A case in which a portion of a nut was impacted in the right bronchus and removed by operation / by J. Walker Downie.

Reprinted from the "Glasgow Medical Journal" for January, 1893.]

A CASE IN WHICH A PORTION OF A NUT WAS IMPACTED IN THE RIGHT BRONCHUS AND REMOVED BY OPERATION.*

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Towards the end of last session Dr. Hector Cameron made an interesting communication to this Society on "Foreign Bodies in the Air-Passages." As that paper aroused considerable interest in the subject, I thought it would not be out of place to here give a brief description of a case which occurred last week.

The patient was a boy, 7 years of age, who, while chewing a Brazil nut, laughed at his companion who had begun to eat a decayed one, and, while so laughing, he accidentally inhaled a portion of the nut in his mouth. Dyspnœa at once supervened, but after a few seconds he was able to run to his father's shop, a distance of some 300 yards. There he told his father that a piece of a nut had stuck in his throat, and, as he appeared to breathe with difficulty, his father administered an emetic in the form of a bottle of soda. After vomiting he breathed more freely, was taken home, and put to bed. This was on Monday, 24th November. During the evening and throughout the night he had frequent attacks of cough, accompanied by very slight difficulty in breathing. On the following day he complained of pain in the region between the lower angle of the right scapula and the vertebral column. For this he was poulticed by his mother, but as no relief followed the hot applications, and as the cough persisted, he was taken to a doctor. Apparently he looked upon the condition as catarrhal, and prescribed accordingly. On Thursday, the 24th, Dr. James A. Adams

* Read at a meeting of the Surgical Section of the Glasgow Medico-Chirurgical Society, 2nd December, 1892.

was called. He found the patient flushed, with a temperature of 104·2° F., breathing rapidly, and with a persistent hard cough. On viewing the chest, it was seen that, while the left side expanded freely on inspiration, no movement could be detected over the right side. On auscultation, air was heard to enter the left lung freely, but it was thought that none whatever entered the right lung, as over it there was complete absence of the respiratory murmur and of vocal fremitis. At the request of Dr. Adams, I saw the patient late the same evening, when, in addition to the above physical signs, there was an area of dulness on percussion over the base of the right lung, and there was slight fœtor of the breath. There was no doubt of the blockage of the right bronchus, and there was possibly suppuration around the foreign body, so I strongly advised early operation, consent to which was very reluctantly given.

On the following morning about nine, the patient, having been put under the influence of chloroform by Dr. A. N. M'Gregor, I cut down upon the trachea. The patient was then allowed in great measure to recover consciousness before the trachea was opened, in order that the full effect might be obtained from the coughing which would follow the entrance of air through the tracheal opening. When the trachea was opened, the edges of the wound were held widely apart by the blades of a pair of tracheal dilating forceps, but as the boy coughed, mucus and blood alone were expelled. When the coughing had somewhat subsided, a fine laryngeal probe was introduced through the tracheal opening and passed down along the right wall of the trachea to the distance of about 3 inches. Then, by moving the point towards the middle line, I attempted to dislodge the foreign body. While this was being done the patient gave a violent cough, which resulted in the expulsion of a quantity of somewhat fœtid muco-pus, and, along with it, a portion of the kernel of a nut. More muco-purulent expectoration followed, accompanied by other two small portions of the the same material. On examination, it was found that air now entered the right lung freely. A Foulis' tube was inserted, and the patient put off to bed.

The largest portion expelled was pyramidal in shape, and the base which exhibited the brown covering of the kernel measured one-fourth of an inch across, and from base to apex it measured three-eighths of an inch. The two smaller portions together equalled the size of a split pea.

The tracheotomy tube was removed the following day, the

edges of the wound stitched, and dressings applied. The patient had an uninterrupted recovery.

While speaking on this subject, I might be allowed to refer to a recent interesting experience of my friend Dr. John Wright. While on his round of visits, his attention was called to the condition of a child, who, while playing at "marbles," had placed one in its mouth, and had suddenly shown symptoms of choking. The child was unconscious, its face livid and covered with perspiration. He at once opened the trachea, and the child coughed the marble into the mouth, from which it was quickly removed, and the child was restored to life.

In such a case, with those urgent symptoms there is, of course, no doubt as to what should be done. Where the symptoms are less urgent, one with little or no experience of such cases tends to counsel delay. But—and notwithstanding the occurrence of occasional cases where, after a considerable interval of time, the foreign body is expelled during a violent fit of coughing—delay is exceedingly dangerous.

When a foreign body has entered the trachea or become impacted in a bronchus, whether the resulting symptoms be apparently trivial and occasional only, or whether they be severe and persistent, that patient is liable at any moment to suffocation by impaction of the foreign body in the larynx during any strong expiratory effort, as in coughing. A specimen exhibited by Dr. Cameron last session illustrated this. The child with a bean in the trachea, while apparently suffering no inconvenience from its presence, suddenly became livid and died of suffocation. But even where such an accident does not occur, can we say that the lungs will remain healthy? The reverse is my own experience, and thus I strongly urge operation in all cases where the method by inversion has failed to dislodge the body. While one attempts dislodgment by inversion, he must be prepared to open the trachea should spasm of the glottis be induced.

GLASGOW: PRINTED BY ALEX. MACDOUGALL.

Reprinted from the "Glasgow Medical Journal" for May, 1893.]

EPITHELIOMA OF LEFT VOCAL CORD REMOVED BY LARYNGOTOMY.*

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Wm. D. aged 50, an engine-fitter, was seen by me at the Throat Department of the Western Infirmary Dispensary early in August, 1892. He then complained of hoarseness which had persisted during the previous six months, though unaccompanied by pain, and as he looked upon the condition as the result of an ordinary cold, he had put off seeking advice. On examination, the whole lining membrane of the larynx was seen to be deeply injected, both ventricular bands were full, and, as a result, they obscured a great part of the vocal cords beneath. These latter were also deeply injected, and from the left one there was a tumour projecting into the glottis about three-eighths of an inch in length. In outline it resembled a horse bean, though smaller than such, and, unlike a papilloma, it appeared part and parcel of the cord from which it sprang.

In my opinion the diagnosis was clear, and I urged immediate operation, but as there was an entire absence of pain or other symptoms, which appealed to the patient as being of serious import, he desired to postpone any surgical interference. However, after thinking matters over, he decided to follow my advice, and was admitted to Ward III on the 12th September. On the following day I performed tracheotomy as a preliminary measure, and this, on account of the short thick-set form of his neck, was somewhat difficult, and it was found impossible to go as low down as is

* Notes read, and patient exhibited, at a meeting of the Surgical Section of the Glasgow Medico-Chirurgical Society, 7th April, 1893.