One hundred sera were examined for the presence of cold agglutinins in the West African soldier. Cold agglutinins were found in 51 sera out of 100 examined. The highest titre recorded was 1 in 64. No agglutinins were found at room (26° C.) or incubator (37° C.) temperature.

I would like to thank the Director of Pathology for his advice, and Dr. G. M. Edington for his encouragement.

REFERENCES


TRAUMATIC HÆMATOMA OF THE LARYNX

BY

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A soldier aged 20 years was admitted to the B.M.H., Nicosia, during the evening of 2nd April, 1956, following a fall in which his neck had struck the mushroomed end of a metal tent-peg. The immediate effects of the injury were aphonia, a paroxysm of coughing with hæmoptysis, lancinating left otalgia and, according to his statement later, a sensation of "something running down into his chest." On admission thirty minutes after the accident his general condition was good although he appeared anxious and slightly dyspnœic (respiratory rate 30/min.). As he was unable to tolerate indirect laryngoscopy, a provisional diagnosis of laryngeal hæmatoma was made. 1,000,000 units of crystalline penicillin were given intramuscularly, followed by 500,000 units eight-hourly.

3rd April. Seen at 0830 hours. Dyspnœa was more marked and tracheostomy was advised in anticipation of increasing laryngeal obstruction. 0900 hours—transferred to the theatre. While waiting in the theatre a paroxysm of coughing occurred, followed by complete laryngeal obstruction with extreme cyanosis, carpo-pedal spasms, opisthotonus and finally collapse. A low emergency tracheostomy was performed immediately. This particular operation was selected to minimise the risk of laryngeal perichondritis at a later date. (Subsequently he developed an inhalation pneumonia which responded rapidly to penicillin and intensive breathing exercises.) Indirect laryngoscopy was performed daily. Initial examination showed complete immobility of the vocal cords and arytenoids, almost a cadaveric picture. A large hæmatoma involving the left ary-epiglottic fold and left arytenoid was present, protruding anteriorly over the posterior third of the left cord. A small hæmatoma was situated on the right cord at the junction of the anterior two-thirds and posterior third. 11th April. Nine days after the injury, the right cord was moving through 80 per cent of its range whilst the left cord had commenced slight movement on phonation.

12th April. Coughing occurred during the night and expectoration produced a discoloured piece of mucous membrane—roughly triangular in shape (3.5 cm. high and 1.5 cm. wide at its base). No hæmoptysis occurred. Laryngoscopy showed that the mucosal surface of the left arytenoid and left ary-epiglottic fold had been detached, leaving raw surfaces with a velvet-like appearance.

13th April. Right cord swinging across the midline on phonation but left arytenoid remains immobile.
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Traumatic Haematoma of the Larynx

14th April. Minimal movement of the left arytenoid and cord apparent on phonation. Oedema gradually subsiding. Voice husky.
16th April. Movements of left cord complete on respiration and phonation.
17th April. Evacuated by air to the United Kingdom.

DISCUSSION

This case is described to underline the difficulties encountered with a mild case of dyspnœa which suddenly became a grave emergency. These difficulties can be resolved in a surgical unit, but the problem to a regimental medical officer is a serious one. There is a great temptation to evacuate immediately to hospital any case of mild respiratory distress whether from trauma, acute anterior poliomyelitis, diphtheria, foreign body or burns of neck, etc. The following suggestions may be used as a guide:

1. If indications for tracheostomy are present the operation must be performed prior to evacuation.
2. If there is little risk of laryngeal obstruction it is justifiable to evacuate the patient providing that the regimental medical officer is free to travel with the patient and is prepared to operate en route if necessary. It should be remembered that even very short journeys may become prolonged under adverse conditions.

SUMMARY

A case of complete loss of laryngeal function due to trauma with recovery in two weeks is described. The management of such a case in the field is outlined.

Book Review


Six years have elapsed since the last edition of this famous book. In this, the seventeenth edition, new knowledge and techniques have been skilfully inserted into the text without disturbing the well-known order of the contents or increasing the size of the volume. There are new chapters on “Treatment of Shock,” “Management of Oesophageal Cases,” “Management of Gangrene of a Limb,” and “Ileostomy and its Management.” The chapter on “Saline and Other Infusions” has been rewritten under the title “Establishing and Maintaining Fluid and Electrolyte Balance.”

This book is a veritable mine of useful and practical information and should be in the possession of all junior medical officers.

P. F. M.