A CASE OF STATUS EPILEPTICUS WITH AN UNUSUALLY LARGE NUMBER OF CONVULSIONS

S. A. SMITH, M.D.
LINCOLN, ILL.

Patient.—Delia N., a girl, white, aged 8½, was admitted to the Lincoln State School and Colony Jan. 29, 1912. Family history shows both mother and father and grandparents on both sides to be living and well. Brothers and sisters of the patient are living and well. She was the fourth born of five children, weighing 9 pounds at birth, full term. It was noted at birth that she had a nevus covering all of the right side of the body and a small blotch on the left thigh. It was also said that she had had a convulsion at the age of 1 year, the character of which is not known. No history could be obtained as to the exact time when epileptic seizures commenced.

Examination.—The patient was a well-nourished child weighing about 58 pounds with a large reddish-purple discoloration of the skin on the entire right side with a small amount on the left thigh on its upper third. There was no deformity of the osseous structure. There were several scars on the child which she no doubt received during convulsions. There was a slight myocarditis and some tympanites. Eye reflexes were unattainable on account of the constant tossing and restlessness of the child during the examination. The patellar reflexes were exaggerated on both sides, somewhat more on the left. Tendo Achillis reflexes were much diminished. The Babinski sign was absent on both sides. No definite information could be obtained, but it seemed as though the hearing and sight of the child were faulty. Gait was affected due to a talipes equinovarus of both feet.

The child was unable to feed and dress herself, was very untidy in her habits and not attentive to the calls of Nature. She cried and fretted very much. The child's parents said that she had been subject to a varied number of seizures for some time but they had never kept any record, so they did not know how many she did have at times.

Clinical History.—She suffered one convulsion on the day of her admittance, January 29; the next day six, and five on the 31st. In the morning of February 1, eleven, and during the night forty-three. On February 2, there were 461, February 3 there were 573, on February 4 there were 403, on February 5, 158, the child dying at 10:15 p. m. The attacks were all of the grand-mal type, the child lying in a stupor between convulsions. She would respond to stimulation of the pain sense as on pricking the ear she would turn her head slightly, or on pinching the arm she would try to move it away. Bromids were administered from the time of her admission in doses of 15 gr. of the triple bromids every four hours. On the afternoon of February 2, she was anesthetized three times with chloroform. During the surgical anesthesia she showed no convulsion, but as soon as the first evidence of the pupillary reaction occurred she would immediately suffer a terrific convulsion much worse than those previous. Morphin in 1/12 gr. doses hypodermically gave no results. Patient was unable to take nourishment at any time. She had no involuntary passages of either urine or feces and it was necessary to catheterize her on the 3d, which was twenty-four hours after her severe seizures started. All other efforts proved of no avail to induce urination. The temperature rose to 102 F. during the afternoon of February 2. At 8 p. m., it was 104.8 F. From then on it showed marked fluctuations until the evening of February 3, when it returned to normal and stayed practically at normal, going to 100.6 a few hours before death. During seizures there would be marked rotation of the head to the right side with a nystagmus of both eyes with the long jerk toward the right side. The pupils would dilate markedly. She would perspire profusely, especially after a severe convulsion. On February 5 continuous normal saline per rectum was started and she absorbed 1 liter in four hours, after which she had a voluntary urination. Her urine examination on admission showed an occasional hyaline cast with no albumin. Catherized specimen during the convulsions showed twenty-four hour collection of only 6 ounces with an enormous number of hyaline casts and a large amount of albumin. A blood examination on February 4 showed normal number of red cells per cubic millimeter, large leukocytosis of 41,400 per c.c. The hemoglobin was 85 per cent. There was nothing unusual in the appearance of the red cells. A differential count of 100 white cells gave the polymorphonuclear neutrophils 85 per cent., the greater percentage of which were evidently young cells, being about 10 microns in diameter and the granules taking a deep stain, whereas the remaining cells were of normal size and staining much paler. The young cells averaged about five nuclei each, whereas the older cells averaged about two. Blood coagulated rapidly.

This case holds interest for the great number of grand-mal seizures that may occur in a case of status epilepticus. Spratling refers to LeRoy's case of 488 grand-mal seizures in twenty-four hours and to another case showing 1,000 seizures in three days, and also refers to cases ranging from 1,400 to 3,000 seizures ranging over a period of three weeks or more, which, he says, is too long a period for status epilepticus to persist, the average time being from twelve hours to three days.

My case gives a total of 1,649 grand-mal seizures in 4½ days, with the largest number for any one twenty-four hours being 573 convulsions.

I wish to thank Dr. H. G. Hardt, Superintendent of the Lincoln State School and Colony, for his kindness in permitting me to report this case.

EPITHELIOMA OF THE TONGUE

WITH NO RECURRENCE NINE YEARS AFTER CLINICAL CURE WITH THE X-RAY

MARTIN F. ENGMAN, M.D.
Barnard Free Skin and Cancer Hospital
ST. LOUIS

This case is of interest as it had every clinical symptom of an epithelioma of the tongue. The clinical diagnosis was confirmed by several of the leading surgeons and dermatologists in this city, and in Chicago.

The patient appeared May 30, 1902, with a hard nodule on the left side of the tongue, situated in the anterior third. The nodule was raised about an eighth of an inch above the surface of the tongue, and extended into the substance for some distance. To the touch, it was hard, indurated, and resistant. The center of the nodule was beginning to ulcerate, and there was some pain, especially when it came in contact with a hard substance. It had existed for several months, having slowly increased in size.

The infiltration, situation and peculiar character of the lesion forced one to the diagnosis of epithelioma. No specimen was taken for microscopic examination, on account of the irritation that comes from such a course, and the possible opening of vessels for metastasis.

The patient refused operation, and on account of the location of the lesion in the anterior portion of the tongue, it was decided to attempt its destruction with the *x*-ray. The following technic was employed: The tongue was drawn out and held by the patient's right hand, which made it very accessible to treatment. An opening, larger than the nodule, was cut in a piece of lead foil, which was so placed that it covered the patient's face and hands, leaving exposed the involved surface. The tube was then placed in gradually decreasing distances ranging from 5 to 2 inches of the nodule. Thirty exposures were given in all. The radiation was continued daily for from ten to fifteen minutes, until the mucous membrane was whitened, and reaction was obtained. This was allowed to subside, when another series of active radiation was begun. The last series was continued until the tumor presented a marked reaction, and all of the mucous membrane exposed was whitened.