

Albo, W. L. THYROID INSUFFICIENCY IN INFLUENZA. [Prog. de la Clinica, 7, March, 1919.]

Two young girls, aged 11 and 10, respectively, had severe attacks of influenza with headache, sleepiness and a mild grade of amnesia. He interpreted these symptoms as due to a subacute thyroid deficiency. In one of these patients thyroid treatment improved the somnolency, the headache disappeared and the memory soon returned. The second patient yielded to the thyroid treatment so far as the headache was concerned, but the somnolency and the memory impairment persisted for three weeks at least. Influenza may exaggerate the function, at times, of the thyroid with symptoms of exophthalmic goiter.

McCaskey, G. W. HYPERTHYROIDISM. [Jl. Am. Med. Assoc., July 26, 1919.]

The basal metabolism and hyperglycemic tests of hyperthyroidism, more especially in regard to the mild and latent cases, are here discussed by McCaskey. The two pressing needs, at present are, first, the differential diagnosis of the borderline cases and the determination of the toxicity of goiter, and, second, the objective determination by the basal metabolism and alimentary glycemic tests. The basal metabolism is the most important of these, understanding by it "that minimal quantity of metabolic change essential to the neuromuscular and secretory phenomena of what might be called the basal and necessarily continuous functions—respiration, circulation and secretion. Rest and food abstinence approximately eliminate all other metabolic activities." The basal metabolism can be quickly and accurately determined by measuring in the fasting subject the oxygen consumption with a Benedict portable respiration apparatus. The average normal heat production, which is an accurate index of metabolism, is about 34 calories for men and 32 for women per square meter per hour under the conditions indicated. Physiologic variations of this are not over 10 per cent., and generally much less, and may occur in either direction. But in hyperthyroidism there is an increase up to 100 per cent. or more, according to the severity of the intoxication, varying according to the case, and in the same case at different times. There is also a diminished tolerance for carbohydrates with alimentary hyperglycemia, and also with glycosuria whenever the hyperglycemia exceeds the renal glucose threshold of the individual case. In every one of the thirty-one cases studied by McCaskey, the blood-sugar content was increased within two hours from 50 to 200 per cent. In 70 per cent. of the thirty-one, the maximal rise occurred at the end of the first hour, and a more or less sharp decline at the end of the second, thus showing that the crest had been passed. Exceptional cases, in which the rise was highest at the second hour, are explained by gastric hypomotility and slow intestinal absorption. "The failure of the hyperglycemia to rise proportionately and to bear any direct rela-

tionship to this intensity of the thyrotoxicosis metabolism suggests that it is an indirect phenomenon due, perhaps, to overexcitation of other organs, for example, the pancreas, which, in exceptional cases, fail to respond to the thyroid stimulation." Use of these tests will probably reveal a greater incidence of hyperthyroidism than has previously been recognized and will enable one to make a clear diagnosis between toxic and nontoxic goiters. While neither increased metabolism nor alimentary hyperglycemia are pathognomonic, together with clinical symptoms they can make a clear-cut diagnosis of the condition possible.

Frankau, C. OPERATION ON SIMPLE GOITER. [Br. Med. J], June 28, 1919, Med. Rec.]

Frankau considers the surgical treatment of simple enlargement of the thyroid gland by a review of fifty cases. Under the head of simple enlargement he includes the following: (a) Colloid goiter, a term which he prefers to parenchymatous goiter, since histologically the most marked change is increase of colloid with distension of the vesicles. A large proportion of the early "soft" cases are amenable to medical treatment, and operation should only be performed for definite symptoms or severe deformity, and for cosmetic reasons require careful consideration. The symptoms most commonly complained of are due to pressure on or dislocation of the trachea, a condition most likely to obtain if the goiter is asymmetrical or partly intrathoracic. Occasionally there is dysphagia. The most advanced cases of this type the author places in the next class. (b) Diffused adenoma. The pathology of this condition is a little obscure; some cases are definitely due to the presence of multiple small cystadenomata with little or no capsule to the growths, others appear to be result of fibrosis in a colloid goiter. The symptoms are nearly always those of dyspnea—especially at night and on exertion. The goiter in these cases grows to a very large size. Palliative treatment gives no relief, and operation is justifiable if the enlargement is marked, even if no symptoms are present. (c) Encapsulated cysts and solid adenomata. Of the 50 cases under discussion, 32 were of this type. The cysts are not infrequently multiple and may grow to a very large size. Usual symptoms are those of dyspnea; pain or dysphagia may occur, but are rare. Even if no symptoms are present, operation is advisable if the tumor is of any size, and particularly if it is situated in the isthmus. The most difficult and dangerous type of case is where the cyst is partly or completely retrosternal, when symptoms are much more severe and stridor may be marked. Any intercurrent respiratory diseases may easily be fatal, and in one of the author's cases sudden death from suffocation occurred as a result of hemorrhage into the cyst before operation could be performed. In five cases there was a history of rapid increase in size of the tumor with exacerbation of symptoms, due in every case to hemorrhage into the cyst. The author also points out the