

Dysentery Carriers.—MACALISTER (*Brit. Med. Jour.*, 1910, ii, 1506) divides carriers into two great classes. The first class consists of healthy persons, who have never suffered from the disease and show no signs of ill health, but nevertheless harbor and scatter the specific organism. In the instance of bacillary dysentery this class is small and unimportant. The author has never found a single case, but Conradi, Collins, and Mayer have been able to demonstrate such conditions in both children and adults living among those affected with the disease. In the second class are people who have had the disease and are thereafter unable completely to eliminate the infection. As agents in the spread of the disease this group cannot well be overestimated in importance. They consist of two groups, in the first of which convalescence is discovered only by the continuation of agglutination. They do not relapse, but they harbor infection somewhere, and an occasional stool contains inueus. The second group is of relapsing and chronic cases, a constant source of infection. Macalister emphasizes the need of isolation, observation, and care during convalescence as a means of prevention of spread of an epidemic. Unfortunately, these incomplete convalescents form a high proportion of the cases.

The Parathyroid Glands and Sudden Death.—As a cause of sudden death in children, not a few cases of status lymphaticus have been recorded. But it often happens that necropsy reveals no adequate cause of death. GROSSER and BETKE (*Munch. med. Woch.*, 1910, lvii, 2077) report 3 cases which would fall in the latter category, had they not carefully dissected and examined the parathyroid glandules histologically. In all their cases no lesion sufficient to cause death was found, aside from the changes in the parathyroids. In 2 cases they found only three glandules—all hemorrhagic. In the remaining case all four glands presented fresh, extensive hemorrhages. Similar lesions were not discovered in other organs. From a study of the literature, they find that more than one parathyroid gland must remain intact to preserve life. They believe, therefore, that the lesions they found in these glands are quite sufficient to explain the death of the patients, and urge the necessity of their careful examination in cases which are obscure. The patients died with spasms.

Anemia and Hemolytic Icterus of Tuberculous Origin.—LANDOUZY (*Presse médicale*, 1910, 761) reports the case of a young man, aged thirty-eight years, with pulmonary tuberculosis. The man had a severe grade of anemia—red blood corpuscles, 1,050,000, and hemoglobin, 10 per cent. The spleen was enlarged. The conjunctivæ were subicteric, and the urine highly colored (urobilin). A diminution in the resistance of the red blood corpuscles was demonstrated (0.54 per cent.). As many as 25 per cent. of the red cells showed granules on vital staining, and the nucleated red cells amounted to 35 per cent. The patient's serum contained neither isolysins nor antolysins. After a time, under treatment, the signs of infection regressed, with a similar change in the anemia and icterus. As the pulmonary lesions seemed to become stationary, the fragility of the red blood cells disappeared. This parallelism of the hemolytic syndrome and the infection and the absence of any other cause leads Landouzy to believe the hemolytic jaundice dependent

upon the tuberculosis. It is known that acquired hemolytic jaundice is met with under various circumstances. Malaria, syphilis, and cancer are among the known conditions in which this syndrome has been met with. The author believes his own observation to be the first in which the hemolytic condition evolved in the course of tuberculosis. It supports the hypothesis of the bacillary origin of certain of the hemolytic syndromes.

Typhoid Fever Statistics.—SALLON (*Med. Record*, 1910, lxxviii, 625) states that from January, 1898, until June, 1909, there occurred in Philadelphia 68,943 cases of typhoid fever. Of this number, 8102 died, a mortality of 11.75 per cent. It is well known that season affects the prevalence of typhoid fever. These statistics show, without doubt, an influence upon mortality also. Starting with a mortality of 10 per cent., it rises during February and March up to 12.37 per cent. Falling during April, it ascends again in May and June. The July mortality is phenomenal, reaching the maximum of 17.61 per cent. Dropping as precipitately as it rose, the mortality of August and the rest of the year varies between 10.21 and 11.75 per cent. On the other hand, morbidity is highest in January and February and lowest in the fatal month of July. Likewise, in September, when the second maximum of morbidity occurs, a second minimum in mortality is obtained. The point is made, however, that a patient dying in January, for instance, probably contracted the disease in December, in the majority of cases. Therefore, Sallom constructed a second chart, in which the mortality for any month was considered with the morbidity of the preceding month. This collaborates the first figures. With the minimum morbidity of July the first maximum in mortality is present; and with the second maximum in morbidity, occurring during September, the minimum mortality is obtained. Sallom concludes that with the maximum morbidity a minimum percentage mortality is present, and *vice versa*; and, further, as morbidity falls mortality rises.

SURGERY.

UNDER THE CHARGE OF

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The Operative Treatment of Penetrating Wounds of the Diaphragm.—MAGULA (*Archiv f. klin. Chir.*, 1910, xciii, 581) collected from the literature 129 cases of penetrating wounds of the diaphragm which had

been operated on, and adds 61 new cases. There were 64, but 3 did not come to operation. In the great majority of the cases the wound comes by way of the pleural cavity. In a very large number wounds of the breast and of the abdominal organs are associated, in Magula's cases in 59 per cent. It is incontestible and recognized nearly everywhere as axiomatic, that expectant treatment in these cases is not to be recommended, for the following reasons: (a) There is always the danger threatening the occurrence of and the strangulation of a diaphragmatic hernia. (b) There exists also the danger that the wound of an organ, the breast or an abdominal organ, will be overlooked and the patient die of internal hemorrhage or peritonitis. Since, on the other hand, the diagnosis of a wound of the diaphragm before operation is especially difficult, and, according to Magula's experience, in about 40 per cent. of the cases impossible, because of the absence of the characteristic signs, the view is gaining ground that every penetrating wound of the thorax or abdomen, not more than twelve hours old, should be enlarged and explored. Magula's experience strongly supports this view. The operation of choice for all cases is by the pleural route. Only in rare cases must the combined method, thoracolaparotomy, be employed. If the closure of the wound of the diaphragm is impossible, the pleural cavity should be isolated, that is, the edges of the diaphragmatic wound should be sutured to the costal pleura. In this way a diaphragmatic hernia is prevented and the avenue for infection of the delicate pleura is shut off.

Arthritis Deformans in Children.—PERTHES (*Deut. Ztschr. f. Chir.*, 1910, cvii, 111) says that the examination in one case showed that while flexion was free, abduction, adduction, and rotation were completely abolished. The trochanter was 1 cm. above the Roser-Nélaton line. There was no pain on movement or pressure and the x-rays showed it was not a case of coxa vara. The angle of the femoral neck was normal and the head cone-shaped rather than globular. Observation during a year gave further indications of the existence of an arthritis deformans. Within a year Perthes saw not less than 6 similar cases. Von Brunn, in 1903, collected 38 cases from the literature, 26 occurring on one side and 12 being bilateral. The frequency and practical importance of this condition in children is greater than has been thought up to the present time. In the greater number of cases trauma does not occur. There is no reason to ascribe the cause to asymmetry of the body. In one of Perthes' cases the condition originated in a bacterial inflammation of the hip-joint, although the first sign appeared only after a symptomless interval of several years. The first pathological change is often a flattening of the epiphysis of the head, which frequently results in a cone-shaped deformity of the head. The gradual change in its shape can be shown by a series of skiagrams, which also indicate disturbances in nourishment within the epiphysis and the development of subchondral foci of absorption. The limitation of movements is the direct mechanical result of the formation of the joint. Pain is not produced by active or passive movement. Spontaneous pain, on the other hand, occurs especially after long-continued walking, and not rarely is referred to the knee. Yet there occur cases in which, notwithstanding a high grade of deformity, pain of all kinds is completely absent. Crepi-