. Mid patella point to mid malleolus point, halve the line and take circumference round leg at the mid point; 4. Circumference of ankle at mid malleolus point.

<table>
<thead>
<tr>
<th>Right limits</th>
<th>Left limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>23&quot;</td>
</tr>
<tr>
<td>2</td>
<td>17&quot;</td>
</tr>
<tr>
<td>3</td>
<td>14.5&quot;</td>
</tr>
<tr>
<td>4</td>
<td>10.5&quot;</td>
</tr>
</tbody>
</table>

Another measurement (by no means an accurate one) was taken round the groins, below the anterior superior spine, over the gluteal region and back to the...
grain—The results were as follows:

Left side 29.5"; right side 27.5"

Treatment—

Some watery blood-stained fluid was
extracted from the swelling in the left
grain for the purpose of growing a culture.
A strepto- or staphylococcal organism
is suspected.

On 18th June the case was removed to the
Medical side. This report is not concerned
in its further treatment, as a Medical case.
It was under observation for 21 days as
a surgical case in ward 18; when the case
was transferred to the Medical House on
18th June, the abscess were not as large
as they were on his admission to the
Surgical House on 28th May. His only
treatment so far has been rest and general
attention;—on the medical side he
will probably be treated by injections
of an emulsion of the causale organism,
at stated periods.

Extra note on the above case:—

Dr. Theodore Shennan (Pathologist to the Edinburgh
Royal Infirmary) has succeeded in isolating
From fluid in the above case, a micrococcos which corresponds to no hitherto described micrococcos. Material for "preventive inoculation" is to be manufactured from the above micrococci, and the effect of this inoculation carefully observed in the patient.

Remarks.

The interesting points in this case are:

1. There is no primary history of repeated attacks of erysipelas or lymphangitis.
2. The patient has not been out of the British Isles, and so it is unlikely that the filaria bancrofti duodenalis is the causal organism.
3. No formation of blisters (the fluid for examination was taken from an artificially produced blister) — the formation of blisters is of course, not a constant feature in cases of Elephantiasis.
4. The isolation of a hitherto undescribed micrococcos, which may or may not be a causal factor in the disease.
Case VI.

(A case of Concussion with Cerebral Irritation)

Ward 3 R.I.E.

Name - George Yates      Age 15
Occupation - Message boy.
Present Residence - 7 Grange Loan Edinburgh
Date of admission - 2nd June 1910

On Admission.

The patient was unconscious.

History.

This afternoon (2nd June) the boy was running round a corner and across the road when he was knocked down by a motor car which was going in the opposite direction. He was struck on the right side of his head. A doctor happened to be in the car, and he at once picked the boy up; he thought at first that the boy was dead, but
findings of life upon examination, he brought him to this Infirmary. The patient was admitted at 6:40 p.m.

On examination

**Temperature** 95.75.

**Pulse** 88.

**Respirations** 28.

He was unconscious, his face was white and his extremities were cold. He kept moaning, and his respirations were heavy and sighing. The right humerus was fractured. The left arm fell in a "powerless" kind of manner, on being raised and then let fall, the movements of the left lower limb were fible. There were abrasions on the face, arms and legs. He had a "scrape" wound on the right side of his head, from which there was slight bleeding. There was no bleeding from the nose or ears. His pupils were equal, reacted in a sluggish manner to light, and were of moderate size—the left pupil was more active. His head was shaved and the wound on the side of the head was dressed. He was given a hypodermic of strychnine.
and put on treatment of 3 iv salines every two hours.

Report of progress.

3rd June—His bowels have moved after two doses of Colomel, "H.S." and an enema. He wet the bed with his urine. From time to time he has convulsions—after a convulsion he is, for a while, cyanosed. He became quieter towards night. The temperature has risen to 93.8° and the pulse is 112 and is feeble.

4th June—He is much quieter. His temperature is 97.4° and the pulse is 80 and is feeble and bounding.

5th June—He is in much the same condition as he was on 4th June. This morning was quiet, but in the afternoon he had a few convulsive attacks. His pulse is between 58 and 68, slow, full and bounding. He swallowed a little milk with some difficulty. He keeps making a sucking noise with his lips. The left knee jerk is exaggerated; there is tendon response (Babinski's sign).
The paralysis appears to be confined to the left side of the body.

6th June — He becomes irritable when disturbed — otherwise he lies quietly. His pulse is 88 and is better than it was yesterday; temperature 36.4°.

7th June — He passed a quiet night. He now cries out just before waking water, and he opens his eyes slightly. He retains his rectal salines well, and drinks more fluid. His temperature is 36.2° and the pulse 52.

8th June — Takes his milk better. At intervals he continues the giving of a "dog-hoaling at the moon" kind of cry. His eyes at times have a faintly intelligent look in them — a passing expression. He tosses about. The right arm (in splints) and leg are moved more than the left. He still uses his bed, although he cries out when just about to make water. During the periods in which the eyes hold for a short interval an intelligent expression, he will, upon firm
request, put out his tongue. The temperature is 96.5°, the pulse 50 and the respirations 24.

9th June — He passed a good night. He put his tongue in and out when asked to do so. He spoke for the first time today (exactly a week after the accident) — he said "oh dear!"

When his bed was being made he said "oh dear! my side" — he was lying on his left side at the time. He has not recognised anyone yet. He is now on 3 vi salines every four hours. The temperature is 97°, the pulse 56 and the respirations 24.

10th June — He has had to be strapped down on account of his movements. He swallowed some pudding today. He has spoken more — counting and saying his A, B, C. The left arm and leg are now moved more. On the whole he is much better today. The temperature is 97°, the pulse 68 and the respirations 24.

11th June — He is still restless.
He speaks more — once or twice he spoke rationally. The temperature is 37.5°, the pulse 64, and the respirations 24.

12th June — He still, at intervals, screams out loudly without seeming conscious of what he is doing. He is much better. Temperature 96.75°, pulse 64, and respirations 24.

13th June — Today he recognised his father (first recognition since the accident). He still screams out at intervals. He moves his left arm and leg much better and is making slow mental recovery. His temperature is 96.75°, his pulse 80, and his respirations 24.

14th June — He is better today, though still restless. He lies with his eyes open for long intervals, and still screams out without seeming to know what he is doing. He reasons very much — this reasoning has been present soon after the second or third day after his admission. His mental powers are still dulled and at times it is very difficult to attract...
This attention, and practically impossible to hold it. He is eating well. The temperature is 36.2°; the pulse 64, and the respiration 20.

15th June — He is in much the same condition as he was yesterday. Still creeps out at intervals. Temperature 36.2°; pulse 60, and respiration 20.

16th June — He was very restless last night, and the "crying out" is a constant feature. He will name various every day articles when they are held up — he does not appear to look at the object held up, for if the article be held at the side of his face (out of his direct line of vision) he will, staring straight ahead, name the article correctly.

His "mental" perception is much clearer, and on the whole he is much better today. Temperature 36.5°; pulse 52, and respiration 20.

17th June — He is able to feed himself with a small piece of bread if it be placed in his left hand — he does this by slowly sliding his left hand along his thorax (he is lying all the time in bed) until it is just below his chin, then he bends his head down and eats the bread. Although the movements of the left side are much
better since his admission, he is yet unable to lift the hand or arm for feeding purposes. Temperature 96.75°, pulse 52, and respirations 20.

19th June — He is not coherent. He is eating well and will feed himself with bread in the manner described yesterday. If given dry bread, he will ask for butter. This evening he was asked where he was, and he replied that he was “riding a bicycle”. He was next asked what was the matter with him, and he, after some thinking and making a sucking noise with his lips, replied that he had a “cracked head”. He was next asked how he got the “cracked head” — he made no reply to this question, but shut his eyes tightly and wrinkled his face; the question was repeated — his only reply was to try and spell a word which has been bothering him all day, viz “battalion”; he gets as far as “batt” — but always sticks there and is unable to finish the word. The question as to how he got the “cracked head” was repeated for the third time and his reply — after a long pause — was that it was “his fault”. Again the
question was asked and this time he replied that "he was riding a bicycle." He was asked "what happened when he was riding his bicycle?" and he replied that he ran into another boy who was on a bicycle—a "brand new bicycle." The question was put again and the same reply was given but this time in an annoyed manner. He was then asked no more questions. He mentioned the name of a Miss Gray this evening. He spends a good deal of his time in spelling words. He will often reply to a question five minutes after it has been put. He is looking better. Temperature 96.75°, pulse 52 and respirations 20.

19th June — He is about the same as he was yesterday. Temperature 96.75°, pulse 64 and respirations 20.

20th June — Great improvement. He is speaking slowly, with intelligence. His fractured right arm is mending well. He is moving his left arm with more freedom. Temperature 96.5°, pulse 52, and respirations 20.

21st June — Still progressing well. Hi.
memory has improved, and he now can remember for whom he was working at the time of the accident, although he can remember nothing about his accident. He still screams out, and spells words. He has made a sudden and excellent improvement within the last three days. Temperature 36.5°; pulse 60 and respirations 20.

22nd June. Temperature 37°; pulse 64 and respirations 20. Practically in the same condition as yesterday.

23rd June. Temperature 37.5°; pulse 68 and respirations 20. A little better than yesterday; he still screams out, and has developed a temper.

24th June. He has a mania for eating, and has begun to refuse his medicines (opium and medicine). When thinkers, he shuts his right eye and starts into space with his left. A little better than he was yesterday; temperature 37°; pulse 60 and respirations 20.

25th June. Temperature 36.75°; pulse 60 and respirations. Practically in the same condition as yesterday.
26th June. Temperature 37°; pulse 60 and respirations 20. In the same state as yesterday.

27th June. Temperature 37°; pulse 68 and respirations 20. He has been removed to Ward 13. The mania for food continues, and he cries when food is refused him. He still makes his urine in bed and so he is being given to Belladonna. X c.c. T. When he cries, signs of facial paralysis are still to be seen.

28th June. Temperature 36.5°; pulse 64 and respirations 20. The leg reflexes are practically normal. He appears to understand all that is said to him — and pleases himself as to whether or no he answers. He has a temper and states his wishes in a regal manner — the temper finding outlet if his wishes are not carried out. When directing with his finger his legs like a baby, and appears to have much satisfaction in so doing.

Remarks:
The patient is still in Ward 13. He has been
watched (for this paper) day by day for 26 days, and one may divide this period into six divisions, as follows:

(a) 2nd to 6th June — In a doubtful condition. An operation to relieve the brain was almost decided upon, on account of his low condition.

(b) 7th to 9th June — Improvement of a decided nature, and signs of possibility of recovery.

(c) 10th to 13th June — Speech, and recognition of his father. The brain beginning to assert itself.

(d) 14th to 16th June — Much better. Recognition of common objects and signs of general intelligence.

(e) 17th to 20th June — A period of remarkably rapid brain improvement.

(f) 21st to 28th June — A gradual slowing in the rapidity of the brain improvement and the advent of the “food-mania” possibilities.

Possibilities: — The final stages of the brain “recovery” will be slow and very probably incomplete, and he will be “irritable.” The “food-mania” is an interesting point.