Five days later she had another hæmorrhage a little less in amount. I did not see her. A week later she had a third, and fainted. I advised immediate delivery, but was unable to obtain the consent of any member of the family, or even permission for a consultation. Impressing upon them the danger of delay, and leaving the responsibility with them, I departed. At intervals of five to fourteen days she had four more hæmorrhages. General malaise was marked throughout; "fainting spells" were frequent.

On July 5th, labor pains continued for several hours, the os becoming the size of a silver quarter, with but slight hæmorrhage. She was now willing to have anything done, but it was my turn to delay a little. Pains ceased until July 20th, when contraction again occurred for three hours, and then ceased for eight hours; when, upon my arrival, I found the os two-thirds dilated, head presenting. Drawing four ounces of residual urine, I dilated manually for a few moments, and ruptured the membranes; when contractions recurred and completed the dilation in thirty minutes (O L. A). Second stage lasted fifteen minutes; third stage, fifteen minutes. The placenta presented upon the lower edge of its maternal aspect an elliptical surface, three by one and three-quarters inches, which was smooth, and glazed with a membrane similar in all respects to the amnion. One drachm of ergot was given. Very little flowing. Mother and boy both well.

# Reports of Societies.

## BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.

F. B. HARRINGTON, M.D., SECRETARY.

Meeting of May 27, 1889. Dr. W. L. Richardson, President, in the chair.

### A CASE OF TETANY

was shown by Dr. F. C. Shattuck.

A characteristic spasm was excited in the right arm and hand by pressure applied below the clavicle, and prompt relaxation was induced by the application of the constant current, — the negative pole on the sternum, the positive on the extensor surface of the arm and wrist. The patient was a well-developed, vigorous girl of twenty-one, who underwent a very severe attack of diphtheria, followed by paralysis of the fauces and right leg, five years ago. After recovery, she began to experience occasional cramps in the right hand, without prodromata or apparent exciting cause. The spasms were, at first, confined to the right hand and arm, lasted only one or two minutes, and were separated by considerable intervals. Gradually they have involved the other upper and lower limbs; sometimes now last an hour, and are much more frequent. Several days ago, in the midst of an attack, she sought advice at the Massachusetts General Hospital, and was admitted to the ward, the attack being promptly recognized by Mr. Chadbourne, the medical house officer. The Trousseau phenomenon is well marked, it being easy to bring on spasm in either or both arms by pressure in the axillary or clavicular regions. She has had two attacks in the left leg since entrance, but pressure on the nervous and vascular trunks of the legs has failed to invoke spasm. The case is thoroughly typical of a somewhat mild form of the disease, except that the peculiar change of electro-muscular contractility, first described in connection with this disease by Erb, is not present, negative closure producing contraction when the current is applied to the nerve before positive closure, in this case, as in normal conditions.

The only disease to be eliminated in the diagnosis of this case is hysteria, and that can be easily excluded by the intermittent and bilateral features of the spasms, and by the total absence of any other hysterieal manifestation. In a case I reported[1] several years ago, the only other I have seen, the patient was a young man, and the spasms began and were very marked in the masseters, but were also severe in the trunk and limbs alike. The possibility of tetanus had consequently to be considered. The prompt relief which is brought in this case by the local application of electricity — both currents seem to act equally well — is noteworthy, and is not mentioned in any work on the subject which I have thus far consulted. My other case was cured by bromide and chloral. I propose to give this patient the former alone.

Dr. F. C. Shattuck also showed

### TWO RENAL CALCULI

voided by a hospital patient under the following circumstances. A woman of middle age was admitted, and a diagnosis of debility was reached after careful and thorough examination. She was doing well until a week ago, when she complained of moderate dysuria, for which no explanation was found in the urine. A few days later she passed two facetted stones, one as large as the terminal phalanx of a woman's little finger, and, immediately afterwards, urine perfectly loaded with pus. The next urines were clearer; and thirty-six hours after the stones came away the renal secretion was again perfetly normal. After the passage physical examination of the lumbar regions was as barren of results as before; and the lax and thin abdominal wall permitted thorough palpation. In the hope that we might ascertain which ureter was traversed by the calculi, Dr. O. K. Newell was so kind this morning as to make an endoscopic examination. He reports that he saw both orifices, and that the left ureter seemed somewhat dilated.

Dr. S. L. Abbot reported

### A CASE of TETANY TREATED SUCCESSFULLY WITH URETHAN.[2]

Dr. F. C. Shattuck read

### SOME REMARKS ON TYPHOID FEVER, WITH AN ANALYSIS OF ONE HUNDRED AND TWENTY-NINE CASES TREATED IN HOSPITALS, AND SPECIAL REFERENCE TO RELAPSE.[3]

Dr. George B. Shattuck thought the position taken by the reader with regard to relapse was a sound one. These views accorded with those adopted by most recent authorities upon typhoid fever, and would probably be found to be in accord with the experience of practitioners having extensive opportunity for observation. The fact that relapse was independent of indiscretions in diet was incontestable, and abundant proofs were to be found in any large hospital service, having numerous cases of typhoid fever, by any one

[1] Journal, 1887, i, p. 497.
[2] See page 230 of the Journal.
[3] See page 221 of the Journal.

who chose to look for them. It was certainly very desirable that this fact should be thoroughly understood by the profession; he thought it questionable, however, whether it was equally desirable that it should be dwelt upon with the laity. There were real dangers and drawbacks attendant upon early indiscretions in diet after typhoid, and it was difficult enough under any circumstances to restrain the greediness of the half-starved fever convalescent.

The trouble with Brand's statistics is that they are too good. A moderate experience with his method has not induced its adoption outside of Germany and Lyons. A proper application of the method demands plunging the patients in cold water from the very beginning of a febrile process, subsequently called typhoid fever, every time the temperature reaches a certain point. If the claim now made is, that the object of this constant disturbance of the patient is simply the stimulation of the nervous centres, Dr. Shattuck had sufficient confidence in the ingenuity of physiologists and the resources of therapeutics to suggest methods of stimulation as effective as the cold bath, and more agreeable, and at the same time less cumbrous, less disturbing, and less costly in our country, both for patients and attendants.

DR. F. C. SHATTUCK said, in reply, that until lately he has been disposed to take somewhat the same view of Brand's statistics, namely, that they are too good; but the evidence of other Germans, and especially of the French who are not prejudiced in favor of German ideas, is too strong to be disregarded. A more or less thorough Brand treatment has now been carried out in Lyons for fifteen years, with the best results, and the method seems to be winning its way in the French army hospitals.

DR. ABBOT said: It was very difficult to explain the cause of relapse in typhoid fever, or of the sudden rise of temperature which sometimes occurs in its course. It was certain that a very critical condition, such as unhealed ulcers in the intestines, might exist during apparent convalescence which gave no outward sign. He mentioned the case of a young man affected with typhoid, under his observation some years since. He had been left in his charge by the late Dr. Cabot, during a temporary absence from the city, and became apparently convalescent. He was so well that he was able to be up all day, and made no complaint. On Dr. Cabot's return home he resumed charge of the case. At his last visit Dr. Abbot gave the patient very strict directions about his diet, cautioning him against indiscretion, and assuring him that he was not yet out of danger of accidents, and he promised to be guided by his advice. On the next day, however, without consulting his physician, he ate a raw apple, which killed him. Severe abdominal symptoms at once came on, which ended in perforation of the bowel, peritonitis and death.

DR. WHITTIER said: It is very evident, Mr. Chairman, that not much other than words of commendation can be said of Professor Shattuck's paper and the subject it places before us for discussion. He has not left much to be said on this most important and timely topic of cold bath treatment of fever, and particularly of typhoid fever.

The figures and the conclusions set forth in the paper present to us incontestable evidence of the need of a change from our long-practiced method of dealing with high temperatures, for figures like these are facts, and conclusions such as are here drawn are safe guides for treatment. It is only recently that it has been conceded by any considerable number of practical, every-day practitioners, that the underlying principle in the cold-bath treatment of fevers is more and better than the abstraction of heat already generated in the tissues, and that, after all, the influence on the nervous system, stimulating to new effort and imparting new power, is the chief effect of cold applied to the surface of the body; and the number of converts to this recently established view is constantly increasing, and in my opinion must continue to grow as men become better informed. We all recognize the obstacles to putting in practice the cold-bath treatment of fevers; large obstacles to the proper adjustment of the mechanical appliances. For instance, the bath should be at the bedside of the patient — an extremely difficult thing to arrange in private practice; we note the need of larger attendance and attention, for the patient must be lifted and not allowed to make any effort whatever; and yet larger difficulties in overcoming popular prejudice against so great an innovation, so radical a departure from previous and well-established methods. But our duty in the matter is none the less clear and positive, and it rests with the profession to insist upon and to carry out the changes in treatment advised and urged by Professor Shattuck.

DR. J. P. REYNOLDS: Many instances of genuine typhoid cases, in which the typical course of the disease and its distinctive features are well marked, will, provided they occur in private practice, and therefore come early under judicious control, recover safely without other management than utter rest of mind and body, the securing of sleep, the simplest form of nourishment, a free use of diluents, and the very slightest medication. With this in mind, would any physician subject an average case of typhoid under his own roof to the continuous application of cold water?

Several speakers have referred to the habit of accrediting relapses to errors in diet. Were that fact generally kept in mind, upon which Liebermeister, in "Ziemssen" so justly lays stress, that no matter what improvement appears in pulse, in temperature, or in general condition, the risks of typhoid are continually present in every genuine attack for not less than thirty days; that at least until that time has passed the attendant must unshrinkingly exact entire tranquility of body and mind, relapses would be seldom if ever known. Errors in diet, rightfully interpreted, mean almost unfailingly, criminal disregard of the all-important clinical truth, that during the whole term mentioned diseased conditions invariably persist.

All that the limits of this discussion strictly permit has perhaps now been said; but one statement, many years since forcibly urged in a leading article of the *British and Foreign Medico-Chirurgical Journal*, appears of such paramount importance as to warrant its repeated mention whenever the treatment of typhoid comes up. The writer of that article maintained that if by simple means, for example, *pro re nata*, once, twice or three times daily, some such pill as the following,

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|---|---|
| Powdered Rhubarb | 2 grs. |
| Comp. ext. Colocynth | ½ gr. |
| Ext. Hyoscyamus | 5-6 gr. |
| Oil of Caraway | q. s. |

adding, in case of need, a simple enema, a daily dejection, fæcal in character, be secured during the first week of typhoid, the graver symptoms of the follow-

ing period, which he thought justly characterized as those of septic poisoning, would not, to any marked degree, occur. Where such a care has been neglected it is believed that the best key to subsequent successful control has been lost.

No one questions the inestimable value of diagnosing early and of treating promptly every variety of grave disease, but this is never more indispensible than during the onset of typhoid; and the clinical gain would be immense, did every practitioner feel himself under bonds at least to entertain the question of impending typhoid, whenever, in the absence of distinctly localized inflammations, two conditions exist, inability to keep any longer erect and utter disappearance of appetite.

Dr. F. E. Cheney reported

AN UNCOMPLICATED CASE OF PROGRESSIVE OPHTHALMOPLEGIA EXTERNA, OR A SYMMETRICAL PARALYSIS OF THE EXTERNAL OCULAR MUSCLES.[4]

Dr. Wadsworth: The case reported by Dr. Cheney is a very interesting one, if for nothing else, from its rarity. It is the only entirely uncomplicated case of ophthalmoplegia externa that I remember to have seen. Such cases I believe are nuclear. Ophthalmoplegia complicated with other symptoms is not very rare. A number of years ago I showed a patient at this society with locomotor ataxia and ophthalmoplegia externa and interna. A few years ago I reported a case of ophthalmoplegia externa and double optic neuritis, apparently due to lead poisoning. At one time I was inclined to regard this case as one of nuclear disease, but am now disposed to think it one of peripheral neuritis. The paralysis of the ocular muscles was acute, and was entirely recovered from. Three days ago I saw a man of fifty years of age with ophthalmoplegia and simple optic atrophy. The ophthalmoplegia had begun twelve years ago, with sudden dropping of the left upper lid; the date at which the right eye was first affected is uncertain. Failure of vision was first noticed six or seven years ago. There is now in the left eye no perception of light; complete paralysis of all the ocular muscles; the right eye counts figures at two feet; ptosis is only partial, but all the other muscles are paralyzed except the superior oblique. It is remarkable that, with total inaction of all the other muscles, the right superior oblique appears to act with normal vigor. I discovered no other symptoms; there was nothing to point to locomotor ataxia, but I was unable to make an exhaustive examination at the time, and hope to have opportunity for further investigation.

Dr. Bullard stated that it was now generally admitted that chronic progressive total opthalmoplegia externa was always nuclear, and the lesion in these cases was disease and destruction of the cells of the nerve nuclei, similar to that which occurred in the gray matter of the cord in progressive muscular atrophy.

Dr. Wadsworth: I should like to say a word as to the nomenclature. Hutchinson first applied the term ophthalmoplegia externa to cases in which the external ocular muscles were paralyzed, in distinction to cases of paralysis of the internal ocular muscles, which he called ophthalmoplegia interna. But he soon after published a series of cases under the former title, in many of which the internal muscles also were paralyzed, and there were other complications. I quite agree with what Dr. Bullard has said regarding the nuclear origin. The term, I think, should not be applied unless more than one nerve is involved. The cerebellar affection referred to by Dr. Prince, involving the red nucleus, and so the fibres of the third nerve as they pass through it, would only affect one of the ocular nerves, and in such case the term would not be appropriate.

Dr. Walton: In connection with the question of neuritis, as causing symptoms similar to those of ophthalmoplegia, I should like to mention a case which I saw at the Eye and Ear Infirmary, at the request of Dr. Sprague. The patient was a middle aged man, who had complete immobility of the globe, together with lid drop in both eyes. He also had, however, optic atrophy and tenderness of the extremities, together with diffuse numbness and motor weakness. It was, therefore, a typical case of multiple neuritis, affecting, among other nerves, those whose nuclei are commonly attacked in ophthalmoplegia. The cause was probably tobacco. I do not mention this case with a view of advancing the theory that neuritis is the cause of the disease under discussion (which I think is undoubtedly nuclear, and analogous to bulbar paralysis), but to call attention to a possible source of confusion in diagnosis.

Dr. Cheney said: Dr. Prince must have misunderstood my statement in regard to paralysis of the intra-ocular muscles in this disease. My statement was: — "The intra-ocular muscles, in the uncomplicated form of the disease, do not suffer." I have examined the reports of between twenty and twenty-five of the uncomplicated cases, and in none of them were the intra-ocular muscles affected.

## FIFTH DISTRICT BRANCH OF THE NEW YORK STATE MEDICAL ASSOCIATION.[1]

Dr. T. H. Allen, of New York, read a paper on

TRAUMATIC PELVIC CELLULITIS.

This cellulitis, he said, was always associated with a unilateral or bilateral laceration of the neck of the uterus, and much more frequently with the former because this was almost always deeper than the bilateral tear. He did not believe that in every case of laceration the involution of the uterus is arrested; but numerous examples of subinvolution, associated with laceration, had led him to consider the relation of cause and effect to the positive and direct. He then proceeded to the narration of cases.

Case I. Mrs. R., aged twenty-nine years, has had three children, the last two of whom are living. After her last labor, nearly eighteen months ago, her health began to fail. The flow did not cease entirely until three months. Since her confinement she has become pale and anæmic; has had intense headache, radiating anteriorly and posteriorly from a point on the vertex, and also attacks of syncope increasing in frequency; pain in back and left iliac region; frequent micturition. Examination: Left lateral laceration, one-quarter of an inch in depth; uterus much enlarged; length of uterine cavity, three and one-half inches; thickening beyond the utero-vaginal junction in left broad ligament, circumscribed and intensely tender to touch. Tonics were given and hot water used faithfully after

[4] See page 224 of the Journal.

[1] Concluded from page 213 of the Journal.

the manner advised by Emmet, but the tenderness persisted. Trachelorrhaphy was then performed in the usual way, five silver sutures being inserted. The patient was placed in bed and her water drawn with the catheter every six hours. Union was complete, and at the time of her getting up there was no tenderness, and the heat and pain on the left side had markedly diminished. She rapidly got well, and continues so at the present time, two years after the operation. The uterus measured two and one-half inches six weeks after the operation.

CASE II. Mrs. P., age twenty-nine; one child, stillborn, two years previous to consultation, labor tedious, instrumental delivery, lochia continued ten weeks. Since then her health had become seriously impaired; loss of flesh and strength; general facial acne; recurring hemicrania; pain in back and left ovarian region; irritability of bladder, dyspareunia; mental depression, and irritability; lack of self-control; suspicion; jealousy. An examination showed unilateral laceration of cervix and traumatic cellulitis of left broad ligament. The patient having already used hot water injections, under the advice of her physician, the operation of trachelorrhaphy was performed five days later. This was successful, and two months after operation she felt much better and her acne had almost entirely disappeared. There was no pain or tenderness remaining, and she was bright and cheerful. Since this time, over a year ago, the patient, whose marital relations were previously strained, has lived happily with her husband.

Having related four other cases, Dr. Allen said it must not be inferred from these that he is prone to operate in laceration complicated with cellulitis. This he would do only in exceptional instances. The opinion of the best gynæcologists he believed was expressed in the following quotation upon a paper read by Dr. C. C. Lee, before the Medical Society of the County of New York, in 1881. "When any decided inflammation exists about the uterus, or so long as any tenderness can be detected in the neighboring connective tissue, it is unsafe to operate." It was also true, however, as stated by Dr. Bache Emmet, in the "American System of Gynæcology." "In other cases the indurated and sensitive angle of laceration will be very marked and easily detached from the first, and in these cases there can be no question as to the necessity of removal of such a foreign body as a cicatrix." In this statement he thought Dr. Emmet had touched the keynote of the treatment, for he believed that this foreign body was the cause of the coëxisting cellulitis. There was a limited class of cases in which the use of copious intra-vaginal injections of hot water and other well-directed local as well as general treatment might improve, but not cure, a coëxisting cellulitis. This class of cases broadened the field for trachelorrhaphy, and to it, Dr. Allen said he had given the designation "traumatic pelvic cellulitis," to distinguish it from the more diffuse form of pelvic inflammation. It was primarily occasioned by a wound — a tear — and nature in her unassisted efforts to repair the loss of continuity in the uterine neck, built up a structure histologically different from the adjacent tissue, which operated in the same way as a foreign body. It was like cellulitis in the forearm of an insane woman, occasioned by stigmatization with small pieces of glass. The wound healed with the glass spiculæ remaining in the areolar tissue, but there was left a chronic form of inflammation which did not suppurate, but which resulted in cellular thickening, attended with pain and slight swelling, which increased to-day and diminished to-morrow, until finally relieved by excision. The operation of trachelorrhapy removed the cicatricial tissue (the foreign body) and completed the sphincteric arc of the neck with tissue identical in character, while it also had the effect of relieving by the bleeding caused by it, the congested blood-vessels and lymphatics, and of imparting a new impulse to the processes of nutrition. In concluding, Dr. Allen recapitulated the points of his paper as follows:

(1) Lacerations of the cervix uteri may result in the formation of cicatricial tissue which produces chronic traumatic pelvic cellulitis.

(2) In a limited number of these cases, local or general treatment, or both, will not subdue this inflammation and pain.

(3) Such treatment having failed, trachelorrhaphy may be performed successfully.

(4) The dense mass of cicatricial tissue operates similarly to a foreign body, and its removal by Emmet's operation is a logical remedy which precludes the possibility of its re-formation.

### AFTERNOON SESSION.

DR. J. A. WYETH, of New York, gave an analysis, with comments, of a number of

### IMPORTANT SURGICAL CASES

recently treated by him. They comprised supra-pubic lithotomy and other operations upon the bladder, ligation of arteries for various conditions, amputations and resection of the knee-joint. In regard to supra-pubic lithotomy, he said that after a career of varying fortune, in which at times it was unduly lauded and at times entirely abandoned, he believed this operation had now attained a secure position, which, on account of the improved facilities at the command of the modern surgeon, it would maintain permanently in the future. He also mentioned the various conditions in which it was applicable and in which it was, in his opinion, decidedly preferable to perineal section.

DR. J. G. TRUAX, of New York, read a paper on

### THE TREATMENT OF ACUTE LOBAR PNEUMONIA.

Within the last four months he said he had attended fifty cases of this disease. Of these he related two cases representing the conditions requiring the greatest variation in the treatment. The first was a patient in middle life, of medium size, and fairly well nourished. All the ordinary symptoms and signs of pneumonia were present, but the attack was not of great severity. The temperature two or three degrees above normal, the pulse rarely above 100, no delirium, no albuminuria, and the crisis occurring in from five to ten days. This class of cases comprised about one-half of those met with by the physician, and nearly all such patients would recover, whatever the treatment adopted.

In the second class of cases, while the difference in the physical signs might not be very great, the clinical history differed widely, and to conduct such a case to a favorable termination required all the care and skill of the intelligent physician. Here albuminuria and delirium were almost always present, the temperature rose to 104° or 105°, and the pulse was from 120 to 140; while there was great embarrassment of the respiratory circulation, and consequently a labored heart action.