

A case of fatal hemorrhage following adenectomy in a haemophilic child.

Contributors

Kenefic, J.A.
Knight, Charles H. 1849-1913
Royal College of Surgeons of England

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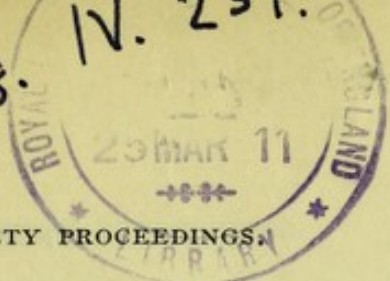
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Wellcome Collection
183 Euston Road
London NW1 2BE UK
T +44 (0)20 7611 8722
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Kenefic
Laryngoscopy
St. Louis. 1898.



infiltration on the left, with characteristic œdematous tubercular looking arytenoids. Dr. Vissman examined his sputa carefully and reported that he could find no bacilli. The speaker had been treating him two or three times a week since January 7, with full strength applications of lactic acid. The ulcerated region is undergoing a gradual process of healing. The arytenoids are not half the original size, and the general symptoms of hoarseness and difficulty in swallowing have been markedly relieved. He gives no history of syphilis, and the evidence does not enable us to make a positive diagnosis. His physical condition does not show any deterioration. There are some of the characteristic features of syphilis, malignancy and tuberculosis. There are no rales in the apex.

Dr. Van der Poel asked Dr. Myles if tubercle bacilli had been found in the case of the young man who has the ulcer of the pharynx. Also, was there any temperature?

Dr. Myles answered that bacilli had been found.

The Curette and Forceps in the Operation of Adenoids.

Dr. W. F. Chappell read a paper on this subject. He believes that one of the causes of incomplete removal of adenoid tissue or other damage in the naso-pharynx is that the instrument, be it forceps or curette, is too large in size. In an examination of 2,000 children the author found that the greatest number of these growth occurred in children under six years of age. In his judgment the curette is the instrument to be employed in the removal of these growths. We should use instruments based on the actual measurements of the naso-pharynx at various ages. He protests against the great amount of force employed by some operators when the curette is applied. The reader showed new curettes suggested by himself, of two sizes. One for infants up to the fourth year, and the other for four years to fourteen years, based on actual measurements. The cutting edge of the blade may be straight or coarse serrated, and not very sharp. With the serrated blade the pieces of growths are caught.

The points of favor claimed for the curette are: First, It shortens the time required for the operation. Anæsthesia may be frequently omitted. It minimizes the danger of injury to the Eustachian tube, septum or soft palate, and of any unnecessary sacrifice of mucous membrane.

A Case of Fatal Hemorrhage following Adenectomy in a Hæmophilic Child.

Dr. C. H. Knight reported for Dr. J. A. Kenefic the case of a boy, four years of age, who was brought to the Manhattan Eye and Ear Hospital, on January 20th, inst., suffering from the usual ac-

companiments of retro-nasal obstruction. Upon examination a large mass of lymphoid tissue was found occluding the naso-pharynx and its removal was advised. On January 25th the child was etherized and the mass quickly removed with Brandagee forceps, Gottstein curette and the fingernail, in the order named. Hemorrhage, no more than ordinarily occurs after this operation, ceased promptly. Two hours after the operation the nurse reported a hemorrhage from mouth and nose, which was finally controlled by packing the naso-pharynx with cotton and the anterior nares with iodoform gauze. Two hours later the packing suddenly became blood soaked and profuse hemorrhage was in progress.

The naso-pharynx was repacked with tampons soaked in tannogallic acid solution; the anterior nares were repacked as before. The patient was now in a condition of profound anæmia. Whisky and strychnine and normal salt solution were given subcutaneously, but enemata of this solution were repeatedly rejected. Supportive measures were continued throughout the 26th, and on the 27th, at 1 p. m., a large clot of blood was vomited, a portion of which was evidently a cast of the small intestine. At 3 p. m. all packings were removed and the nasal chambers and the naso-pharynx were washed out. No hemorrhage followed. At 9:30 p. m. oozing was reported which was checked by fresh packings. At 6 p. m., January 27th, fresh oozing was again observed, which soaked through all subsequent packings until 11:30, when the child died. No post-mortem examination was allowed.

Dr. Newcomb opened the discussion. He said that he was unfortunate in losing a case, the history of which was recorded in the *American Journal of the Medical Sciences*, 1893. He had had three cases of hemorrhages. In one of the cases hemorrhage followed the removal of adenoids, in a young woman, eighteen or nineteen years of age. He was sent for, but when he had arrived at the house of the patient the hemorrhage had ceased and but little blood had been lost. The last of these cases occurred quite recently. The patient was a girl of thirteen years, from whom the faucial tonsils had been removed without bleeding. Later, some adenoids were removed under cocaine anæsthesia. Forty-eight hours afterwards the mother came to the hospital and said there had been severe hemorrhage and the child was practically exsanguinated. After the operation the child was sent home, but the mother insisted upon her going to night school, contrary to advice, and while there her hemorrhage came on. He offered to go down and do what he could for the child, but his offer was refused. He presumed that the child recovered; if the child had died he probably would have heard of it.

The case which was reported in the *American Journal of Medical Sciences* occurred in a boy, aged four, who gave no history of hæmophilia. In this case the hemorrhage came on four hours after operation. The mother had been advised to send for the nearest one of the clinical assistants in case anything went wrong. The speaker happened to be the nearest one in this instance, but he was not sent for until the next morning, when he found the child exsanguinated, and the little patient died in about five minutes after his arrival.

At that time he found recorded some sixteen cases, one or two of which had proven fatal. Dr. Hooper had reported a fatal case occurring from a digital examination. There had also been reported fatal cases occurring in the work of Dr. Delavan, and others. Of eleven cases, four of them occurred during the first decade, five during the second. The youngest was four years of age; the oldest, twenty-eight. In three cases chloroform was administered; in three, cocaine. The instruments used included the forceps, fingers, and curettes. The time of occurrence was from immediately up to twenty hours. In a paper by Dr. Delavan there is recorded a fatal case in a child of four years, and three fatal cases occurring in the practices of others.

The speaker then referred to a case of a boy, two and a half years old, who, under ether, had had adenoids removed with finger and forceps. Hemorrhage occurred eight hours afterwards and death in twenty-four hours.

The speaker also referred to the practice followed at the Manhattan Eye and Ear Hospital, as one giving excellent results; there they demanded that patients to be operated upon should spend the previous night in the institution, so that they can be carefully watched and prepared for operation.

Dr. Delavan said that the case, to which reference had been made, had already been fully reported. It occurred in a child, two and a half years of age, and was secondary, the hemorrhage having come twenty-four hours after operating. The question asked before the operation, as to the possible existence of hemophilia, had been answered in the negative by both parents. Upon careful questioning, however, without much difficulty there was established a marked tendency, on the mother's side, to the bleeding diathesis. The case in all respects was typically one of hemorrhagic diathesis, and typically answered the accepted description of the disease. This case and one other, in which it had been necessary to tampon the nasopharyngeal space after the removal of a small mass of adenoid tissue

which had been left at an operation done several years before in a young girl of thirteen, were the only instances of severe or serious bleeding occurring after the removal of adenoids he had known after many years of active work. Patients usually bleed but little.

The chairman, Dr. Wright, mentioned the cases of two young women, seventeen or eighteen years of age, in whom post-nasal plugs were tried where the hemorrhage was very profuse. He introduced pledgets of cotton, and at the end of thirty-six hours the question of their removal came up; he feared that bleeding might be set up, so he kept putting vaseline into the nose, which ran back into the pharynx as it melted, apparently loosened the plugs, and at the end of an hour or two, gagging resulted and the plugs came away of themselves.

Dr. French said that fortunately he had never had a case of secondary hemorrhage, after the removal of lymphoid growths, to contend with; but, as they often learned more from their misfortunes than from their fortunes, he felt sure that the report made by Dr. Knight would impress a healthy lesson upon them all.

Because of the danger of hemorrhage in these cases, the patients should be kept under close observation for at least twelve hours after the operation. They should be turned upon their side from time to time, so that if hemorrhage occurs it will be detected by the escape of blood from the lips or nostrils.

He was favorably impressed with the views of Dr. Newcomb in regard to bringing poor patients into the hospitals or infirmaries so that they could be properly watched. In this way, he said, they might occasionally save a life.

The speaker said that as the chairman was willing that the discussion should expand beyond the limits of the subjects presented in the papers of the evening, he would venture to bring before the section two questions for discussion. The first was in regard to the propriety of continuing the use of the term "adenoid" to designate these growths, when they are clearly of a lymphoid character.

Adenoid elements enter into the structure of the growths to some extent, but as lymph tissue constitutes the largest part of the mass, lymphoid would seem to be a better term to use in speaking of these masses of tissue. Adenoid and lymphoid are terms often used synonymously by rhinologists, and, indeed, by histologists, especially the older writers, who believed that lymph tissue was glandular in character. These growths are almost entirely made up of lymph tissue, and should, therefore, be described as lymphoid, and not adenoid, as is now the almost universal custom.

The other point which he brought up for discussion was the degree of completeness with which these growths should be removed. It is, he thought, the common belief that it is not necessary to remove the entire mass, but that after enough had been removed to permit free nasal respiration, the remnant could, with safety, be left to atrophy. In those cases in which a thick base is left, he believes that not only do they not atrophy, but that frequently fresh attacks of acute inflammation of the tissue ultimately result in an increase in the size of the growth. The only cases in which he had been obliged to operate the second time had been those in which the entire mass of tissue had not been removed at the first operation. If a considerable amount of tissue is left, not only is there more likelihood of a reproduction from frequent attacks of acute inflammation, but the tissue left would maintain a catarrhal condition which might ultimately extend to other structures. It seemed to the speaker that if there was no other danger than that of extension of catarrhal inflammation to the Eustachian canals and middle ears from these growths that this would in itself be a sufficient reason for their complete removal.*

He did not think that it was altogether fair to leave any of this tissue which, no doubt, is frequently the cause of deafness in early adult life. A rhinologist said to the speaker, after witnessing a complete extirpation which takes him from twenty-five to thirty-five minutes under ether, that such an operation was for the rich; that it takes too much time. Surely that is not an objection which should be considered valid, for if we have not the time to operate thoroughly on all the patients who apply for relief, we should seek the assistance of those who have the time as well as skill.

When a patient seeks our advice and treatment for relief of deafness, one of the first things we do is to look for lymphoid tissue in the pharyngeal vault, and if it exists advise its removal. If we consider this tissue, of so much importance as a causative element in deafness, why should we not, when we have the opportunity, when the patient is under ether, remove the growth completely? We should never be content with less than a complete extirpation of these growths. Short of that we cannot do full justice to our patients or reflect the highest credit upon ourselves.

Dr. Van der Poel said that his experience with severe hemorrhage following adenoid operations embraced two cases. One of them occurred in the person of a girl, aged eight, who presented herself for treatment, at the Manhattan Eye and Ear Hospital, some six or eight years since. A diagnosis of adenoids was made and an appointment

for subsequent operation agreed upon. As the patient was about to leave the clinic, a small portion of the growth was removed with forceps, in order to demonstrate its character to some students. The patient was then dismissed to return for operation. The following morning, at four o'clock, the speaker was summoned to Brooklyn to attend the case, which proved to be one of alarming hemorrhage. The child was almost exsanguinated, with a small, thready pulse. The nasal chambers and naso-pharynx were plugged, but the oozing continued for two or three days. What so frequently occurs in these cases took place in this instance, *i.e.*, the more the packing was changed and other styptics or methods employed, the more the patient bled. It was finally decided to leave the child alone and not disturb the packing. The case subsequently recovered. It was ascertained afterward to be an instance of undoubted hæmophilia; there was a history of bleeding in the family, and the patient had had, one year before, an alarming hemorrhage, following the extraction of a tooth.

The second case occurred in private practice. In this case he was so fortunate as to have the aid and advise of Dr. Knight in consultation. The patient, a lad of fourteen, was operated upon in my office, without anæsthesia, because the amount of adenoid tissue was small and the boy was far from robust. The bleeding was somewhat profuse at first, but soon stopped. After three hours, the patient returned home; at the end of another hour, he was sent for and found an alarming bleeding; at that time, he used to plug with cotton from behind and employed a *urethral* sound, introducing it into the mouth in order to force the plug well up into the naso-pharynx. After several hours, Dr. Knight saw the case, the hemorrhage continuing in the mean time; plugs removed and others with styptics introduced, and the bleeding slowly stopped. The following morning there was a recurrence, and this kept up, off and on, for two days; on the second day, he employed a single long strip of iodoform gauze to plug the naso-pharynx; this was introduced through the mouth with the urethral sound, and could be packed more closely and firmly than cotton, and when moistened with cocaine to contract the tissues, could be more readily removed. This case recovered from the hemorrhage.

The lesson to be learned from these two cases is most obvious, *i.e.*, never attempt an exploratory procedure in adenoids, no matter how trivial, until one is thoroughly prepared to operate, and has made a physical examination; for in this second case the boy had recently had inflammatory rheumatism, and only four weeks be-

fore he had an attack in which there was heart involvement. There was a mitral regurgitant murmur, the result of rheumatic endocarditis.

LARYNGOLOGICAL SOCIETY OF LONDON.

Annual General Meeting, January 12, 1898.

Henry T. Butlin, Esq., F.R.C.S., President, in the chair.

St. Clair Thomson, M.D., and Herbert Tilley, M.D., Secretaries.

Edited by Dr. St. Clair Thomson.

Two Pressure Pouches of the Œsophagus.

Shown by Mr. Butlin, President. Removed from living subjects. The references are to be found in the "Medico-Chirurgical Transactions," vol. lxxvi, p. 269, 1893, and in the "British Medical Journal," 1898, vol. i, p. 8. The attention of the members of the Society is particularly directed to the return of particles of undigested food many hours or even days after they have been swallowed, as the one constant symptom in the diagnosis.

Nasal Hydrorrhœa—Analysis of Liquid.

Mr. Cresswell Baber read notes of this case, and brought forward the analysis of the liquid. Patient, a married lady æt. 42. The right side of the nose only affected. Five years before, after eight months' excessive watery discharge following influenza, she had had a polypus removed; the secretion then stopped, but returned again at Christmas, 1896, after another attack of influenza. A polypus was removed in May, 1897, and the galvanic cautery applied, but as the secretion still continued, the case was referred to me. When I first saw her, on June 16th last, there was no obstruction, very little sneezing, no pain, only profuse non-fœtid watery discharge from the right side, which continued day and night. No headaches of consequence. Examination showed that the right nasal cavity was much narrowed by deflection of the septum, and the mucous membrane was sodden and catarrhal in appearance. No polypus, but a little irregularity on the middle turbinated body. Transillumination showed both infra-orbital regions light, and nothing came out of the right antrum on hanging down the head. The fundus was normal in both eyes. No loss of sensation could be detected in the right nasal cavity. Spirit and cocaine spray was tried, but without any effect; the dripping of watery liquid continued constant, and on one occasion (July 17th) I collected 70 min. in five minutes. On this date I began the constant current, applying eight cells externally to the nose. This stopped the secretion for a few minutes. Patient was ordered

to use it for five minutes twice a day. In a week's time (July 24th) she reported that the running was rather less in the mornings, but when I saw her it still continued. A small piece of projecting mucous membrane was snared from the middle turbinated body, but only proved to be hyperplasia of normal tissue. Ordered, in addition to the constant current, a 20 per cent solution of menthol in paroleine for a nasal spray twice a day. I did not see the patient again till September 15th, when she reported that about a month previously the running began to diminish, and had got so much less that she only used two handkerchiefs daily instead of twelve. Character of the secretion as before. Treatment continued. October 5th—No watery discharge at all for the last four days. Examination shows that there is much less swelling of the mucous membrane in the nasal cavity. To use spray and galvanism once a day only for three weeks. November 3d—No discharge at all from the right side since the last visit. Omit all treatment. Letter received from patient dated January 3, 1898, reports that there has been no return of the nose trouble. About an ounce of the liquid was sent to the Clinical Research Association, and they report that its chemical composition is as follows:

	Per 100 c.c.
Organic solids	0.160 gramme.
Containing—Mucin	0.060 “
Proteids	0.025 “
Undetermined constituents	0.075 “
	<hr style="width: 100px; margin-left: auto; margin-right: 0;"/> 0.160 “
Inorganic solids	0.880 gramme.
Containing—Sodium chloride	0.770 “
Calcium phosphate, &c	0.110 “
	<hr style="width: 100px; margin-left: auto; margin-right: 0;"/> 0.880 “

Microscopical examination showed the presence merely of a few squamous epithelium cells and a few leucocytes. They note that the greater proportion of the solid matter consists of sodium chloride, and that the proportion of this closely approximates to the “normal saline” fluid.

From the absence of head symptoms, and especially from the beneficial effect of the continuous current, I think we are justified in concluding that the liquid in this case is simply an excessive secretion from the nasal mucous membrane, and not an escape of cerebrospinal fluid. It seems probable that many of the cases reported may be explained in a similar manner.

Dr. St. Clair Thomson said that the analysis which had been made