Clinical and other Notes.

NOTES OF THREE INTERESTING CASES OCCURRING IN THE BRITISH CORPS OF OCCUPATION, CONSTANTINOPLE.

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Case I.

Serjeant E., R.F.A., was admitted to hospital late at night with a history of of having been shot[1] in the chest some two hours before.

The patient was very little shocked from the journey and after rest in bed with warm applications his condition was very fair. He complained of a pain in the right side of his chest, but was not seriously troubled by it. On examination a small wound—less than $\frac{1}{4}$ in. in diameter—was seen in the anterior axillary line in the eighth interspace on the left side of the chest. The bullet could be felt at the back, on the right side, just under the angle of the scapula, lying in a subcutaneous position. There was no other external sign of wound or injury. It was impossible to tell the direction of the bullet in the body as it had hit the rib above, but it appeared to have started in an upward direction. The pulse and temperature were normal, the whole of the abdomen moved evenly and well and there was neither superficial nor deep tenderness on palpation. The bowels had not moved since the wound had been received, but there had not been any vomiting, and apart from the pain in the chest the patient was quite comfortable. The wound was treated, but nothing further was done. The patient passed a very fair night and was no worse the next morning. The condition remained *in statu quo* until just past midday when the pulse rate began to rise and vomiting commenced, and for the first time the patient really looked ill. Rigidity was noticed in the upper left abdomen and the blood-pressure was falling. Immediate operation was advised. The abdomen was opened by a vertical incision in the outer upper left rectus. A large amount of free blood was seen in the abdominal cavity and investigation showed that the bleeding came from a torn vessel in the omentum. The transverse colon was also wounded in two places and a large blood clot was seen at the bend. The wounds were repaired, but the clot was not touched. A large rubber tube was inserted down to the clot and the skin wound closed round it. A wide-bore suprapubic drain was also inserted. The patient's condition was extremely critical and he never really rallied from the operation, and he died before eight o'clock that night. His temperature had never been above normal and it was markedly subnormal just before death. He lived for twenty-two hours after being wounded, and for the first fifteen or sixteen hours showed no signs or symptoms of a serious wound.

The bullet was removed through a subcutaneous incision at the time of the major operation.

[1] The bullet was fired from a small automatic rifle ·22 at a range of about ten yards.

The post-mortem was performed the following morning. The original wound and the surgical wounds, were found as described above. The body was opened and it was found that the bullet had penetrated the pleural cavity at its base so that beyond a slight contusion the lung was not damaged. The diaphragm was perforated immediately opposite the pleural wound. There was some old pleurisy on the right side and there was some hypostatic congestion of both lungs. Beyond this the whole of the thoracic contents were normal.

There was a considerable amount of free fluid in the abdominal cavity with an acute general peritonitis. The fluid was bloodstained.

The liver and spleen were undamaged and quite normal. The great omentum was packed round the sutured wounds in the colon, and as this was being rearranged very definite areas of fat necrosis were seen. Practically the whole of the pancreas was destroyed and the portions were almost unrecognizable in a mass of blood clot, which already was infected from the bowel.

The bullet having passed through the pancreas, entered the perirenal fat without damaging the kidney, and buried itself in the thick muscles of the back and then in some manner passed between the spinous processes of the tenth and eleventh vertebræ to the other side and finally came to rest in the subcutaneous tissues where it was found.

The whole of the stomach and intestines were carefully examined, but beyond the sutured wounds described, no other damage was found. The kidneys and suprarenals were normal,

Cause of death: Gunshot wound of abdomen perforating a hollow viscus and causing destruction of the pancreas which give rise to an acute hæmorrhagic pancreatitis. Immediate cause of death, toxæmia from the pancreatitis and general peritonitis from the perforated colon.

(Clinical notes supplied by Major J. Dunn, F.R.C.S., R.A.M.C., Surgical Specialist to the Command.)

Case 2.

Boy, G. H., R.N., who was found dead in his hammock in the morning.

There was no apparent cause for death, his history sheet was clear and externally no abnormality could be found. The only history of any value was that the evening previously he had eaten a whole tin of salmon just before turning into his hammock, and that there had been some bad tins in the batch in the canteen.

The body was opened and the organs examined in the following order: thyroid gland: normal; œsophagus: normal; trachea: normal; larynx: normal; aorta: normal; thymus: very much enlarged, quite three times the size of the gland seen in a normal infant; bronchial glands: pale and enlarged; cervical glands: pale and very definitely enlarged; lungs, etc.: pleura normal; lungs small, good colour and normal; heart: slight excess of pericardial fluid; muscle good and no other abnormality; liver: enlarged and blood dripping; spleen: enlarged and very flabby, malpighian bodies enlarged and standing out clearly: kidneys: congested; pancreas: normal; adrenals: normal; stomach, etc.: empty to the beginning of the ileum and thence contents were normal; the stomach was intensely congested, but there was no loss of mucous membrane seen in any

part of the congested stomach or duodenum; all the lymphatic tissue in the abdomen was hypertrophied; brain, etc.: normal.

Cause of death: status lymphaticus. Cause of stimulation: (?) toxæmia from tinned food.

N.B.—There was no evidence as to whether there had been any vomiting before the patient went to his hammock.

CASE 3.

An English lady of 75, non-inoculated, was ill three weeks in her home with slight diarrhœa. A Greek doctor saw her, diagnosed acute T.B. lung and eventually sent her into a women's and children's hospital. Just before she died I saw her with the medical officer, and we both thought of typhoid. I took a blood culture on chance and got a very good growth of *Bacillus typhosus* in thirty-six hours. Fæces also positive; Widal negative. Temperature subnormal until just before she died.

TWO CASES OF LEUKÆMIA.

BY CAPTAIN D. POTTINGER, M.C.
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Case 1.—Sapper X, aged 22, was admitted to Fort Pitt Military Hospital on February 2, 1922.

Family History.—Nine brothers and sisters. Two brothers killed in the war. All other members of the family alive and healthy, including father and mother.

Condition on Admission.—Stated he had been on full duty previous to admission but lately felt a bit "off colour." Complained of headache and sore throat of twenty-four hours duration. Temperature 100° F., pulse 76. Pain in left side and slight cough. Slight friction rub could be heard. Lymphatic glands in anterior triangle of neck were moderately enlarged and tender.

Stated that he had noted a similar "lump" some weeks before but it had gone away of its own accord. On third day of admission moderate epistaxis occurred. Pain in the left side continued, and the painful site was painted with iodine. Temperature continued at 100° F., and pulse rate 80.

The counter-irritation of the iodine relieved the pain but produced a purpuric rash exactly coinciding with the area painted; a similar rash, but very much milder in type, appeared on the forehead.

Blood examination at once cleared up the diagnosis, showing: red blood corpuscles, 1,375,000; leucocytes, 268,000; hæmoglobin, twenty-six per cent.

Laboratory Report.—Blood picture was typical of an acute lymphatic leukamia. Lymphocytes exceed ninety-nine per cent and are very irregular in size and shape of nuclei. No myelocytes or eosinophils were seen, and no nucleated red cells.

The progress of the case was rapidly down hill. The epistaxis continued and was more severe. Other lymphatic glands in the neck, axilla and groins became enlarged. Temperature varied from 100° to 104°, rising towards the termination of the illness. Pulse rate from 104 to 136.