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[Reprinted from THE MEDICAL NEWS, December 17, 1892.]

THREE CASES FROM PRIVATE PRACTICE.

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THE DIFFICULTY OF LOCATING BRAIN-LESIONS, AS ILLUSTRATED BY DEPRESSED FRACTURE OF THE FRONTAL BONE.

ON October 6, 1891, I was called to see a boy, eight years old, who had been kicked by a horse, receiving a compound depressed fracture of the frontal bone. There was a triangular tear of the scalp over the right eye. On raising the flap, the depression was found to extend from a point half an inch above the external angular process of the frontal bone, obliquely upward and toward the median line, a distance of one and a half inches. It was half an inch in width, and about one-eighth of an inch in depth. There was very little splintering of the adjacent bone. The boy was in good condition, and had not been unconscious.

On consultation with Dr. Jacob Price, it was decided to trephine and raise the depressed portion. Before we operated, the patient had two convulsive seizures, the muscular movements being strictly confined to the left side of the face and neck and left arm. With a one-inch trephine, a piece of bone was removed above and overlapping the depression. The dura had not been injured. The frontal sinuses not being developed in a child of eight years, we had no difficulty from that source. The injury to the internal table was much more extensive than that to the external table. With a lever the

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depressed portion was elevated, and the loose fragments removed. The tissues of the scalp were then replaced and the wound closed. The boy had no more convulsions, and made a satisfactory recovery.

I have reported this case because it seemed to me noteworthy that a wound in the frontal region should produce the motor symptoms described. If we had been operating for these symptoms alone, and had not had the external wound to guide us, we would have trephined over the motor centers of the parts convulsed, which are fully two and a half inches from the point of injury. The possibility of having the irritation transmitted for a considerable distance may explain some failures in brain-surgery, and lends an additional element of doubt to the exact location of brain-lesions.

ANGINA PECTORIS IN A FEMALE, WITH OBLITERATIVE ENDARTERITIS OF THE ANTERIOR CORONARY ARTERY, AND AN AREA OF ANEMIC NECROSIS IN THE HEART-WALL.

About January 1, 1892, I was called to see a woman, sixty-two years old, who was subject to spells of severe pain in the precordia, radiating to the left shoulder and arm. The attacks occurred at variable intervals of time, not oftener than once a month at first, and were generally induced by exertion. The first attacks lasted but a few seconds. They gradually became more frequent and more prolonged, and occurred at times when there was no apparent cause. Between the attacks the woman had dyspnea on exertion and edema of the lower extremities. The heart-sounds were feeble, rapid, and irregular. The first sound was accompanied by a soft blowing murmur, heard best at the apex. The peripheral arteries were not rigid.

The heart-tonics, digitalis, strophanthus, and caffeine, increased the number and intensity of the attacks, as well as the general distress. The woman could tell

with great accuracy that the "medicine made her worse," whenever any of those named was used.

Amyl nitrite had very little effect on the attack, and that effect was soon lost. Morphine and atropine alone helped her. They relieved the attacks, and prevented their recurrence. The woman's general condition gradually became worse, although the original attacks seldom occurred during the latter part of her illness, as she was kept constantly under the influence of morphine. She died suddenly August 9, 1892.

At the autopsy the heart was found dilated and flabby. The mitral ring admitted four fingers. There was no thickening or retraction of the valves and no calcareous plates about the origin of the aorta. The anterior coronary artery was occluded, and in an area supplied by it, in the wall of the left ventricle near the apex, involving the whole thickness of the heart-wall, from the visceral layer of the pericardium to the endocardium, there was a collection of necrotic tissue. The endocardium was perforated, and some necrotic material was in the left ventricle.

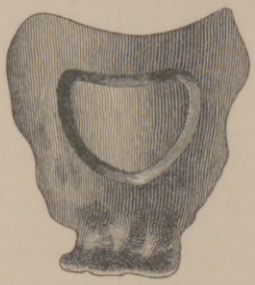
I have reported this case because anemic necrosis of the heart is not a very common condition, and because the symptoms during life, as well as the post-mortem conditions, render the diagnosis of angina pectoris allowable, although Osler says that the disease occurs "almost exclusively in men."

A CASE IN WHICH A MAN SWALLOWED A PLATE FOR ARTIFICIAL TEETH.

On October 9, 1892, a patient came to my office, who, while eating his dinner, had swallowed a plate for artificial teeth. The plate had originally carried two incisor teeth, but the teeth having come out he had worn the plate for several years because he had become accustomed to it. He complained of severe spasmodic pain in the region of the cardiac orifice

of the stomach. A soft stomach-tube was passed and was arrested at about this situation, not entering the stomach. As the plate was too low down to be grasped by instruments, I gave him apomorphine, gr. ⅙, hypodermatically, with mustard-water by the mouth (which he swallowed without much difficulty); but copious emesis failed to dislodge the plate. Then, with a stiff esophageal bougie, I pushed the plate into the stomach. The pain was almost instantly relieved.

The "potato treatment" was adopted, and in forty-two hours from the time of swallowing the plate it was passed per rectum. The sharp edges slightly lacerated the anal sphincter. Otherwise no harm was done.



The dimensions of the plate are 1½ by 1¼ by ⅝ inches, as shown in full-size cut.