

earlier. This appeared in spite of the fact that there had been some circulation for four hours, at least a slight radial pulse having been detected at 6 p. m. At this time there was also a slight restoration of sensation.

On June 15, 1905, five days after the injury and three days after the incisions were made, the notes say that sensation had everywhere returned. This, I think, shows positively that the conclusions by the physicians at the Orthopedic Hospital, that the nerve had been severed at the time the incisions were made, to be erroneous. Nor do I believe that there could have been any involvement of the nerve in the cicatrix, for the incision was in the upper third of the arm and did not involve muscular tissue.

At the time of the patient's discharge "the tendency to contracture was quite marked." The hand was flexed at the wrist, the fingers semi-flexed, and not in the typical *main-a-griffe* shape.

I saw the patient but seldom during the interval between discharge and admission to the Orthopedic Hospital and do not know when the ulnar neuritis developed.

The points of interest in this case are, then:

1. A brachial thrombosis or embolism which was not followed by gangrene.
2. An ischemic contracture, as evidenced by rigidity of the hand and flexion at the wrist appearing not later than fifteen and one-half hours after the blocking of the circulation.
3. The re-establishment of the circulation and sensation (nerve conductivity); the sensations are recorded as everywhere present five days after the injury and three days after the incisions.
4. The onset of an ulnar neuritis at a subsequent period, due presumably to a pressure neuritis from the contracture of the degenerated muscle.
5. The probability of some involvement of the median nerve, as shown by the note from the Orthopedic Hospital, "some lessening of sensation of other fingers from the tip to the distal phalanges."
6. The partial recovery at any rate from the ischemic contracture, for when the patient presented himself at the Orthopedic Hospital he could extend the index and middle fingers as well as flex them.

I regret that it has been impossible to find the patient in order to report on his present condition.

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**Polydipsia in School Children.**—G. Paul Boncour, in *Progrès Médical*, Aug. 22, 1908, calls attention to a little noticed factor which he thinks accounts for certain difficulties in school children attributed to other factors. Certain children show a marked inaptitude for work and feebleness of attention, learn their lessons poorly, but seem more apathetic than unruly. According to the parents, such children suffer from headaches, sleep poorly, have irregular appetites, but are inclined to drink large quantities of water. These symptoms appear after the first heat of summer and can not be traced to any organic disease like diabetes, etc. Boncour attributes the nervous symptoms to a bad habit, originating in the desire for water during the first hot weather. The stomach is overloaded and dilated and fermentation and autointoxication result, which in children with a nervous predisposition reveals itself in the symptoms complained of. The desire for water is compared, by him, to a tic. The desire for drink is felt and expressed without reflection. It is simply a bad habit based on an original nervous and psychic debility already existing. The facts demonstrate, he thinks, the necessity of a medico-pedagogic study of school children presenting abnormal symptoms that are liable to be taken as the result of overstraining.

## INFLAMMATION OF MECKEL'S DIVERTICULUM SIMULATING APPENDICITIS.

D. A. EWING, M.D.

SEATTLE.

The presence of Meckel's diverticulum and acute inflammation of that rare appendage is of sufficient interest to merit reporting.

This case is especially interesting because it occurred in a man who had previously had two attacks of appendicitis and whose present illness was thought to be due to an inflamed appendix.

**Patient.**—A rather heavily built man, aged 37. As a boy he had frequent attacks of pain in lower abdomen; had an acute attack of appendicitis five years ago and another one two years ago. For several weeks prior to the present attack he had had an uncomfortable feeling in lower part of abdomen but no acute attacks of pain.

**Present Illness.**—The patient was taken suddenly with severe pain in the lower part of the abdomen about noon, Sept. 27, 1908. An ice-bag was at once applied, affording only moderate relief. I saw the patient at 4 p. m., when he was in very severe pain and was vomiting bile-stained fluid. The pain was low down on the left side and there was tenderness on deep pressure over both sides of lower abdomen and considerable muscular rigidity, the same on both sides. On account of the thickness of abdominal walls no particular point of tenderness could be found. A soap-suds enema was given and bowels moved, with considerable relief of the pain. Temperature was 98.5; leucocytes were 9,200. At 10 p. m. pain was less; temperature 100.6; pulse 92. Next morning pain was about the same; temperature 99.6; leucocytes 12,000; tenderness and rigidity continued over both sides lower abdomen.

**Operation.**—Made at 2 p. m. Incision over appendix. The appendix was firmly bound down by adhesions, and when I endeavored to get it to the surface a portion of the lower ileum came into view, showing a diverticulum about the size of a small walnut. Its attachment, as is usually the case, was opposite the mesentery. Its lumen communicated with the bowel by an opening about the size of a dime. It was acutely inflamed and contained no concretions. Its walls were thin, and while we were examining it the diverticulum inflated to twice its natural size. It was easily ingavinated into the bowel and a double row of linen sutures placed. The appendix showed only a mild degree of inflammation and was bound by adhesions. It was removed. The appearance of the appendix showed that it had been the seat of previous inflammation, but the present condition seemed hardly to account for the symptoms that the patient had. The cause of the trouble was probably the distention of the diverticulum and a consequent localized peritonitis; the walls being thin, the diverticulum could easily have been inflated to the size of a baseball.

**Postoperative History.**—The patient made a good recovery. 615 Alaska Building.

## Therapeutics

### INFANTILE PARALYSIS.

Acute anterior poliomyelitis, though by no means a frequent disease, occurs more frequently unrecognized than any other serious disease of young childhood. The difficulty of its recognition is that a mild attack may leave such slight symptoms that at first the localized muscle debility is not discovered. The future welfare of the muscles affected depends so much on the early recognition of the presence of the disease and its proper treatment that too great care can not be exercised in testing the condition of the four extremities of a child who has had a sudden unexplained febrile attack. Epi-