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Medical Adventures in Korea

FLORENCE J. MURRAY, M.D.,C.M.

Native Customs and Treatment

ONE of the commonest native treatments for pain is needling or acupuncture. There are one hundred points on the human body where needling is said to be safely carried out. For the abdomen a slender blunt needle about three inches in length is used, being bored into the flesh, either cold or red hot, up to the handle the full length of the needle. For the joints a triangular spear pointed needle of large size is the favorite. This treatment is carried out by so called doctors of the ancient Chinese school of medicine who have been licensed to practice until the present time and in whom many people still have firm faith, so much so that probably a majority of the population go first to these old style doctors when they need medical care and, only after their treatment has failed, do they seek some one else.

The results are not always happy, as in a case of Colles' fracture where the hand and forearm had been well needled one hundred times. In spite of this, or because of it, pus was dripping from the puncture wounds and the fracture was still unreduced. The patient very nearly lost his life from septicaemia and had a useless hand the rest of his days. In cases requiring abdominal surgery, adhesions from former needlings are a common complication.

Moxibustion or fire treatment is carried out by placing a quantity of inflammable powder made from dried leaves upon the skin in several of the many points where this is thought to be effective. This is repeated until the pain is cured or the patient can stand no more, sometimes as many as one hundred times in the same spot until the skin is burned through to the muscles leaving deep ulcers that take a long time to heal, as they invariably become infected. When surgery becomes necessary these ulcers are a real problem. One or two can be excised but when a dozen occur in the operative field they are not so easily disposed of.

I was once amazed on looking at the x-ray film of a patient's abdomen to see several metal nails in various parts of the abdominal cavity, two or three having been driven into the spine through the anterior abdominal wall. The patient on being questioned said the nails were driven in fourteen years previously to cure indigestion. He still had the former symptoms but apparently had suffered no ill effects from the nails or the method of their insertion.

Tourniquets are applied and left on for long periods for snake bite and many limbs have been lost from gangrene due to the prolonged use of the tourniquet. There are few snakes in Korea and most of them are harmless. A patient once came with a gangrenous leg due to the use of a tourniquet for snake bite. Several weeks had passed and the flesh was black and stinking and falling from the bones. The foot was beginning to shrivel up. The dead flesh was completely separated from the healthy tissues and, in the space between, a small area of living tissue could be seen between the tibia and fibula. The patient was sure this meant the flesh was beginning to grow again and she wanted the dead and separated flesh put back in place so it could grow on again. When told this could not be done, she left in haste to find a doctor who would do what she wanted.

Favorite dressings are leaves, paper, dirty rags, thick impervious plasters,

and even manure. Splints are neatly made and well fitted to the part from bark of trees or small twigs but are invariably too short to be effective.

Mental disease is believed due to demon possession and the unfortunate sufferer may be beaten or otherwise tortured in order to drive the supposed evil spirit out. Many insane people roam around harmlessly and are treated kindly enough, but violent patients, in the absence of any hospital to which they can be sent, are likely to be tied to a tree or post or handcuffed and allowed to go about wearing shackles. One of these handcuffed fellows terrorized our hospital for weeks. He came daily, wandering about the grounds, frightening the patients, and keeping others away. On trying to get rid of him I found that the hospital was one of three places in the city where he was not driven away with stones. We let him stay but were relieved when he stopped coming.

Obstetrics

Most deliveries are carried out at home without benefit of doctor, nurse, or midwife. As there are no beds the birth takes place on the floor where, in preparation, the straw matting is usually put away and fresh straw spread on the floor. The majority of labors are fairly easy and the squatting position is the usual one. According to local custom the cord may be cut with the kitchen knife or sawn through with a rough edged blade of grass, and tied about a foot from the body of the fetus with anything that will serve the purpose. The child is then wrapped in whatever is handiest and laid on the hottest part of the floor next the cooking pots in the kitchen. Burns of the back and buttocks often occur from this well meant kindness. The village is scoured for some one to nurse the baby and this is done at frequent intervals by anyone capable of doing it until the mother has milk for her child.

The placenta is wrapped in straw, tied in a neat bundle, and stood up in a corner of the room until the cord drops off when both are disposed of together. If the placenta is retained, an old shoe may be tied to the end of the cord to prevent its going up again.

Immediately after delivery the woman is fed large quantities of seaweed soup to promote the formation of milk. The soup is forced down her throat even if she happens to be in eclamptic coma. In the hospital we were never able to persuade the staff, and still more the friends, that this was not an essential step in the obstetrical proceedure. As soon as a woman in labor was admitted, word was sent to the cook who at once set to work to make seaweed soup.

In an ordinary uncomplicated case of labour, the mother will go to the outside toilet the same day, and the next day take the soiled things to the river and wash them.

Very rapid easy labors are fairly frequent. One woman at full term, feeling uncomfortable, went to the toilet. This consisted of a rude shelter, with two planks wide apart for the feet, built over the pig pen. Her child and the placenta was born with one pain into the pig pen. The mother was quick and she got there first and rescued the infant from the pigs and the muck, and after considerable cleansing no one was the worse.

In difficult labour the mother is urged to strain and bear down long before this can possibly be of any use. She will then be made to lean forward while the heaviest person in the village tramps with his feet on the lower part of her

back. If this fails, manual efforts to deliver may be made, babies having been delivered piecemeal by the hands alone by some ignorant old woman knowing nothing but that desperate situations require desperate remedies.

In some of these cases medical aid will be sought. It is no easy task for a doctor to deliver a difficult forceps case in the patient's home. Patient and doctor will be on the floor and there will probably be no light but that of a candle or a wick in a saucer of oil. If there is electric light there will be one bulb for the whole house and the cord will not reach to the place where it is required. The mother is invariably in the smallest room, usually about six feet square with a clothes chest occupying one side. Half the women of the village sit about the house to show their sympathy while a number of the men will be in the yard to see whatever they can of what goes on.

When the sterile outfit is spread on a small table about a foot high a swarm of flies immediately settles upon it and some helpful bystander smoothes out the towels with her none too clean hands. The use of forceps is generally required but with the patient on the floor their application is not always easy, nor can the proper angle of force always be attained.

When cases that should have abdominal section are seen, often the old people in the home refuse to let the woman be taken to hospital, or it may be already too late on account of previous attempts to deliver under unclean conditions. The use of the sulphonamides and penicillin in the future will be of great value but of course these drugs have not been available.

If the mother dies, the fetus still must be delivered in order to be buried separately. Otherwise, according to popular belief, its spirit will return to haunt the family. There is no objection to abdominal section in this case.

In labor with obstruction due to vaginal stenosis, which follows native treatment for prolapse, incisions are made laterally through the ring of scar tissue, avoiding the bladder in front and the rectum behind, and keeping in mind the fact that there may be considerable change in the normal anatomic relationships from the contraction of scar tissue. Usually after the obstruction is thus dealt with, the patient delivers herself though the fetus is often dead from the prolonged labor. I hesitate to use forceps lest there be further tearing of the incisions with severe bleeding or injury of the soft parts. No immediate bad results have been seen from the above mentioned treatment. The end results have usually not been seen as the patients seldom remain long in hospital and do not return for treatment.

A patient seen at home for retained placenta after she had delivered herself without any assistance whatever from anyone refused to go to hospital. The house was so small the family slept in relays as there was not sufficient floor space for them all at once. Conditions for asepsis were not too favorable but, knowing that if I did not help her someone else would be called who had probably never heard of the necessity for cleanliness in obstetrics, I did the best possible under the circumstances and removed the placenta. In spite of my protests, in order to show her appreciation she walked home with me. She did well.

Eclampsia usually responds to treatment if the patient is brought to hospital. The fetus was often dead before admission of the mother though sometimes even after many convulsions the child would be born alive. In one case where coma and extreme edema had persisted for days after delivery in spite of orthodox treatment and it was obvious the woman would die if not

relieved speedily, as a last resort 100 cc. of saturated solution of sodium chloride was given intravenously. Improvement was apparent almost immediately and from that time on recovery proceeded rapidly and completely. This was tried in other severe cases where the usual sedative and elimination regime failed, always with good results and no ill effects.

Neglected or unwisely conducted labors not infrequently result in rupture of the uterus. One woman who came to hospital on the fourth day of labor gave the following history. She had had a normal pregnancy but because no progress was being made in labor, she called a native doctor on the second day. He saw her at her home in a village three miles from the town where he lived. After a very cursory examination he gave her an injection that greatly increased the severity of the pains, and returned home leaving her to deliver herself. No further progress was made, however, and after an hour, the pains became less severe. On the third day the same doctor was called again. He gave her a second injection following which she had a terrific pain, simultaneously felt a tearing sensation, and the fetus suddenly moved upward. From that time both pains and fetal movements ceased. The doctor left without doing anything more. On the fourth day the patient came to the hospital.

The fetus was lying transversely in the upper abdomen, the contracted uterus below it. There had been little external bleeding and her condithon was remarkably good considering what she had been through. If there ad been shock, it had passed off before she reached hospital.

The abdomen was opened, the dead fetus, placenta, and attached membranes removed. The rupture was found to have taken place through the lower uterine segment posteriorly where the tissues were severely lacerated and infiltrated with blood clot. There had been little intraabdominal bleeding. In view of the time the patient had been in labor, the lapse of twenty-four hours between the occurrence of the rupture and the patient's arrival in hospital, and the severely damaged condition of the uterine tissues, a supravaginal hysterectomy was done. There were no further complications.

A diminutive patient who was first seen in the eighth month of pregnancy had an ovarian cyst of such size that she was extremely dyspnoeic and could hardly have survived another month without relief. An incision large enough to permit the removal of the cyst intact did not seem advisable in view of the greatly thinned condition of the abdominal wall and the near approach of labor. Consequently the size of the cyst was reduced by evacuating a bucketful of thick fluid through a large trocar. This gave relief and the next day the cyst was removed. It still filled a bucket. The patient did well and the pregnancy continued uninterrupted. Although advised to remain near by till delivery, she returned to her home and the subsequent history is unknown.

Another woman was first seen on the third day of labor with a dead fetus the head being impacted in the pelvis. Delivery was by forceps and extremely difficult, the head moulded to a degree seldom seen. There was so much pressure on the vaginal walls that sloughing appeared inevitable. However, the patient returned to her home on the second day after delivery and was not seen again until the second day of her second labor which was an exact replica of the first. On the third occasion she came early in labor. Caesarean section was performed and a fine healthy child obtained. An ovarian cyst impacted

in the pelvis was also removed. It would probably have completely obstructed labor this time and no doubt was the complicating factor on the previous occasions.

A woman, little over four feet tall, with pendulous abdomen, kyphosis of the lower dorsal spine, and ankylosis of both hip joints in the flexed position, one of them also adducted, came to the hospital in labor. (She was sixteen and her husband sixty-five. He was a widower without a son who must therefore get another wife of childbearing age at once. She, being such a cripple, could not be choosey in husbands. It was as good a match as either could make and they made the best of it.) The fetal head could not be made to engage in the pelvic brim and the force of the contractions was driving it against the sacral promentory. In view of the patient's not being able to lie on her back nor extend her legs, a little difficulty was experienced in finding a place to make the incision. However abdominal section was carried out and a healthy child delivered. Sterilization was advised but, since the child was not a son, neither parent would consent. Two years later they were so delighted at the arrival of a son in the same manner that they again refused to agree to tying of the tubes.

Ectopic pregnancy seems more common than in the west. During four months seventeen cases of ruptured ectopic pregnancy were operated upon, all with good results. During several years we lost only one case who was moribund on admission and died in half an hour. In severe cases an incision was made under local anaesthetic, the patient's own blood lying free in the abdomen secured and transfused back into her veins, and when the general condition improved enough to permit it, the operation was proceeded with. Blood donors are seldom available and if the patient's own blood were not utilized, many of these patients would die. Even close relatives refuse to give blood, saying it would be better for the sick person to die than for a healthy one. Permission can seldom be obtained to remove the other tube even if it is diseased and a second operation for rupture of the remaining tube is not infrequent. One woman had a twin pregnancy, one fetus having been extruded through the rupture into the pelvic cavity and one remaining in the tube.

One woman gave a history of having had at full term a couple of days of mild pains which then passed off without labor ensuing. From that time fetal movements also ceased. She came to hospital one month later. A well developed fetus was removed from the abdomen by abdominal section. A thinned out and broad placenta was attached to the pelvic organs and to several coils of intestine. Removal would have meant extensive haemorrhage so it was left in situ and the abdomen closed without drainage. There were no other complications.

Another woman with a similiar history did not come till a year after the death of the fetus at full term. The child was well developed and in a remarkable state of preservation. The body fluids were becoming absorbed but there was no maceration. The placenta had disappeared and there was no indication of its former site.

A third case of abdominal pregnancy that went on to full term and then was carried for fourteen years came to operation when a lithopaedion of stony hardness and about the size of a five months fetus was removed from the right iliac fossa, a subperitoneal fibroid from the uterus, and an ovarian cyst from the pelvis.

Hydatidiform mole is relatively common and some of the patients suffering from this condition are real problems, being so anaemic when first seen as to be poor surgical risks, while blood transfusions are usually out of the question. One such patient who had been bleeding for many weeks, and thought she was in premature labor when she entered the hospital, filled a large basin with blood and vesicles while the operating room was being prepared. At operation a second basin was filled. During operation bleeding is often formidable and will not cease till the uterus is completely emptied, which is not always easy since the finger or even the blunt curette may not reach the fundus or the posterior wall of the uterus in cases where the mole has reached a large size. After the haemorrhage is controlled the chief complication to be feared is the development of chorionepithelioma but in my experience this is infrequent. I have seen it happen only once. There may have been other cases who did not return.

Prolapse and Vesico-vaginal Fistula

Precipitate labor and labor in the squatting position with no after care predisposes to prolapse which is very common.

One woman who could endure her discomfort no longer cut off the prolapsed parts herself with the kitchen knife. Six months later, when she came to the hospital for relief of incontinence of urine, one could thrust half one's hand into the bladder where the whole anterior wall was missing.

Another woman with a similar condition following a neglected difficult labor had such prolapse of the bladder that the organ was almost inside out and the distal ends of the ureters could be seen out in the world spurting urine as rhythmically and unconcernedly as though they were in their natural position. This woman had been in this condition for twenty years. Even in such long standing cases the text book picture of sodden excoriated skin with secondary infection about the vulva is seldom seen. Rubber shoes are worn so that the feet, soaking in a pool of urine in the shoes, are often in a worse state than the skin higher up. Complaints are mostly of the constant discomfort from wetness, the odor, and the necessary frequent washing of clothes.

One such patient said as she left the hospital, "You have made me human again. Now I am going to visit the friends whose homes I have not been able to enter for ten years."

Complete prolapse of the whole uterus is common and causes great distress as the woman can neither sit nor walk comfortably. Deep ulceration may occur on the cervix or fundus from friction. Nothing short of a combined operation with some type of fixation or suspension from above and restoration of the pelvic floor will cure these. In older women vaginal hysterectomy with pelvic repair is satisfactory. Most cases of vesico-vaginal fistula occur as a result of difficult and neglected labor followed by sloughing. Some of the larger ones have a minimum of scar tissue surrounding them and are often closed without much difficulty, though it may take two stages. Small ones high up in inaccessible parts of the vaginal vault, especially if the tough tissues of the cervix are also involved, may present a serious problem. There may be much scar tissue which is friable, will not come together without tension, and does not hold the stitches nor heal well. If it is entirely removed, the fistula may become so large that closure with the available tissue is impossible without

tension and tension is fatal to a good result. The fate of those with such a condition is often sad indeed, for in addition to the physical distress, they are often turned out by their husbands.

Transplanation of the ureters into the sigmoid is one solution for intractible cases but infection of the kidneys follows sooner or later. I never had a case who would consent to the abdominal operation for what she considered a superficial condition. Formation of a vesico-vagino-rectal fistula with closure of the vaginal orifice and passage of the urine by the rectum is another means of overcoming the trouble. The danger of infection is still present in this case of course but may be long delayed. Other complications may occur, as in a case of mine who used to come back about once in six months to have a urinary stone removed from the vagina where it caused pain on sitting. The urinary control was satisfactory.

In my experience in cases of fistula with complete loss of the urethra there was usually so much scar tissue that there was no hope of successfully reconstructing a urethra.

The native treatment for prolapse usually cures the prolapse but as frequently leaves other troubles in its place. This treatment is carried out by old women who travel from place to place putting their services at the dispoasl of any who require them. I frequently tried to find out the names and addresses of these quacks but no sufferer at their hands ever admitted that she knew either.

One such woman wound a long string round and round the prolapsed parts as tightly as possible. She then departed, to return a week later when gangrene was well advanced. Borrowing a razor from the son of the victim, she cut off the sloughing mass. This was said to have caused little pain but the suffering was intense for the days preceding. The prolapse was cured with great shortening and distortion of the vagina and complete loss of the cervix causing stenosis resulting in dysmenorrhoea and haematometra.

A more frequent method is to replace the prolapsed parts, stuff the vagina with rags soaked in kerosene oil, and set fire to them in situ. This heroic method also generally cures the prolapse but leaves behind it stenosis that may interfere with the menstrual flow, prevent intercourse, in which case the wife is usually discarded as useless, or if pregnancy takes place, be the cause of obstructed labor.

One such patient gave a history of having had severe menstrual pains every month but no flow with a gradually increasing mass in the abdomen ever since her first labor twenty-seven years before. There had been no other pregnancy. On questioning she admitted she had had the fire treatment for prolapse. Her son who accompanied her insisted upon having an abdominal operation to remove the tumor and continued to demand it in spite of explanations to the effect that it would not be necessary. The ring of scar tissue in the vagina was incised and a large bucketful of black tarry material slowly drained away. The opening was then enlarged and a hard rubber tube inserted to prevent its closure before healing took place. When the son entered the operating room, he demanded to know if the tumor was removed and, on seeing for himself the flat abdomen, he was satisfied. I have never seen infection follow in any of these cases.

The method of delivery with stenosis of the vagina has already been mentioned but to cure them is another matter. There is always more scar

tissue than appears on examination. The bladder and rectum may be involved in it or one may find oneself entering the peritoneum in a place where it should not normally be found. When the contracted tissues have been all removed, it is not easy to bring the normal tissues together as the space to be filled in is too great, and contraction will occur again. Many methods of preventing this were tried such as packing, placing a mould of dental wax or other material in the vagina, frequent dilatation, etc., but owing to the patient's leaving the hospital too early, or failing to return for dilatation or changing the mould, these methods could seldom be successfully carried out.

In spite of failure to achieve all that one attempts, or perhaps because of it, medical practice in Korea has more than a touch of the adventurous about it and one never knows what is going to turn up next.

Interlobar Effusion Associated with Heart Failure

S. T. Laufer, M.D.

IN the following a case of interlobar effusion is reported associated with congestive heart failure. This is being done not only for its relatively rare occurrence, but also because of some of its features which may constitute a further contribution to the more recent views concerning the pathogenesis of hydrothorax in heart failure.

Case Report

A. Mc.F., a white, male aged 72 was first seen on February 1, 1945, complaining of an indefinite sensation of heaviness in the chest, cramps in the arms and legs and extreme tiredness. Lately he lost some weight and had been noticing some shortness of breath when walking upstairs and after meals. He mentions that he would fall asleep while at the table. His habits are regular.

On physical examination the patient appeared pale. There was no dysponea present. He was weighing 169½ pounds and was 67 inches tall. The respiratory rate was 20, the temperature, 90. The jugular veins were not distended and examination of the head, eyes, including fundi, mouth and throat were essentially negative except for a grade one pathology of the fundi. Examination of the chest did not reveal any noticeable abnormality on percussion or auscultation.

Cardiovascular System: The heart appeared enlarged to the left with a systolic murmur of musical character audible over the apex region and increasing in intensity towards the basis. Here the second aortic sound was only of low intensity. Over the apex region, both the first and second sounds were well audible. The blood pressure was 146/96.

Examination of the abdomen was essentially normal. The hemoglobin was 70%, and the urine was normal. The Kahn was negative.

A full blood picture was done and revealed the

Red cell count	3,730,000 per cu. mm.
Hemoglobin	74%
Colour index	0.90
White cell count	9,680 per cu. mm.

Differential Schilling count (200 cells counted)

Myelocytes	0.0%
Juveniles	0.5%
Band forms	3.5%
Segmented Polymorphs	59.0%
Lymphocytes	21.0%
Large monoculears	7.0%
Eosinophiles	8.0%
Basophiles	1.0% (Dr. R. Smith)

Electrocardiogram: The electrocardiogram showed a regular sinus rhythm with a frequency of 60 per minute, the PR interval measuring 0.40 seconds

in lead 2. Here the P wave is rather large and split. The ventricle complex is upward directed in leads 1 and 2; downward in lead 3 and measures 0.12 seconds. The ST space is slightly sagged in leads 1 and 2, while the T waves are low to bi-phasic in leads 1 and 2 and upright in lead 3. In the chest leads we note an inversion of the T wave in leads CF-4 and CF-5 with the ST space showing a downward course as seen in digitalis effect. The ventricle complex in lead CF-4 shows a notching in the descending limb of the R wave, which sometimes assumes the form of an M, in other words the intrinsic deflection comes very late over the left ventricle. In conclusion this electrocardiogram indicates the presence of a block type 1 with a conduction period of 0.40 seconds and inter-ventricular defective conduction, and possible also some indication of left bundle branch block.

An X-ray examination on February 2, 1945, showed the pleura thickened on the right base, obliterating the costo-phrenic angle. The inter-lobar pleura on the right side is thickened and there is a fluid level extending from the right hilus transversally across the chest wall, and a considerable degree of fluid appears to be present in the inter-lobar space.

Of the other features seen from the chest plate, it may be mentioned that the aorta appears much wider than average, the transverse diameter measuring 9 cms. with calcification in the aortic arch. The heart appears enlarged with a transverse diameter measuring 18 cms. while the transverse diameter of the chest on the level of the diaphragm is measuring 30 cms. The right and left lung fields do not show any infiltration. There is only some signs of congestion visible probably due to back pressure from the enlarged heart.

At that time the radiologist considered the possibility of a neoplasm on the hilus, for which also the marked secondary anemia, the absence of cardiac symptoms and the weakness of the patient appeared to be additional favouring features. The patient was treated by his doctor with digitalis and iron preparation.

On June 27th, the X-ray was repeated and showed that the round opacity which was present on February 2nd, had disappeared and free fluid was present about the right and left bases. The heart and the aortic arch appeared wider than previously.

The patient was then put on an intensive treatment with digitalis and diuretics following which he improved considerably, so much so that a re-check on November 9, 1945, revealed the disappearance of the fluid with freely movable domes of the diaphragm and no lag on the right. The aortic shadow appeared, however still wider than in previous examinations and in the right lung a small strand of pleural thickening indicates the side of the inter-lobar effusion previously noted.

To summarize briefly the X-ray examination revealed in a first moment the presence of a marked inter-lobar effusion on the right side, later on disappearance of the interlobar effusion, but free fluid on both sides, associated with further enlargement of the heart; and in a third stage after proper treatment complete disappearance of the fluid and clear lung fields with only a small strand of pleural thickening on the side of the previously noted effusion.

Discussion: In this case the interlobar effusion was the first sign of congestive heart failure, and would have remained clinically undetected because of the pauperity of the symptoms. Correct diagnosis could be made only by X-ray examination. The possibility also of a neo-plasm came into consid-

eration because of the absence of symptoms referable to the cardiovascular system and the presence of a marked secondary anemia. Successive X-ray examinations showed the disappearance of the interlobar effusion while free fluid in both sides and considerable enlargment of the heart became noticeable. The patient presented also Cheyne-Stokes breathing now. Proper treatment was able to make most of these symptoms disappear.

The presence of pleural effusion in heart failure, especially as the only and early signs of congestive heart failure has been noted and reported in some instances, but it deserves to be stressed because of the ease with which it might be overlooked or even be mis-interpreted.

As to the pathogenesis of interlobar effusion or hydrothorax in heart failure, in former times, systemic venous stasis was considered the main factor in the causation of the effusion in heart failure. More recent authors Fishberg,[1] Bedford et al[2] have pointed out that if this were so, hydrothorax should not be observed early, and not in the absence of edema. It should also be found in cases of pure right heart failure with massive edema or ascites. Yet in cases of this type hydrothorax is not regularly found. It has therefore been postulated that both systemic and pulmonary engorgment are necessary factors in the production of hydrothorax, the pulmonary stasis being the more important prerogative in its production. This is also born out by the anatomical disposition of the pleural veins. The visceral pleura drains its capillary network almost entirely into the pulmonary veins. The parietal pleural veins however drain into the superior vena cava or its tributaries mainly by the Azygos through which also a connection with the inferior vena cava is intermediated via the lumbar veins.

Since the interlobi have no connection with the systemic (azygos) venous system, its manifestation can only be explained in terms of pulmonary stasis.[2]

In the above described case the interlobar effusion had disappeared while free fluid in the main right pleural cavity was formed as the congestive heart failure increased in intensity, with concomitant enlargement of the heart and aorta. An antecedent adhesive pleurisy, obliterating the entire pleural cavity with the exception of the small space between the lobes of the lung, could therefore not be made responsible for its development. This view may still hold for a true encysted effusion and may have been an important factor in some of the reported cases in which necropsy revealed the presence of either an adhesive pleurisy obliterating the entire cavity with the exception of the interlobar fissure[3],[4],[5], or local adhesions. In this case as in a few without adhesions on post-mortem examination, Zdansky's[6] viewpoint would appear the most acceptable, namely that edema and congestion of the lung may be unevenly distributed and may be localized at the side of the pleural thickening or pulmonary fibrosis, a viewpoint shared also by Bedford et al.[2]

Interlobar effusion cannot be directly related to pulmonary infarction. Any effusion that clears up with treatment should not be attributed to pulmonary infarction. On the other hand there is no direct relationship between pulmonary infarction and hydrothorax except for cases of chronic hydrothorax in which pulmonary infarction is often found. In all other cases of hydrothorax, the effusion may precede the infarct or even be bilateral when the infarct is unilateral.

This case presents a further interesting finding, namely an aneurysmatic dilatation of the aorta of arteriosclerotic basis. These aneurysms show a

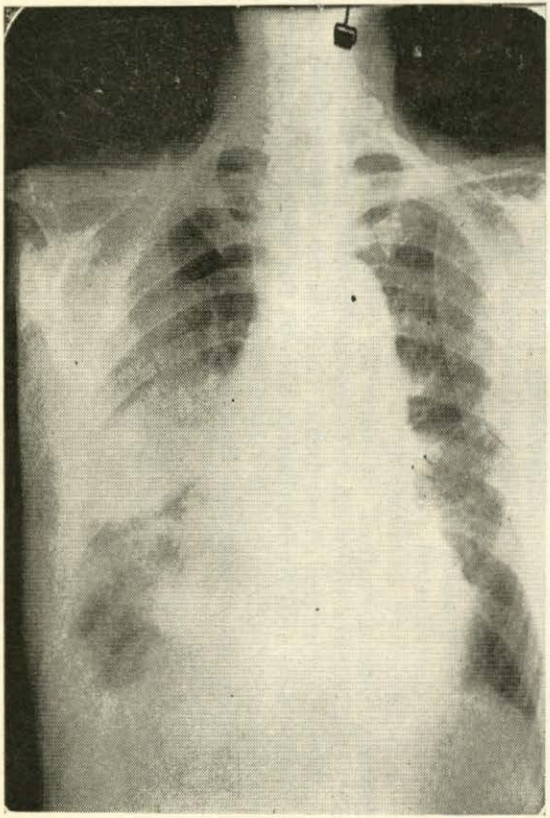

Fig. 1—X-ray on 2-2-45 showing interlobar effusion on the right side, also aneurysmatic dilatation of Aorta.

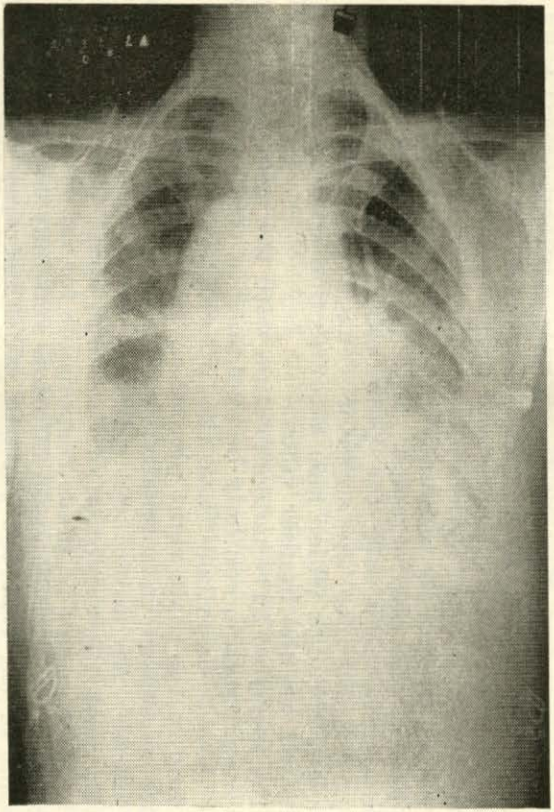

Fig. 2—X-ray on 5-27-45, the interlobar effusion has disappeared but there is free fluid in both sides, the heart is more enlarged than previously.

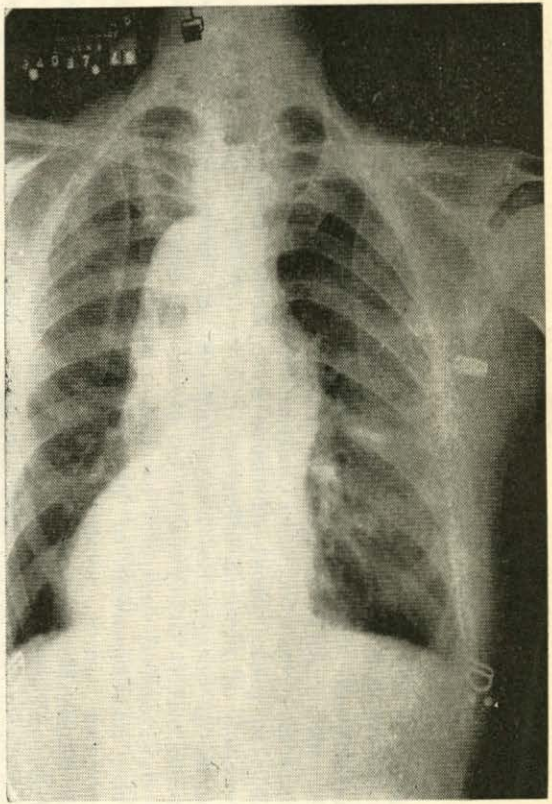

Fig. 3—X-ray on 11-9-45. Disappearance of fluid following treatment.

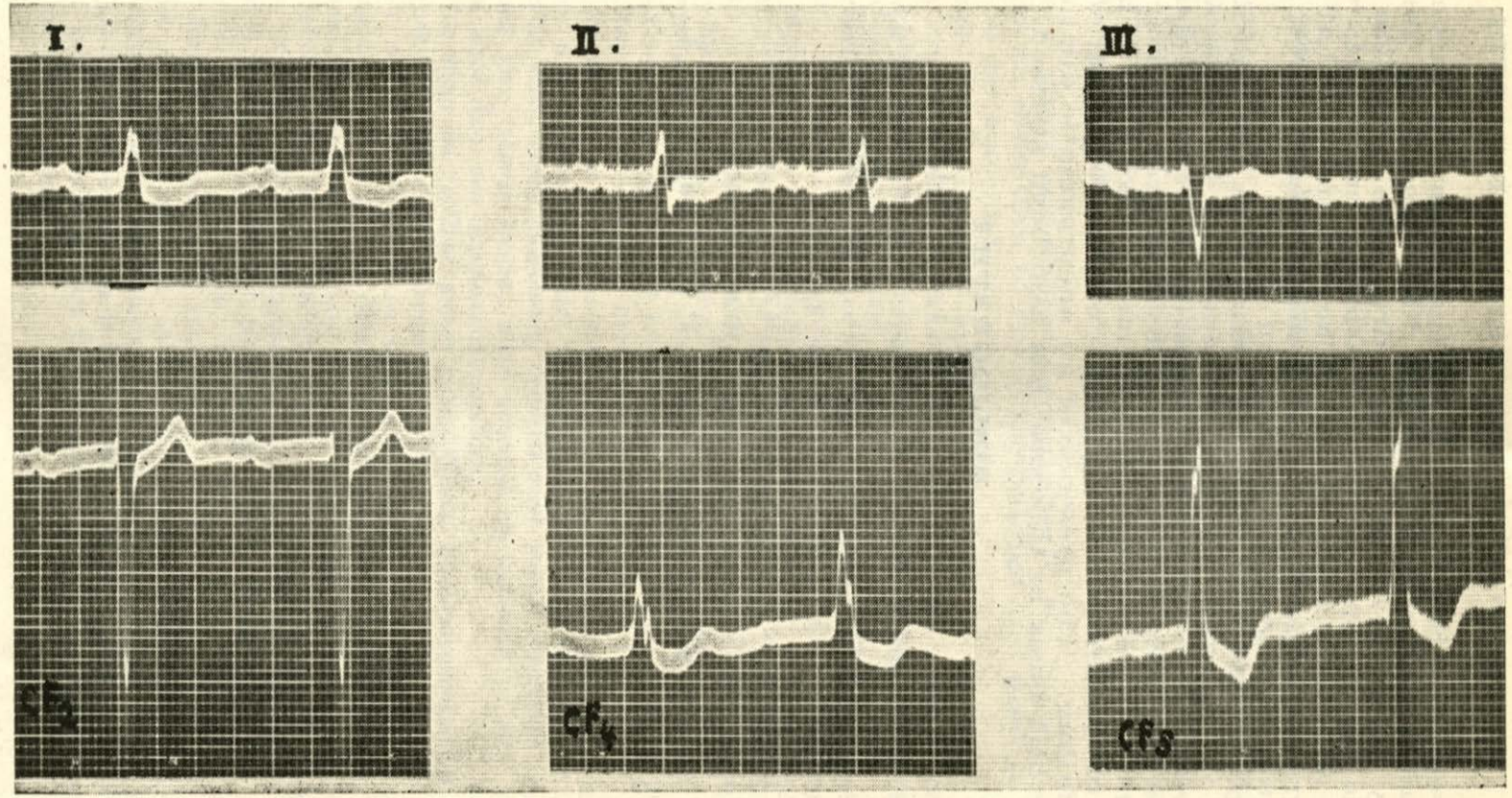

Fig. 4—Electrocardiogram limb leads and chest leads CF-2, CF-4, CF-5—for description see text.

tendency to rupture. Since most of the thoracic aneurysms are syphilitic, the opinion prevailed that any aneurysmal dilatation of the aorta was of leutic nature. Only recently Ruffin el al[7], drew the attention that even large *thoracic* aortic aneurysms may be of arteriosclerotic nature and that they may rupture with fatal hemorrhage. They postulated that these aneurysms will assume greater importance in the coming years as a result of a constantly aging population and gradual decrease of lues.

Summary: A case with interlobar effusion as the first sign of congestive heart failure is reported. The pathogenesis of hydrothorax and interlobar effusion in heart failure is briefly discussed. Certain pecularities of this case prove that of the causative factors of hydrothorax in heart failure, namely pulmonary and systemic venous engorgement, the former is the more essential one as a rise in systemic venous pressure will cause pleural effusion only if the left heart is failing. The presence of an aneurysmatic dilatation of the aorta of arteriosclerotic basis in this case has also been stressed.

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Case Report

PREGNANCY IN GENERAL PARESIS

I WISH to present briefly to you the case of a woman, the history of whom is rather unusual.

This patient was a colored woman aged 48 years. Admitted on August 11, 1934, with a history of syphilis and pregnant about 6 months.

History previous to admission was that she had had seven children—one of whom died in infancy. The others were living aged from twenty years to three years.

About thirteen years ago she was mentally ill for six months or so. At that time she paid no attention to her surroundings and used to wander away so that she had to be watched.

Five years ago she had a sick spell, the history of which is vague except that there was a lot of headache and her hair fell out. She had used alcohol to some extent. On neither occasion was she admitted to a hospital and so far as is known did not see a doctor.

About two months previous to admission it was noticed that she did not appear just right. There was some confusion, movements were uncertain and she did not appear to know what she was doing. She had been in bed for about two months without any special complaint. Ten days previous to admission went to a nearby village, wandered around all day aimlessly and was finally taken in charge and detained at a County Home.

Medical Certificates by which she was committed state that she has been very erratic in her movements and her actions rather aimless. They also state that Kahn reaction was Positive, two plus.

When examined after admission she was disorientated in all spheres. Conversation was disconnected and rambling. None of her statements were at all reliable. She was very restless, would not keep dressed and went about the ward upsetting the other beds. She would occasionally cry in a loud tone for several hours and for no apparent cause.

Physically she was in rather poor condition, was emaciated and examination of urine showed albumen present.

Owing to her restless condition and the fact that she was so destructive it was very difficult to do a great deal in the way of treatment. Her physical condition appeared to get worse and she continued to lose weight. Her diet had been supervised as far as possible with a patient in her mental condition.

About three weeks after admission she began to have oedema of feet and legs, appeared rather drowsy and was much weaker.

In the meantime exa ination did not show any foetal movements nor could the foetal heart sounds be heard.

The question of bringing on labor was considered and an obstetrician was called in consultation. Examination found the cervix dilated to admit two fingers and patient already in labor. Foetal movements or heart sounds still could not be heard. About an hour after the pains became quite strong and about one minute apart.

Without much warning or any sign of bulging the patient had a strong pain and expelled a complete ovum with membranes unruptured and placenta complete. While this foetus was being cared for the patient had another pain and was delivered of another foetus in the same manner as the first. There was little or no hemorrhage. The infants are both living and the membranes had to be cut to get them out of the sacs. They were small—one male, the other female. The boy weighed 1 lb. 13 ozs., the girl 2 lbs. 6 ozs. One lived one day, the other two days.

Patient's condition after this was fairly good. She had no elevation of temperature.

About three weeks after she began to develop a number of bedsores, was very restless and difficult to care for and was running a septic temperature. She was given one or two treatments of tryparsamide but condition became very poor, and she died on October 21, 1934.

At no time during the period spent in hospital was her physical condition good enough for Thermal Therapy and her mental state was such that she would not co-operate in treatment.

Blood examination was one plus. A lumbar puncture was done. The spinal fluid was three plus and the large curve 5544332211.

She had also six living children, aged from 20-3 years, some of whom, at least the three year old, must have been born after her illness had begun to develop and at the time of admission she was a far advanced and deteriorated case.

The diagnosis was General Paresis and the interest lies in the fact that a case of Paresis evidently quite advanced was able to complete pregnancy to the 7th month despite the fact that most text books state that it is impossible for pregnancy to occur let alone continue under these circumstances.

E. Pearl Hopgood, M.D.

PSYCHIATRIC TRAINING

Several requests have been received for recent graduates desiring training in Psychiatry.

Would anyone interested, please communicate with:

R. O. Jones, M.D.
Associate Professor of Psychiatry
Dalhousie University

Abstracts From Current Literature

BURNS TREATED IN OVERSEAS ARMY GENERAL HOSPITAL. Rawles, B. J. and Massie, J. R.: Va. Med. Jour., 1944, 71: 605.

Rawles and Massie list as fundamentals in the treatment of burns (a) the prevention and control of shock, (b) the relief of pain, (c) the prevention and control of infection and (d) the prevention of contracture and excessive scarring by proper splinting and early skin grafting. The local surface treatment should be limited to a minimum amount of debridement and cleansing and, finally, the burned area should be covered with sterile petrolatum or, if this is not available, with boric acid ointment. A firm pressure dressing should be applied over this, which should not be changed for ten to fourteen days unless complications arise. The authors review observations on 78 patients with burns. Forty-two of the patients were grafted, a total of 63 operations being done. The preparation of third degree burned areas for grafting was often a real problem when much secondary infection was present. Dressings wet with isotonic solution of sodium chloride with fine mesh gauze next to the granulating wounds were applied on admission in nearly all cases, since an average time of thirty days had elapsed in those cases in which grafting was necessary. Slough was removed by sharp dissection if necessary. The skin around the wounds became macerated from the moisture, and since it had been felt that the dead debris probably acted as a culture medium, this was cleaned away with neutral soap and water. All patients were given a high protein diet, multivitamins and iron. A patient was not considered ready for skin grafting unless the plasma proteins were above 6.5 Gm. per hundred cubic centimeters and the red blood cell count was 4,000,000 or above. Fifteen of the 39 patients grafted received blood or blood plasma to bring their readings above the minimal levels. Split grafts are the best type from the standpoint of preventing further scar tissue and for furnishing a durable skin surface. They were used in 54 of the 63 operations. Pinch grafts were used in the other 9. In a few of the extensive wounds in which it was difficult to cut enough split grafts, pinch grafts were used to fill in gaps. Grafts were sutured in place with a slight overlap at the edges with a continuous suture of fine silk. Fine mesh gauze impregnated with an ointment was placed next to the grafts. Sterile gauze and mechanics' waste was next applied and an Ace bandage for pressure. In the case of extensive burns in which almost an entire extremity had to be grafted the percentage of takes was from 95 to 100. Poor results were obtained in the cases with relatively small granulating wounds which had been neglected because they were small, with the hope that they would heal over without grafting. As a result, scar tissue formed in the bed, which often did not prove to be a fertile field. This should bring home the necessity of covering the smallest of granulating wounds with epithelium.

PERFORATED PEPTIC ULCER. Illingworth, C. F. W., Scott, L. D. W. and Jamieson, R. A.: Brit. Med. Jour., 1944, 2: 655.

Illingworth and his associates obtained records of all perforations treated in hospitals of over 15 beds in the West of Scotland and in private practice

during the year 1943. From 1924 to 1938 there was a progressive increase in the incidence of perforations. During the war the steady increase was interrupted by a great rise in 1940-1941 followed by a return to a lower level. These changes almost entirely concern duodenal ulcer. The 1940-1941 rise was not correlated with air raids in this part of the country. It is suggested that, in addition to anxiety about the war situation, overwork and perhaps undernutrition may have exerted an influence. The sex ratio has undergone little change during the twenty year period. The rise in 1940-1941 and the fall in 1941-1942 were confined to men. Perforation is rare in childhood; its incidence rises rapidly in adolescence and attains a maximum between the ages of 30 and 40 years. Perforations are unduly common in December and relatively uncommon in August, September and October. This low incidence in the summer months may possibly have a nutritional basis or may be related to the holiday season. Perforations are less frequent on Sundays and Mondays than on other days. This may be related to rest at the week end. Perforations are unduly common between 3 p.m. and 6 p.m. and comparatively uncommon during the night and morning. There may be a correlation with periods of stress and rest respectively. The fatality rate from perforations increases with age and with delay in treatment. It is greater in gastric than in duodenal ulcer, in females than in males, in winter than in summer.

Appendicitis and Pregnancy. Johnson, B.: Med. Jour. of Australia, 1944, 2: 379.

The incidence of appendicitis in women is not influenced by pregnancy, Johnson says. Primary acute appendicitis occurs at the same rate in all women irrespective of whether a pregnancy is present or not. Although primary acute attacks of appendicitis are rare in pregnancy, an existing chronic appendicitis is unfavourably influenced by it. The course of acute appendicitis during pregnancy is rapid and perforation may occur within a few hours, especially in the later months. When doubt exists, operation should be performed if the patient's general condition is grave. With early operation the maternal prognosis is good, but if perforation has occurred a mortality rate of 50 per cent must be expected. There is little danger of abortion in simple cases, but after perforation 50 per cent of uteri will empty themselves, thus increasing the mortality by 5 per cent. In the last two months perforation is extremely dangerous both to mother and to child. Cesarean section followed by appendectomy is advocated as the procedure most likely to give good results. The type of cesarean section depends on the extent of involvement of the parietal and uterine peritoneum. If involvement is very severe, Porro's operation is safest. In most other cases the lower segment operation will be best. Whenever possible the diseased appendix should be removed if there is a possibility of the occurrence of pregnancy.

Section of Vagus Nerves in Duodenal and Gastric Ulcers. Dragstedt, L. R., Palmer, W. L., Shafer, P. W. and Hodges, P. C.: Gastroenterology, 1944, 3: 450.

The presence of gastric secretory and motor fibers in the vagi and the large volume of experimental and clinical evidence indicating the crucial importance of gastric juice in the genesis of ulcer led Dragstedt and his associ-

ates to undertake complete division of the vagus nerves to the stomach in 11 cases of peptic ulcer. This was found to be most readily accomplished by opening the left pleural cavity, exposing the lower esophagus and isolating and dividing the vagus fibers before they pass through the diaphragm. The operation was well tolerated; there were no deaths, and the most serious complication was a postoperative pneumonia in one case. Gastrointestinal motility was not greatly altered, neither constipation nor diarrhea was produced, and it seems likely that food traversed the intestinal tract without delay. Fluoroscopy after the operation revealed the persistence of peristalsis in the esophagus and the absence of cardiospasm, but in one case considerable atony in the wall of the fundus of the stomach was seen. No abnormalities in the motility or tonus of the small intestine could be determined. The continuous night secretion in most of the cases before operation was abundant. In seven it exceeded a liter in twelve hours. This secretion was reduced by the vagus section over 50 per cent in all cases and in many to a still greater degree. This provides final proof that the hypersecretion of gastric juice in cases of ulcer is neurogenic in origin and is probably due to a continuous hypertonus of the gastric secretory fibers in the vagus nerves. The striking relief of the ulcer pain and distress secured by the operation, the absence of untoward sequelae and the decrease in gastric secretion all indicate that this procedure will find a place in the treatment of many cases of intractable peptic ulcer. The first operation was performed only eighteen months ago and accordingly the time is still too short to pass judgment on the final result.

MIGRAINE HEADACHE. Torda, C. and Wolff, H. G.: Arch. of Neurol. and Psychiatry, 1945, 53: 329.

Torda and Wolff state that distention of cranial arteries induces pain of an aching quality. The speed with which vasoconstrictor agents such as ergotamine tartrate reduce the intensity of the headache approximates the rate of constriction of the cranial arteries. In many patients the headache arises in the distended branches of the external carotid arteries, although any or all of the cranial arteries may be involved in migraine headache. Secondary to pain from prolonged distention of cranial arteries, the skeletal muscles of the neck and scalp contract and become painful. After several hours of such a headache the vessel may appear more prominent and distended. Instead of being collapsible it becomes rigid, pipelike and less readily compressible. Patients may report that after the first hour or two of an attack of migraine the quality of the headache may change in that the initial pulsating or throbbing headache turns into a steady ache. To account for these changes the authors have postulated that after sustained dilatation there occurs thickening or edema of the muscular and adventitial structures. Sections taken from the temporal artery of the patients during attacks of migraine involving this structure revealed on microscopic examination that there was thickening of the arterial wall. Since comparable control sections during periods of freedom of headache cannot be obtained, the authors studied the structure of the arteries of the ears of 6 cats after infusion for two hours of 10 cc. of mammalian isotonic solution of three chlorides containing 0.5 mg. of acetocholine bromide per hundred cubic centimeters. Measurements demonstrated thickening of the walls of the infused vessels. Ergotamine

tartrate was less effective in constricting arteries with thickened walls than arteries with normal walls. It is suggested that during attacks of migraine the cranial arteries involved may undergo similar changes after prolonged vasodilatation. Such changes may explain the rigid, pipelike texture of the arteries, the steady aching pain and the tenderness of these structures when headache has persisted for many hours. Also these changes may explain the decreased ability of ergotamine tartrate to reduce promptly the intensity of the prolonged headache.

HODGKIN'S DISEASE. Goldman, L. B. and Victor, A. W.: N. Y. State Jour. of Med., 1945, 45: 1313.

Goldman and Victor report 319 cases of Hodgkin's disease. The youngest patient in the group was 5 and the oldest 76 years of age. A clinical diagnosis of Hodgkin's disease can frequently be made by palpation of the involved lymph nodes. It is possible to count from 3 to 5 nodes in each of the involved groups. The nodes may vary in size from 2 to 12 cm. As a rule more than one area is involved. Thirteen of the author's patients showed involvement of the sternal nodes, never before mentioned in the literature. The skin was involved in 39 per cent of the patients. Roentgenographic findings in the chest characteristic only of this disease were never found. There was a gradual transition from a bilateral thickening of the hilar areas to a widening of the mediastinum and invasion of adjacent lung fields. Hodgkin's disease of the gastrointestinal tract was observed in only two patients. It was unusual to palpate the spleen in ambulatory patients. The abdominal form of Hodgkin's disease was observed in 27 patients. They exhibited weakness, loss of weight, intermittent bouts of fever and a more rapid course. Collapse of a vertebra may occur without symptoms of spinal chord compression. The characteristic changes in the sternal marrow were a polymorphonuclear shift to the right with severe toxic granulation, increased eosinophilia of young myeloid elements and increase in the monocytic series. Pregnancy occurred in 11 patients; therapeutic abortions were performed in three; miscarriage resulted in one, and the pregnancies were carried to term in the remaining seven. There was no evidence of Hodgkin's disease in the offspring. Even under the most optimal conditions permanent arrest of the disease has not been obtained, but useful life has been prolonged for many years. The patient should receive the smallest quantity of irradiation that is compatible with relative well-being, just sufficient to cause gross disappearance of involved lymph nodes. The authors utilized a voltage of 200 kilovolts, a filtration of 0.5 copper and 1 aluminum, a port of 10 by 15 cm. and a skin-target distance of from 40 to 50 cm. Voltages that were either higher or lower produced inferior results. In addition to the irradiation the patient should receive supportive hematinic therapy.

PENICILLIN IN BACTERIAL ENDOCARDITIS. Meads, M., Harris, H. W. and Finland, M.: New Eng. Jour. of Med., 1945, 232: 463.

Meads and his associates present observations on 9 cases of subacute bacterial endocarditis caused by Streptococcus viridans and on 7 proved or probable cases of acute bacterial endocarditis due to other organisms, all of which were treated with sodium penicillin at the Boston City Hospital during

1944. In the 9 subacute cases the dose generally used was 25,000 units intramuscularly every two hours for two weeks. Seven of the patients are alive and have been free from evidences of active infection for one to eleven months. Two patients had recurrence of infection, one after four months and the other after only one month. It is not certain whether or not these recurrences represent reactivation of the original infection or reinfection. An additional fatal case of Streptococcus viridans endocarditis was treated. Improvement occurred in another extremely severe case with a characteristic clinical course of subacute bacterial endocarditis with multiple emboli, with survival three months after treatment, but no bacteria could be grown from the blood before penicillin was started. In the fatal cases heart failure resulted from extensive damage to cardiac structures. In the 7 cases of acute bacterial endocarditis small doses were generally used because of the greater susceptibility of the organisms. Three of these patients are living and well. The diagnosis in all the fatal cases was confirmed at necropsy but in those who survived it is only highly probable. Heparin was used together with penicillin in three of the Streptococcus viridans cases and in two of those due to the pneumococcus. There appeared to be no benefit from this therapy to justify the additional effort and risk. Early and intensive treatment with penicillin maintained for an adequate period offers the best hope for recovery or arrest of infection in cases of subacute and acute bacterial endocardisis.

E. David Sherman, M.D.
Abstract Editor

Medical Society Meetings

Western Nova Scotia Medical Society

The annual meeting of the Western Nova Scotia Medical Society was held at Lakeside Inn, Yarmouth, on June 27th, with twenty seven in attendance. Doctors T. M. Sieniewicz and J. A. Noble of Halifax read papers on Allergy and Peripheral Nerve Injuries, which were well received. The following officers were elected:

President—Dr. L. M. Morton, Yarmouth.

Vice-Presidents—Dr. J. A. Webster, Shelburne; Dr. P. H. LeBlanc, Little Brook; Dr. R. M. Caldwell, Yarmouth.

Secretary-Treasurer—Dr. D. F. Macdonald, Yarmouth.

Representatives on Executive of The Medical Society of Nova Scotia—Dr. S. Y. Shirley, Shelburne; Dr. F. J. Melanson, Saint Anne du Ruisseau.

D. F. Macdonald,
Secretary-Treasurer.

Colchester-East Hants Medical Society

THE annual meeting of the Colchester-East Hants Medical Society was held in the Scotia Hotel, Truro, on June 18th. Dinner was served at 6.30 p.m. followed by a professional programme and the election of the following officers:

President—Dr. D. F. McInnis, Shubenacadie.

Vice-President—Dr. P. R. Little, Truro.

Secretary-Treasurer—Dr. D. S. McCurdy, Truro.

Representatives to The Medical Society of Nova Scotia—Dr. H. B. Havey, Stewiacke and Dr. S. G. MacKenzie, Truro.

Doctor Clyde Holland of Halifax presented an interesting paper on "Atypical or Virus Pneumonia;" Doctor J. B. Reid of Truro a paper on "Early Rising Following Operation" and Doctor D. S. McCurdy a case report on "An Acute Abdominal Ruptured Dermoid Cyst in a Girl Aged Fifteen Years."

A summary of Doctor Holland's paper stated that atypical pneumonia or virus pneumonia occurs chiefly in young or middle aged persons and is probably communicable as he related how several cases occurred in one family. The onset is gradual with malaise, frontal headache which is usually present and is worse on coughing. The cough is non-productive, paraxysmal with substernal soreness and chest muscle soreness from the cough. There are slight chills, temperature of 99°-105° within the first few days. Heart rate is usually below 100, respirations 18 or slightly higher. Leococyte count is normal. The sputum should be examined for tuberculosis. The physical signs may be negative. The X-ray usually shows areas of congestion in the bases. Sometimes a lateral film is necessary to show up lung consolidation hidden by the heart shadows. There is not any specific treatment for atypical pneumonia which usually lasts about three weeks. Supportive treatment, glucose and sedatives for the cough are indicated. The sulpho drugs do not influence the pneumonia, but are indicated for complications.

Doctor Reid's paper reviewed 681 cases, from the literature, which were observed for getting up on the first, second and third post-operative day, adding his own personal observations. By rising early is meant getting up carefully on the first, second or third day, post-operatively, for ten minutes twice a day and sitting in a chair and gradually walking around the bed. In such patients strength is regained quicker. Patients are more comfortable, have fewer gas pains, are more active in bed and can be discharged to their homes earlier. If the case feels tired and weary and more comfortable resting in bed then these should not be encouraged to rise early. Each case should be treated individually.

The following complications and percentages have been noted.

Complications	Early Risers	Later Risers
Pulmonary	4.9 %	7.9%
Phlebitis	3.2 %	1.8%
Infarcts	1.6 %	0.4%
Wound disruption	1.1 %	2.8%
Wound infection	2.7 %	5.0%
Pneumonia	.54%	1.6%

The kind of anaesthesia did not affect the pulmonary complications; spinal and local anaesthetics giving as many as inhalation anaesthesia.

Doctor D. S. McCurdy's case report of an acute abdomen which was not appendicitis. The case was of interest in diagnosing, as the complaints were of acute low abdominal pain on the left side in a girl of fifteen years. The previous health had been good until she suddenly developed this pain without temperature, rigidity, tenderness or spacticity. The following say she was well until night time when the severe pain returned. She vomited and now was developing tenderness and rigidity in the left pelvic region spreading to the mid pelvis and one into the right pelvic region. Rectal examination showed the pelvis filled with a rather firm mass; not moveable.

At operation she was found to have a large haemorrhagic dermoid cyst of the left ovary which had a twisted pedicle and a rupture 2″ long causing blood to be present in the peritoneal cavity. From a diagnostic point of view the torsion caused the first pain. The following day the rupture and haemorrhage caused the pain to move across the abdomen to the right side causing leucocytosis, pain, tenderness and rigidity.

Other conditions are commonly found in girls of this age as appendicitis, salpongitis, ruptured Graafian follicle, fibroid, ectopic, etc.

Following the presentation of these papers an interesting discussion added much to the success of the meeting.

D. S. McCurdy, M.D.
Secretary-Treasurer

The Combined Meeting

of the

DALHOUSIE MEDICAL SCHOOL REFRESHER COURSE

and

THE MEDICAL SOCIETY OF NOVA SCOTIA

will be held at the

Lord Nelson Hotel, Halifax, N. S.

October 7th to 11th, inclusive.

The Refresher Course will run from Monday, October 7th through Friday, October 11th. Clinics will be held each morning and lectures in the afternoons. Two of the visitors will be Doctor Francis M. Rackemann of Boston who will speak on "The Classification and Treatment of Asthma," and Doctor John C. Whitehorn, Psychiatrist-in-chief, Johns Hopkins Medical School, whose topics will be "Patients' Personalities" and "Psychotherapeutic Strategy." There will also be a visiting team from the Canadian Medical Association whose names and subjects will be announced later.

The Executive Meeting of The Medical Society of Nova Scotia will be held on Tuesday afternoon, October 8th—the first business session Wednesday afternoon, and the second business session on Thursday evening, October 10th. Doctor Wallace Wilson, the President of the Canadian Medical Association will be present at our meeting. Doctor T. C. Routley, the Secretaryof the Canadian Medical Association, will be in England at that time, and consequently will not be here. Doctor A. D. Kelly, the newly appointed Assistant Secretary, will be visiting us with Doctor Wilson.

Everything points to a good and useful meeting. **If you plan to attend, make your hotel reservations now,** as it is still difficult to secure accommodation in Halifax.