

On one side of the uterus, corresponding to one of the tubes, a hard, adherent mass was found, which was removed entire with great difficulty, on account of firm universal adhesions, in the separation of which severe hæmorrhage was incurred. After the mass was removed the large cavity was filled with a tampon, and all bleeding arrested by compression and ligature. Section of the mass revealed in its interior a hairpin. This common instrument of destruction had evidently been used to produce abortion, had perforated the uterus, and caused the suppurative parametritis—another sad illustration of the folly of women in attempting limitation of offspring.

A number of recent laparotomies showed no temperature and were on a fair way to recovery. All abdominal operations are performed under strict antiseptic precautions, with the exclusion of the doubtful spray. I examined with interest numerous frozen sections illustrating the normal anatomy and various pathological conditions of the female pelvic organs, which were fastened upon a wire framework, according to the device of Professor Freund, and kept as wet specimens. You will recollect that Professor Winckel adopted this method of mounting in obtaining his photographic illustrations for his great atlas.

A visit to the Pathological Institute brought me face to face with one of Germany's greatest pathologists, the distinguished von Recklinghausen. I found him smoking his morning cigar, but deeply engaged in his arduous work. Previous experience satisfied me that the director of one of the best pathological museums would spare neither time nor labor to show me the most interesting specimens. I found here the largest collection of specimens illustrative of diseases of the pancreas. I was exceedingly anxious to examine the specimen of pancreatic calculi with ectasia of the common duct, but when we searched for it where it should naturally belong it could not be found, a circumstance which almost instantaneously changed the placid temper of the professor into a rage. Shelf after shelf was examined, but that specimen, in some unaccountable way, had disappeared. I suggested that we abandon the search, but this only stimulated him to renewed energy, and I heard from behind the cases language more forcible than elegant, until the unhappy "devil" of the museum remembered the exact *locus* of the wandering pancreas, and he brought the specimen triumphantly to the excited director, whose countenance at once assumed its wonted tranquil, peaceful aspect. The average German professor is a typical representative of system and order, and the displacement of a specimen is considered in the light of a criminal offense, and, as the learned professor said on this occasion: "So etwas darf hier nicht vorkommen."

In a short time three new specimens have been added to the pancreatic collection. One of them consisted of a solid tumor, probably malignant, in the head of the organ, with a large cyst on the peripheral side. During life only the cyst was recognized, and after an exploratory puncture a probable cyst of the pancreas was diagnosticated. Professor Luecke performed abdominal section, stitched the

cyst to the wound, opened and drained it. Next day *exitus letalis*. The post-mortem examination showed that the primary disease had originated in the head of the pancreas and had involved the adjacent tissues; the cyst had been caused, undoubtedly, by progressive destruction of the secretory structures of the pancreas and obstruction of the cystic duct. The second specimen is a large cyst, removed post-mortem, where no communication exists between the cyst and the duct. The third specimen represents a primary carcinoma of the pancreas without the formation of cysts. The more I study the etiology of cysts of the pancreas, the more I become convinced that simple obstruction is inadequate to cause a cystic dilatation of the duct, as in such cases, as long as the gland remains intact, the pancreatic juice is absorbed; in other words, a retention cyst cannot be produced as long as auto-absorption remains intact. But, in cases in which the cause of the obstruction affects deleteriously the parenchyma of the organ, absorption no longer takes place, and the combined effect of obstruction and accumulation of the products of secretion from intact portions of the gland on the distal side of the obstruction, result in the formation of a retention cyst.

This museum contains three beautiful specimens of myositis ossificans. In all of them the production of new bone is most marked in the extensor muscles of the back and in the vicinity of the hip joint; in the latter location braces of new bone connect the pelvis with the femur, so that, with an intact hip joint, perfect immobilization of the thigh bone has taken place, always in a flexed position. In regard to the true pathology and etiology of this singular disease, little or nothing is known. At the meeting of the German Congress of Surgeons recently held in Berlin, Professor Helferich, of Greifswald, showed a young man suffering from this disease who had been under his observation for seven years. The disease commenced as an acute attack resembling rheumatism, followed in a short time by production of bone along the course of the affected muscles. It is more than probable that the ossifying process is limited to the connective tissue around and within the muscles, and that the muscular fibres disappear in consequence of pressure, atrophy, and interstitial absorption on the part of the new osteogenetic material.

N. SENN.

DOMESTIC CORRESPONDENCE

LETTER FROM NEW YORK.

(FROM OUR OWN CORRESPONDENT.)

Cancer of the Pancreas—Epithelioma of Penis—Intubation; Feeding after Intubation; Statistics of Intubation; Pathology of Intubation.

At a recent meeting of the New York County Medical Association, Dr. Thomas C. Taylor read the report of a case of *Cancer of the Pancreas*, with infiltration of the omentum and walls of the stomach, along the greater curvature, occurring in a female of

30 years. The case was interesting both on account of the infrequency of the affection and the obscurity of its diagnosis. In this case, three important and common symptoms generally regarded as diagnostic of pancreatic cancer: jaundice, œdema, and fat in the alvine discharges, were absent. Dr. Taylor thought Da Costa's manner of diagnosing these cases the most feasible—that by exclusion. As to the possibility of prolonging life by operation in a case of cancer of the pancreas, if the diagnosis could be made early enough, the two cases reported by Billroth were of much interest; he had made a partial resection of the organ, removing the tail in one and a portion of the head in the other case, but, of course, not injuring the duct. Both patients recovered from the immediate effects of the operation, but how long they lived, or whether the disease returned, is not stated. Dr. Taylor thought that when he first saw his case, but a very small portion of the head was involved, and that if the diagnosis could then have been made, it would have been an excellent opportunity to perform an operation similar to Billroth's.

At the same meeting Dr. J. R. MacGregor presented a portion of a *Penis Amputated for Epithelioma*. At the operation care was taken to prevent subsequent constriction of the urethra in the stump, and thus far the result was satisfactory. The chances were fair that the growth would not recur. Dr. J. W. S. Gouley said it was of interest that in epithelioma of the glans or prepuce there is always antecedent balanitis or balano-posthitis, and most cases occur in persons who have chronic balanitis; this condition being chiefly due to lack of cleanliness. In such cases epithelioma develops rapidly, and soon involves both the mucous membrane and the corpora cavernosa. In his experience, amputation, as usually resorted to in these cases, is insufficient, and is likely to be followed by a more or less rapid recurrence, which always commences at the end of the stump. Atresia urethræ is also likely to be a very unpleasant consequence of the operation, and he related a case in which, although there was no return of the cancer, the patient died within two years from pyelo-nephritis due to atresia thus produced. In one case of amputation for epithelioma, he first used the écraseur to break up the cavernous bodies. Then, leaving the urethra fully three-quarters of an inch longer than the stump, he fastened it to the free extremities of the cavernous bodies. On account of the frequency of recurrence, he determined to excise the whole penis in his next case; and in April, 1878, he did this operation on a patient 50 years old. He dissected out the entire organ, without opening the cavernous bodies, and removed the crura and all. About one half of the cavernous bodies had been invaded by the growth. The patient was discharged cured within two months; but he knew nothing of the subsequent history of the case. It seemed to him that such a radical operation was the best safeguard against recurrence; for if the slightest deposit remained the growth would recur. In the majority of cases it was not only justifiable, but the most proper measure to adopt. It is not a formida-

ble operation, and in his case the patient made a rapid recovery.

Dr. Bryant referred to three cases of amputation of the penis in his own practice. In two the operation was done for cancer involving the glans and anterior portion of the organ, and in the third for general carcinoma, involving not only the penis, but the whole system. He believed that the entire removal of the penis is the only ultimately safe procedure. But if the growth be very slight, it might be allowable to consult the patient's wishes, and if he object, make the amputation præ-scrotal.

Intubation was the subject of discussion at the first meeting of the Academy of Medicine in June. Dr. F. Huber's paper was a study of forty-seven cases from his own practice. Of these twenty-nine, with eleven recoveries, were in children under 3 years of age, and eighteen, with nine recoveries, in children of 3 years or over. Of the children under 3 years, one was 9½ months old, one 10½ months, two 11 months, one 1 year, two 2 years, two 2½ years, and two 2 years and 8 months old. Of all the children that he had been of late called upon to treat for laryngeal stenosis, he had found it necessary to resort to intubation in only one out of every three or four cases; and he thought it should not be done until dangerous symptoms set in. He used it in the same class of cases in which, up to a year ago, he would have performed tracheotomy. The dyspnœa is as effectively relieved by intubation as by tracheotomy. The utility of intubation was fully established, and it has now passed the experimental stage. One of the most serious accidents that can occur is the pushing of dislodged membrane before the tube, and in such a case Dr. E. D. Ferguson, of Troy, performed tracheotomy. Several deaths have been reported from this accident, and Dr. Waxham has recently devised a long tracheal forceps for removing the membrane in such cases. In a case under his care he gave the child brandy, which excited such a fit of coughing as to expel both the tube and the membrane. As a rule, the tube can be dispensed with at a much earlier date than the tracheotomy tube. If respiration continues free, it should generally be allowed to remain until at least the fifth or sixth day; but if the breathing becomes noisy, it should be promptly removed and afterwards reintroduced, if necessary. When there are diphtheritic patches in the nose or pharynx, it is advisable, as a rule, to leave the tube in position until they disappear. In intubation, as in tracheotomy, the prognosis is more favorable when there is simply local obstruction in the larynx than in cases of marked constitutional infection from diphtheritic poison. No positive prognosis should ever be made until 48 hours after intubation. Intubation, he believes, will save many cases in which tracheotomy will not be permitted, and many which would die if the latter were performed, especially in children under 3 years. No age appears a contraindication to intubation. Of 12 cases in which he had done tracheotomy, 10 died. He felt warranted in assigning to intubation a much higher position. As regards medicinal treatment, he uses bichloride of mercury throughout the disease, whether intubation were prac-

tised or not. He gives gr. $\frac{1}{6}$ -ss, and in severe cases gr. j, in divided doses, in twenty four hours. If there be much dysphagia, he uses tablet triturates, gr. $\frac{1}{40}$ each, mixed with sugar, and placed dry upon the tongue. With extensive diphtheritic membranes in the fauces he also uses tincture of iron and chlorate of potassium. In threatened heart-failure he uses brandy, caffeine, etc. If the temperature be very high, antipyretics are used, by the mouth or rectum. He also uses the steam atomizer to produce a moist vapor.

Dr. J. O'Dwyer read a paper on *Feeding after Intubation*. As a rule, solids and semi-solids are taken much better than liquids after intubation. In a number of cases he had removed the tube in order to give nourishment; but the results were scarcely better than when it was in position. Sometimes swallowing is easier after than before intubation, on account of the relief afforded to the urgent dyspnoea. The longer the tube remains in position, the easier it generally is to swallow. When the patient is old enough to understand, he should be instructed to drink rapidly, and to take as much fluid as possible at one time. Sometimes he uses rectal alimentation, but very seldom uses the stomach-tube. He does not think that food is a cause of pneumonia after intubation, as he has never seen any evidence of milk or other nourishment being found in the minute bronchi. He had known an adult patient to wear a tube for more than ten months, who not only did not have pneumonia, but meanwhile was cured of bronchitis, which he had when the tube was put in. The secretions, he thinks, are the source of the pneumonia met with after intubation, they being aspirated into the finer bronchi. It is due primarily to the presence of the tube, because it impairs the patient's power of expulsion. As to removing membranes with the forceps, the subglottic division of the tube is of such narrow calibre that it is practically impossible to use this instrument, and he has devised a flexible apparatus for this purpose, somewhat on the principle of the umbrella probang.

Dr. Dillon Brown read a paper on the *Statistical Records of Intubation*. So far as he had been able to ascertain, 760 cases, by 54 different operators, had been reported; he had tabulated 502 cases—211, or 27.07 per cent., had recovered. The average age in fatal cases was 3 years and 2 months; in recoveries, 4 years and 1 month. In the recoveries intubation was resorted to at an average period of 2 days and 9 hours after symptoms of laryngeal stenosis first appeared; and in fatal cases at an average period of 1 day and 19 hours. In the fatal cases the average time between intubation and death was 2 days and 8 hours; in the recoveries the tube was worn on an average for 5 days and $3\frac{1}{2}$ hours. O'Dwyer had operated 78 times, Waxham 106, Dillon Brown 84, and Huber 47 times. Extension of the membranes to the bronchi was the most frequent cause of death. He believed that pneumonia, when present, was secondary in character.

Dr. W. P. Northrup read a paper on the *Pathological Anatomy of the Respiratory Tract after Death from Laryngeal Diphtheria and Intubation*. Since

he read his paper on this subject before the Academy in December, in which he reported 87 cases, 20 additional fatal cases had occurred at the New York Foundling Asylum, to which he is pathologist. The cause of this large number during so short a period as four months was the occurrence of diphtheria in connection with a fatal epidemic of measles and scarlet fever. In his former paper he stated that he had never met with ulcers of the trachea; but in the 20 cases now reported for the first time there were deep ulcers, laying bare the rings of the trachea, in five cases. He had not met with ulceration of any consequence caused by the head of the tube; nothing more than necrosis of the epithelium. He had seen no evidence of aspiration pneumonia, as it had been called, due to the entrance of fluids into the finer bronchi.

Dr. Caillé had performed tracheotomy in 21 cases, with 5 recoveries, and intubation in 16 cases, with 6 recoveries. In his cases of intubation diphtheritic membranes were observed on the nares or pharynx in nine cases. In most of the cases intubation was done rather late. He believed that all the patients would have died without surgical interference, and that one who died would have been saved if intubation had been done earlier. The cause of death after intubation was catarrhal pneumonia in a majority of his cases. Most of the children who died had taken liquids, and of late he had allowed only solids cut up fine, with ice to allay thirst. Since doing this his results were better.

P. B. P.

BERGEON'S METHOD.

Dear Sir:—Permit me briefly to call attention to a few points in the preparation of gas for Bergeon's treatment. After trying several methods I have, by travelling in a circle, again reached and for the present settled upon, marble chips and H_2SO_4 for generating the CO_2 .

The objection which Dr. Babcock¹ makes regarding the irritating properties of the gas made from mineral acids is, in my practice, entirely avoided. A gas which made his "nostrils sting" was clearly unfit for use whether there were enteric ulcerations or not. I have discarded HCl. and use only H_2SO_4 (C.P.) because the by-products, (such as free chlorine gas) are much harder to get rid of with the former. I use a large mouthed half-gallon generating bottle, in which the marble chips (not dust) are placed. This is connected with the first wash bottle, (of which there are four, half-gallon size,) filled with a strong solution of sodium bicarbonate. Any acid fumes which are carried through would combine with the sodium liberating pure CO_2 . The next two wash bottles are filled with simple water, unless it is desired to eliminate the H_2S , which is sometimes formed, in which case Ferric sulphate can be dissolved in one of them. As H_2S is not objectionable this is unnecessary. The last wash bottle is filled with the sulphur water, natural or artificial, which it is decided to use. I am using both, and have but little choice, except that the artificial water can be

¹ JOURNAL, May 21, 1887, p. 582.