Clinical Notes

A CASE OF ACETANILID POISONING FROM HEADACHE CAPSULES, WITH EXTREME TACHYCARDIA THE DOMINANT SYMPTOM.

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History.—On July 28, 1907, Dr. A. W. Hon was called to see Mrs. F., a rather delicate woman, aged 44. She was complaining of great prostration, nausea, some dyspnea and a sense of oppression and pain in the precordial region.

Examination.—I saw the patient in consultation July 30. An examination at that time revealed, besides the symptoms above enumerated, the following: Normal temperature; slight puffiness of the skin, notably of the hands and face; mild degree of palor, but no cyanosis; abdominal viscera normal; lungs negative except accelerated respiratory movements, but not a labored breathing; urine and blood negative. The conspicuous sign was an extreme grade of tachycardia. The pulse, although weak, was palpable at the wrist, but could not be counted there. The rate, as determined by auscultation and a sphygmographic tracing, was 210 (Fig. 1). The heart was small; its sounds were clear, with accentuation of the second pulmonic. The Riva-Rocci instrument registered a blood pressure of 80 mm.

Further History.—On August 2, Dr. A. C. Kimberlin was asked to see the patient when there was noted some improvement in the rate (204), as well as the quality of the pulse

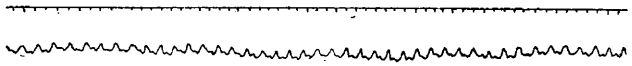

Fig. 1.—Sphygmogram showing tachycardia. Rate 210. Time markings one-fifth of a second. Jaquet instrument.

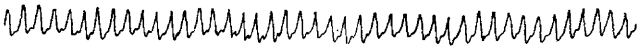

Fig. 2.—Tachycardia slightly improved over that shown in Figure 1.

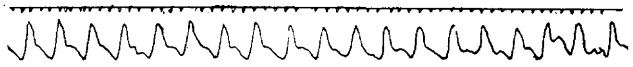

Fig. 3.—Sphygmogram showing a pulse rate of 100, the sixth day after the poisoning.

(Fig. 2). The blood pressure had risen to 90 mm. and the patient herself was conscious of gain.

Treatment.—Under the free ingestion of water and moderate saline purgation, the pulse rate gradually dropped to 100 on August 5 (Fig. 3), since which time convalescence has been rapid.

Diagnosis in the case was at first perplexing. Certainly no infectious process was present to account for the symptoms, nor did there appear to be any source of autointoxication. The rapid heart action was too prolonged for paroxysmal tachycardia. The absence of exophthalmos, thyroid enlargement, tremor and general nervousness excluded Basedow's disease. The conclusion forced was that the patient's condition arose from taking "neuralgic capsules" obtained at a drug store. For several years past she has been subject to severe and prolonged attacks of facial neuralgia. It was while suffering from the last seizure that she sought relief at the hands of the druggist. He was willing to prescribe and furnished her with his stock remedy ("Neuralgic Capsules") for pain, in a neat little box, with printed label which read: "Take one, repeat in fifteen minutes, and then every two hours." She took six of the capsules, obtaining relief from the pain but developing the alarming symptoms for which medical aid was sought. Qualitative analysis by the state chemist, H. E. Barnard, shows that the capsules consist of acetanilid and caffein.

A SIMPLE, ASEPTIC MOUTH-PIECE FOR THE SPIROMETER.

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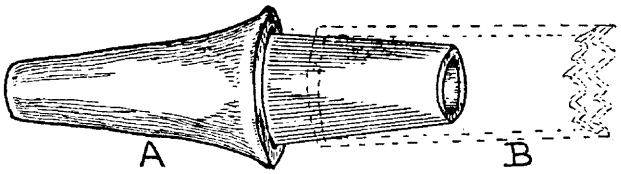
So far as I am aware there is no spirometer tip on the market which can be cleaned easily. In view of the thousands of spirometer tests that are made each year in our various gymnasiums, this fact assumes a serious hygienic significance. A recognition of these facts justifies me, I believe, in presenting this device to the medical profession and particularly to those men engaged in anthropometric work.



Simple, aseptic mouthpiece for the spirometer.

This mouth-piece (A) is made of wood, bevelled on one end to fit easily between the lips. The other end is made to fit snugly in the bore of the rubber tubing (B) which leads to the spirometer. These may be made anywhere. The Narragansett Machine Company of Providence, R. I., has furnished me with tips at the rate of three dollars a thousand. Each mouth-piece is used but once. It is then thrown away. At one-third of a cent apiece this is not extravagant. With such tips in use the danger of spreading contagion from mouth to mouth in our anthropometric examinations would disappear.

TRAUBE'S SEMILUNAR SPACE IN EMPYEMA.

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The value of Traube's semilunar space in differential diagnosis is briefly discussed in modern texts. The statement usually found is that the tympany is replaced by dulness in pleurisy. Cabot[1] says that it "is of very little value in diagnosis. This tympanitic area is obliterated in many pleuritic effusions (not in all)." In this connection the following history is of value:

A boy with pneumonia continued to have fever and severe general symptoms after the time of the anticipated crisis. Pleurisy, possibly empyema, was considered.

Physical examination showed a normal tympanitic semilunar space. Next day, before tapping, the same condition was found. After withdrawing about one-half pint of pus, the space was dull as far as the lower boundary of the pleural sinus. This last examination was not more than fifteen minutes after the second examination when tympany was found. During this interval the patient had taken neither liquid or solid matter.

While being tapped the patient was fairly quiet; no local anesthetic was used. Within a few hours a portion of a rib was resected by Dr. Nifong and a thick fibrinous deposit was found on the parietal pleura. A large quantity of pus was removed.

Undoubtedly, the pleura on the thoracic wall had been glued by the deposit to the diaphragmatic pleura, thereby preventing the pus from filling the sinus. The manipulation of the patient during puncture broke the

1. Physical Diagnosis, Third Edition, p. 370.