

CASE II: Mrs. M.M., aged eighty-six years, was ill for one week. She noticed a lump protruding from the vulva a few weeks before admission on June 1, 1931. She had been walking about and had had no pain. She had some urinary incontinence. The swelling was not bleeding on admission, but caused a slight purulent discharge.

On examination the lump was irreducible and appeared to be a proliferative type of cervical carcinoma in a senile uterus, completely prolapsed.

She had had two children and menstruation, according to her statement, continued until she was sixty years of age. There was no other noticeable abnormality in her history or on examination.

The pathologist, Dr. Bull, reports the section of growth as a squamous-celled carcinoma.

During the week after admission the patient exhibited mental disturbance of a senile type. The growth has increased in size, partly from congestion, and has now an extensive area of necrosis from friction, strangulation and degeneration.

The condition appeared unsuitable for radium treatment on account of the difficulties of nursing and incontinence *et cetera*. Deep X ray therapy was considered appropriate, and will be carried out if the condition of the patient permits of it.

Discussion.

On consulting the literature, there are reports of cases in young and old women. One may quote Fairbairn,² who states:

The greatest liability to cervical cancer occurs towards the end of a woman's reproductive life. It is very rare before 25, rare before 35, the vast majority arise between 35 and 65 . . . It is unusual to see cases above the age of 75. Virgins are very rarely and *multipare* rarely affected. The great majority occur in parous women.

Wilson³ (Birmingham) supports these opinions and remarks that:

Cancer of the cervix is very rare in extreme old age. However, cancer of the cervix occasionally is seen at extremes of age. Joseph Adams relates a case in a child of 2½ years; de Rouville a case in a girl of 13; Findlay records a case in a woman of 93 who had borne eight children, one of whom died at the age of 43 of uterine cancer.

Nevertheless, these are extreme rarities. It will be noticed that the senile patient had had two children. On the other hand, the youthful patient had had no children nor any miscarriages. The youthful patient had had a radical Wertheim hysterectomy followed by deep X ray therapy and two years later appears quite free from local recurrence or distant metastases. Her general health, she recently remarked at a post-graduate clinic, was better than for four years. In this case it seems an interesting possibility, that the inflammatory condition accompanying the cervical carcinoma might have had a protective influence against malignant spread.

The case also illustrates, as Dr. Ralph Worrall has suggested, that the most unpromising case sometimes may yield a great victory to the surgeon who does his best.

References.

- ² Fairbairn: "Gynaecology and Obstetrics," 1928, page 667.
³ Wilson: Eden and Lockyer's "Gynaecology," Volume II, 1917, page 449.

PRIMARY KIDNEY INJURY, APPARENTLY DUE TO LEAD.

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In those instances of chronic nephritis in young people in which lead is held to have been the cause, it is commonly supposed that the action of the lead was rather primarily on the vascular system and only secondarily

on the essential kidney tissue. Thus patients are seen in whom the blood pressure is rising steadily, although urea concentration and blood urea are almost within normal limits.

The following case report, however, is an instance of tubular injury, with renal failure such as Fishberg states is produced in laboratory animals by prolonged feeding with white lead.

M.B., aged three years and eleven months, a female, was first seen by me on March 5, 1930. I later learned that she had been attending the out-patient department at the Hospital for Sick Children with great irregularity.

There was one younger healthy child in the family.

For eighteen months the patient had suffered from abdominal pain, weakness in the knees, clumsiness of the feet, weakness of the hands and increasing pallor. For the past three days she had had a slight cough and was feverish at night. The parents stated that she neither bit her nails nor sucked her fingers (these statements were disproved by the most cursory examination of the child), but that there was ample powdered lead on the veranda.

Examination revealed a thin, limp and anæmic child, a mouth breather with slightly enlarged cervical glands. The teeth were good; there was no blue line. The tonsils were enlarged and adenoids appeared to be present. Heart and lungs were normal. The systolic blood pressure was 90 and the diastolic pressure 60 millimetres of mercury. These figures were approximate only, owing to the size of the cuff. This figure is normal according to Fishberg.

In the abdomen nothing was palpable; the child offered no objection to deep pressure. The parents stated that during attacks of pain she preferred deep pressure to any other form of relief.

The urine had a specific gravity of 1.015; it contained a definite cloud of albumin and many granular casts. The blood gave no reaction to the Wassermann test.

Slight double wrist drop, very marked double foot drop and weakness in extensors of knees were present, so that the child was unable to stand. The deep reflexes were absent. The plantar reflexes were sluggish and flexor in type.

Blood examination revealed a secondary anæmia and the film showed gross basophilic stippling and polychromasia. The red cells numbered 4,000,000, and the leucocytes 12,800 per cubic millimetre; the hæmoglobin value was 70%.

The parents were instructed to bring the child in two days for splinting and treatment by intravenous injection of sodium thiosulphate. They were also instructed to bring up a litre of urine. They returned a week later with the child gravely ill, after being apparently much better for five days. (Hence their non-return.)

She now had "pains all over" and general loss of power. The temperature was 37.8° C. (100° F.) and the pulse rate 140 (the child was much distressed by examination). Slight basal bronchitis was present. The abdomen was clear. All limbs were completely paralysed. No strabismus, no headache and no papilloedema was present. The patient could not be cared for at home, so she was sent to the Hospital for Sick Children.

There she became rapidly worse and the paralysis became general; the abdomen was affected, so that her breathing was greatly distressed. Blood urea was found to be 125 milligrammes per 100 cubic centimetres. The temperature rose to 39.4° C. (103° F.). There was almost complete suppression of urine, but no cause for the condition could be determined, though a deeply placed pneumonia was thought the most likely cause. Delirium supervened and she grew rapidly worse.

The child died almost immediately after blood transfusion on April 16, 1930, from 270 to 300 cubic centimetres of citrated blood being introduced.

Examination of the kidneys only was permitted. Dr. J. V. Duhig, Pathologist to the Brisbane and South Coast Hospitals Board, kindly made the following report:

The striking feature of the section is the severe damage done to the tubules, while the glomeruli remain to a great extent unaffected. This is well shown in the photomicrograph (see figure in supplement). It

will be seen that the convoluted tubules show distinct change, the epithelium having undergone the whole range of change from cloudy swelling, granularity of the cytoplasm without much nuclear change to complete necrosis with pyknosis and karyorrhexis of the nuclei. The tubules are filled with granular casts in which can be detected nuclear debris. The picture is fairly representative of the section in general, which also shows in parts: (i) A secondary glomerular change, in areas where the tubular lesion is most advanced, consisting of epithelial proliferation of tuft and capsule, fusion and occasionally crescentic hyalinization. (ii) Such interstitial change as has occurred is scanty and confined to the areas about the interlobular arteries. The vessels themselves have escaped gross damage. Note the healthy state of the afferent vessel of the glomerulus in the picture.

This appears to me a case of acute tubular (catarrhal) nephritis.

The foregoing illustrates two points:

1. The rapid increase of paralysis in cases of plumbism on the advent of an acute febrile illness. In some cases when a paralysis has appeared *de novo* this has led to a diagnosis of acute anterior poliomyelitis.

2. The evidence of early tubular damage, shown clinically by the albuminuria and casts, without evidence of vascular damage.

3. It is probable that the grave condition here described is an advanced form of the kidney damage which produces the albuminuria so commonly seen in juvenile plumbism. Thus of twenty-two patients with plumbism shown at a clinical meeting at the Hospital for Sick Children in February, 1922, no less than seven showed albuminuria, sometimes with granular casts.

Bibliography.

M. A. Fishberg: "Hypertension and Nephritis," 1931.

FIBRO-SARCOMA OF THE NECK.

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F.K., aged fifty-eight years, was first attended by Dr. Rice in an attack of dyspnea on April 12. The attack lasted half an hour. He had another attack next day, lasting about three-quarters of an hour, after which I saw him.

Three weeks previously he had a little shortness of breath when he first started to play tennis. This had gradually worn off after playing for a short while. His voice has been getting a little husky for the last twelve months and the family had complained that he made a slight noise on swallowing. He thinks he has lost weight. He says he has always been liable to colds in his throat and similar complaints.

On examination I found a smooth and firm looking mass filling up the whole of the right side of the pharynx and larynx as far as but not overlapping the left aryepiglottic fold. Apparently it was not attached to the pharyngeal wall laterally or posteriorly; it was oedematous. On hooking the mass aside after swabbing with cocaine, the glottis could be seen pushed over to the left, but apparently normal. I could not determine if the mass originated in the pyriform fossa or from the right aryepiglottic fold, nor whether the latter was involved or merely overlapped.

Externally the thyroid cartilage was rotated to the left and forwards. No glands were palpated. It was decided to do Trotter's transthyroid pharyngotomy.

"Avertin" was given half an hour before by Dr. Gilbert Brown. Tracheotomy was performed and a skin incision for glands was made before ether was necessary; ether was then given through a tracheotomy tube. The deep cervical glands were enlarged, but subsequent inspection showed them to be normal. The sternomastoid muscle was sutured

to the prevertebral muscles, the ala of the thyroid and the great cornu of the hyoid were removed, and the pharynx was opened. A mass the size of a hen's egg was found in the pyriform fossa overlapping the aryepiglottic fold and pushing the larynx over to the left. It was covered with pharyngeal mucosa, except at its attachment below. It apparently originated from the cricoid cartilage internal to the cricothyroid joint, being extrapharyngeal in origin. It had then invaginated the pharyngeal mucosa and filled up the pyriform fossa. Some of the fibres of the *cricothyroideus lateralis* and the oblique fibres of the *cricothyroideus* were damaged in removing it.

Sections show a fibro-sarcoma. The tumour possesses a capsule in some parts, but there does not appear to be any definite invasion of normal tissues, however, the tumour pushing them aside rather than invading them. There are areas of degeneration and sclerosis, and in the cellular areas mitotic figures are rarely to be seen.

The feeding tube was removed on the twelfth day and the tracheotomy tube on the thirteenth day. Convalescence was uneventful, except for some coughing with his earlier feeds after removal of the tube.

REMOVAL OF CLINICAL THERMOMETER (HALF MINUTE) FROM THE BLADDER BY MANUAL MANIPULATION.

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WHILST looking through some papers I came across the notes of this case and thought it might be of interest.

In 1924 a married woman, aged thirty-five years, was admitted under my care at Sydney Hospital with the history of having attempted to take her temperature in the vulva and having lost the thermometer. She was examined by her family doctor and an unsuccessful attempt was made to recover the thermometer. On admission the patient had no pain, but could not micturate properly, only a few drops of urine being passed at a time. X ray examination revealed the thermometer lying transversely in the bladder.

As the patient was thin, it was quite easy under general anaesthesia to palpate the thermometer with one hand on the abdomen and a finger in the vagina. The bladder contained several ounces of urine. With patience it was found possible to work the rounded upper end of the thermometer towards the urethra and to get the thermometer in the long axis of the pelvis. As it could not be made to enter the urethra, I placed the tip of my little finger in the urethra and gently dilated it, and with my assistant's finger in the rectum I was able to press the thermometer by the hand on the abdomen against the tip of the finger in the urethra and, maintaining the pressure, I gently withdrew my finger from the urethra with the thermometer still pressed against it.

It was a tedious manoeuvre, and the successful termination was enhanced by the quiet remark of the theatre sister as she looked at the thermometer, to the effect that "the temperature was normal."

The patient made an uninterrupted recovery.

Reviews.

PROGRESS IN OBSTETRICS AND GYNÆCOLOGY.

"OBSTETRICS AND GYNÆCOLOGY" (Practical Medicine Series, 1930) is one of a series of eight year books issued at various intervals during each year by "The Year Book Publishers" of Chicago. They cover the entire field of recent medicine and surgery and each volume is complete on the subject of which it treats for the year prior to the time of its