

ing and purging. Magnesium sulphate, by enema, as concentrated as possible, was used on account of its being the chemical antagonist of barium chlorid.

Shoemaker states that $2\frac{1}{2}$ grains of barium chlorid have caused death when given in divided doses. The U. S. Dispensatory mentions two cases. In one, in which 60 grains were taken, the patient recovered; while in the other death followed the taking of 300 grains in five hours. I have been unable to find any other references in a number of available works on materia medica. I find that the weight of the one and one-half drams, by measure, taken by this patient, would be approximately 250 grains.

CHRONIC SUPPURATIVE PAROTITIS CAUSED BY THE STREPTOCOCCUS MUCOSUS CAPSULATUS

REPORT OF A CASE

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SURGICAL REPORT BY DR. McKENNA

The tumor in this case resembled, in contour, firmness and close connection with the ramus of the jaw, a sarcoma, but a positive diagnosis could not be made without the removal of a piece of the tissue for microscopic examination. In doing this a small amount of pus escaped from the depth of the gland and was sent to the laboratory for examination.

History.—Miss T. L. reported at the hospital complaining of a swelling in the region of the right parotid gland accompanied by severe pain in opening her mouth. The swelling had appeared three days previously (May 22, 1909). The family and personal history are negative except for the following points:

The patient had had measles and diphtheria. About twelve years ago an abscess had appeared on the right side of the face in the same region as the swelling mentioned above. This had been opened and drained by the family doctor. Since that time exposure to cold caused the patient pain and swelling in the same region and would last only a short time and then recede completely. The patient was always troubled with boils and carbuncles. The patient lives at home and works downtown as a clerk. She gets very little exercise, arises early and retires early; she does not eat much and very often skips her meals. She uses tea and coffee moderately.

Examination.—Negative except the above-mentioned swelling, which was a solid, spherical tumor situated in front of the ear and extending over the upper ramus of the jaw on the right side and so intimately associated with the jaw-bone that for a time it was thought that there might be a connection between the two. The patient was treated at the hospital for one week before being operated on, during which time an attempt was made to reduce the swelling by hot compresses frequently applied. The mass was so persistent that it was decided that it should be opened and a piece removed for examination. The report of this examination by Dr. Davis follows. The wound was drained for one week and the patient made an uneventful recovery.

BACTERIOLOGIC REPORT BY DR. DAVIS

In smears obtained from the operation wound Gram-positive diplococci and short chains were found in small numbers outside the many polymorphonuclear cells present. Cultures made on plain media give a pure growth of an organism presenting all the characteristic features of the *Streptococcus mucosus capsulatus*. It was Gram-positive, non-motile, arranged in pairs or in short chains and possessed a definite capsule. The growth in twenty-four hours on blood-agar slants was raised, moist, profuse and mucoid in character, and when left in the incubator forty-eight hours the slimy mass largely disappeared,

leaving a smooth shining surface. On blood-agar plates about the colonies was a distinct greenish halo. This organism was practically non-phagocytatable *in vitro* by human leucocytes plus human serum, and three small loops in 1 c.c. of salt solution injected into the peritoneal cavity of a guinea-pig caused death in forty-eight hours. The organism was recovered in pure culture from the peritoneal serofibrinous exudate and the heart blood of the animal.

Pieces of the parotid gland from the region of the abscess were sectioned and presented evidence of a marked chronic inflammatory reaction. The gland tissue was infiltrated with large numbers of round cells and a few polymorphonuclear cells and considerable increase of the connective tissue in places occurred.

Encapsulated streptococci have been described by numerous observers. Howard and Perkins¹ were among the first to describe this organism and it was they who first called it *Streptococcus mucosus*. Schottmüller,² Newmann,³ Richardson,⁴ and Longcope⁵ have all described organisms which probably are identical with this streptococcus. Buerger⁶ has recently given a good review of the subject.

This organism not infrequently occurs in the sputum in various throat and lung infections, especially croupous pneumonia, and is commonly found in ear discharges in otitis media, which explains its relative frequency as the cause of acute meningitis. Of seven cases of infection with this organism reported by Schottmüller, three were acute meningitis. I have isolated it in pure culture in a case of meningitis following otitis media and have cultivated it from the throat in cases of acute articular rheumatism, lobar pneumonia, "grippe," and from the ear discharge in otitis media. Longcope obtained it from an abscess in the breast wall and from the blood in a case of lobar pneumonia, and Howard and Perkins from an ovarian abscess and the organs post-mortem. It evidently may localize in various parts of the body, though preferably it localizes in the respiratory tract or its accessory structures. I have not been able to find reported other cases of chronic suppurative parotitis due to this organism.

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PERFORATING ULCER OF THE SIGMOID—A SEQUEL TO MEASLES

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Involvement of the intestinal tract in measles is by no means an unusual complication, diarrhea and dysentery being occasionally seen. In a careful review of the available literature found in the library of the New York Academy of Medicine, I failed to find any record of intestinal perforation in this disease; but it is logical to presume that it could occur. Various authors state that post-mortem findings have shown Peyer's patches to present the same ulcerated condition found in typhoid fever. Dawson Williams,* of London, in speaking of gastrointestinal complications of measles, mentions a case in which dysentery occurred and post-mortem examination showed intense enterocolitis of sigmoid and rectum, with ulceration identical with that seen in true dysentery.

1. Howard and Perkins: Jour. Med. Research, 1901, vi, 163.
 2. Schottmüller: Med. Wehnschr., 1903, I, 909.
 3. Newmann: Centralbl. f. Bakteriöl., 1904, xxxvii, 48.
 4. Richardson: Jour. Boston Soc. Med. Sc., 1900-01, v, 499.
 5. Longcope: Univ. Penn. Med. Bull., 1902, xv, 51.
 6. Buerger: Centralbl. f. Bakteriöl., 1906, xli, 314.
- * Williams, Dawson: Twentieth Century Practice of Medicine, xiv, 145.

REPORT OF CASE

History.—A. S., farmer boy, aged 14, one of several children, had had good health until he became sick with measles in February, 1909. The attack was of unusual severity with marked gastrointestinal complications, dysentery persisting after the usual symptoms had disappeared. The dysentery ultimately ceased and was soon followed by symptoms consisting of pain, increase in size of abdomen, nausea, fever, and constipation, which seemed to the observer to indicate intestinal obstruction. I was called by the attendant on March 5 to operate for a supposed intestinal obstruction.

Examination.—Patient's temperature was 104, pulse 120; appearance indicated sepsis; abdomen was enormously distended; there was complete dullness from one iliac crest to the other, and from umbilicus to pubes.

The examination did not suggest intestinal obstruction to me. The boy's condition being critical and the nearest hospital sixty miles away, I undertook the operation amid very dirty surroundings, two other children being sick of measles in the same house, which contained three small rooms.

Operation.—After such preparations as were possible, the boy was placed on the kitchen table, and after the usual toilet of the operative field the abdomen was opened by a median incision, which was followed by the discharge of huge quantities of pus and fecal matter. The abscess cavity, however, was well walled off. After cleansing the cavity a ragged hole was seen in the sigmoid, large enough to admit two fingers. The opening in the bowel was surrounded by an indurated area, such as one finds in ulcer. On account of the considerable destruction of tissue, and for fear of disturbing the adhesions, no effort was made to suture the bowel. The cavity was wiped clean and drainage established.

Postoperative History.—The patient was put to bed in good condition and placed in the Fowler position. The subsequent history was uneventful, the bowels moving normally on the second day. The after-treatment was left to the attending physician. I saw this boy about three weeks after the operation, the abdominal wound was practically healed, bowels moving normally and general health good. It is now over eight months since the operation; the patient is in perfect health with no symptoms of cicatricial stricture of bowel which I feared might occur. The apparent rarity of bowel perforation in measles prompts the report of this case.

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DIVERTICULUM OF THE STOMACH

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In a clinic characterized by a large percentage of digestive disturbances, I have found it easy to distinguish a certain number in which the symptoms were due to gastric or duodenal ulcer. This statement I make, because in all cases in which operation has been performed on this diagnosis, I have demonstrated the ulcer on the table. The following case is reported because of the definiteness and simplicity of the symptoms, their difference from the symptoms of the more usual conditions, and their complete explanation by the pathologic findings at operation. These last may be briefly described as narrowing of the pylorus and diverticulum of the stomach caused by stretching of its wall, the whole being due to the scar of an old ulcer completely healed.

History.—A. B., aged 56, fisherman (Hosp. No. 457), was subject to indigestion for some years but two years ago began to have severe pains in epigastrium after eating. At times he would vomit, very bitter substance; and the vomiting gave immediate relief. Otherwise the pain would last perhaps from fifteen minutes to half an hour. Since then he has eaten only liquid food. The eating of anything solid always causes this pain, which is unbearable. He has always been well and healthy in every other way.

Physical Examination.—A well-developed and nourished healthy looking man. Physical examination shows nothing abnormal. He shows the epigastrium to be the seat of the pain and says there is tenderness there at the time the pain is there. There is now no tenderness on deep pressure.

Operation.—Oct. 18, 1909, after the usual preparation, the patient was operated on under ether anesthesia. The stomach, the capacity of which was normal, was washed out on the table. A four-inch incision was made in midline between ensiform and umbilicus. With the exception of the following condition, the abdominal contents were normal. There was a whitish-looking scar running from the upper part of pylorus downwards and to the left along the anterior stomach wall. To the right of this was what I took at first to be the duodenum but which turned out to be a diverticulum of dilated stomach wall, lying in front of the duodenum and capable of holding about six ounces. There were no adhesions or palpable thickenings of the walls. The stomach was opened by an inch incision on its anterior aspect. The finger carried forward, toward the pylorus, entered a ring of tissue which just admitted it. Feeling around, the finger entered another ring, which just barely admitted it. This latter turned out to be the pylorus lying behind and above the former, which was the opening into the diverticulum. Inspection showed no ulceration of the mucous membrane, which looked normal. With a finger in the pylorus, an incision an inch and a half long was made in the pylorus extending (longitudinally to axis of stomach) from the duodenum across the pylorus into the diverticulum. This incision was then sewed up transversely to the axis of the stomach. This pyloroplasty caused, at the same time, enlargement of the pylorus and drainage of the diverticulum. The hole in the anterior wall was then closed in like manner by an over-and-over stitch through all layers, followed by a continuous Lembert suture. The abdominal wall was closed by layers.

Recovery was uneventful. The patient has been on ordinary diet and has had no symptom since.

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APPENDICITIS DUE TO THREADWORMS

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The patient, a married woman aged about 21, suffered with intense pain at McBurney's point, together with intense nausea. She had no desire for food and, when food was taken, it was immediately rejected. On Sept. 8, 1909, about two weeks after I first saw the patient, I operated, removing the diseased appendix. The contents of the appendix were forcibly expelled on my finger, and live worms could be seen crawling therein. The appendix contained about eighteen threadworms. The mucosa of the appendix was congested and thickened, and contained many punctate hemorrhagic spots. The patient made a good recovery.

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APLASIA OF THE UTERUS

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Several years ago I reported¹ a curious malformation of the internal genitalia in a child, classifying the malformation as either pseudohermaphroditism masculinus externus or bilateral inguinal hernia of the ovaries with aplasia of the uterus. Since reporting this case I have seen two other cases in which I was unable to detect a uterus. Neither of these presented the condition found in the labia majora in the reported case, but both gave evidence of a marked interference with the development of the internal organs of generation.

1. Patton, C. L.: Case of Malformation of the Internal Genitals with the Reproductive Glands in the Labia Majora, *Am. Jour. Obst.*, October, 1904.