cacy. Lack of laboratory facilities in isolated localities would prevent the application of this form of treatment to a great extent, but in our large towns and cities, where good laboratory equipment is found, there is no reason why an autogenous vaccine should not be prepared in from twenty-four to forty-eight hours. A successful polyvalent serum seems to be impractical, and even if it were practical, it is more than likely that stock preparations frequently would be found to lack the valence demanded by a particular infection.

The question of diagnosis enters largely into these cases, and here the greatest likelihood is that of overlooking diphtheria. When this question is present I think the patient should have the benefit of the doubt, and receive a large injection of anti-diphtheritic antitoxin. This may exercise no influence on the ultimate course of the disease, but so many cases of streptococcus infection of the throat present

the appearance of diphtheria, that it is best to at least give a good-sized dose of antitoxin where the condition is in the least suspicious. When seen by me a week ago, May 11, 1912, there was no aural discharge, and hearing was normal.

I believe that a large portion of the fatal cases of diphtheria seen nowadays, which fatalities do occur at times even where antitoxin is early used, are due to the pernicious action of the streptococcus associated in mixed infection. Certainly those cases of a pronounced type of mixed infection of this character run a malignant course. Yet, on the other hand, it cannot be questioned that there is a type of streptococcus infection of the throat, without the association of the diphtheria bacillus, producing great prostration in the patient, and assuming occasionally a most malignant aspect.

Memphis Trust Building.

A CASE OF OVARIAN PREGNANCY.*

By J. B. ELIOTT, M.D.,
Moundville, Alabama.

Patient, Negro, Age 26—Gave no history of specific troubles, but presented some signs of having had syphilis, though she denied it. There was no hair on her scalp or pubis. Her mother said the patient had been a taker of teas, and a user of other so-called preventatives of pregnancy, and abortifacients. She had been fairly regular in menstruating, most of her life since fourteen years old. Had one child now living, seven years old.

In May last year (1909) she had a miscarriage, and has menstruated none since then till in November. November 8 she first came under my observation. At the time she first consulted me she was apparently in good health, except that she was not menstruating, and asked me to treat her for her condition, which I concluded was only one of amenorrhea. She

was having some slight symptoms of an approaching menstrual epoch. I saw her two days later. She was then suffering from malaria complicating the menstrual symptoms. She was relieved till a few days later when the menstrual epoch came in about its normal way, or as it usually occurred with her. In the latter part of December she menstruated profusely for about ten days. January 14 and 15 I treated her for an attack of influenza. In February she saw just slight signs of menstruation. March 1 she came to my office complaining of some abdominal swelling, located in the uterine region, and some digestive disturbance. Said she began to notice the enlargement of her abdomen as soon as she got up from the attack of la grippe in January, but felt special pains only occasionally, which

*Read before the Hale County Medical Society at its April meeting, 1910.

she described to be, and thought were, gaseous. She thought she was pregnant, and looked as if she were. I put her on a simple treatment for the digestive symptoms.

March 4 I was called to see her, and found her suffering severe pain that had started on March 1, as she returned from my office over the rough, swamp road.

The pains had grown worse till by the 4th she was suffering terribly, as she described it. The pains resembled abortion pains, or those of a threatened miscarriage, continuing all the time, but more severe at intervals of from fifteen minutes to an hour. Her pulse was 114, temperature 100 1-2, abdomen enlarged, very sore and painful to touch, with a smooth, shiny appearance, with an oblong, glossy elevation at and around the umbilicus. This particular point was extremely sore. While the entire abdomen was tender, most of her pain was in the left side. On percussion dullness was elicited and the pain intensified. Fluctuations were felt at the top of the tumor, with a semi-solid or spongy feeling mass at bottom, or nearer the symphysis. Vaginal examination showed the uterus pressed down, and of a normal, or practically normal, size. Later in the day I saw her again. Pulse and temperature were the same as in the morning. By this time a thick, tough, glairy and bloody mucus-like discharge was coming from the uterus. All day she had been on a sedative treatment, which had accomplished nothing in the way of relief. This treatment was continued, except that it was made more sedative. By 10 o'clock next morning (March 5) I received word to send her something to keep her quiet that day, and not to visit her any more till I heard again how she was. She was reported better, and had been all the night before. All the time after my first visit and examinations I felt sure of an ovarian cyst, or a tubal or ovarian pregnancy.

In the afternoon of the 6th I was again sent for. The patient was still suffering constant pain. Pulse 118, temperature 101 1-2.

Her abdomen had continued to enlarge till it had gotten to be the size of an abdomen at about the seventh month of pregnancy as compared to an appearance of about a three or four months' pregnancy only three days previously. The pain on touch was more severe than before. Patient was complaining of painful and frequent urination, due to pressure. Urine was voided plentifully. Dr. Williamson was called in consultation the 7th and confirmed my diagnosis of a cyst or ruptured extra-uterine pregnancy. We catheterized and got about four ounces of urine, then we tapped the abdomen in the median line about half way between the umbilicus and symphysis. The fluid that came away was very bloody water, the canula at times becoming plugged, apparently with clots. We then thought we had a malignant cyst with twisted pedicle. The amount of fluid drawn off was between one-fourth and one-half gallon. The tapping furnished some relief. Patient was then put on just codeine sulphate enough to keep her quiet, and Epsom salts to keep her bowels freely open. This treatment was carried on for one week, by which time pulse rate had returned to 98 to 100, and temperature had reached 99 1-2.

On March 15 she was sent to a sanitarium in Tuscaloosa, and operated on the 16th. The abdomen was opened in the median line. The mass was found to be bound by numerous adhesions, all of which were very easily broken up. One band of adhesion about two inches broad extended from the front of the mass to the diaphragm and was adherent all the way. Just the weight of the hand was all that was necessary to break up the adhesion. An attempt was made to move the mass, but it broke up and had to be removed part at a time. It was a hematoma containing both old and fresh looking clots, considerable dark, unclotted blood, some fresh blood and large amounts of hypertrophied ovarian tissue. Proper ligation was done and the sac, including the entire left ovary, was removed. The abdominal cavity was washed out with normal

salt solution, part of which was left in the abdomen. The total mass would have weighed about fifteen pounds. It was carefully examined for a fetus, but none found.

While we found no fetus, we were practically sure of an ovarian pregnancy that had been ruptured long enough for the fetus to have disintegrated and been absorbed, with a continuous hemorrhage into the sac.

The patient had an uneventful recovery and is now doing nicely.

DISCUSSION.

Dr. Crisler, Memphis, Tenn.—Such a case of ovarian pregnancy is very rare, doubted by many to have ever existed. Dr. Elliott, I take it, is sincere—I give him credit for that—and while I believe that he thought he had an ovarian pregnancy, it occurs to me that his report would lack evidence, because he had not a pathological report of every feature showing the existence of extra uterine pregnancy. Take a tumor weighing at least fifteen, and probably twenty pounds, and you have a pretty big tumor, and, I fancy, in pregnancy you would find a pretty good sized foetus. The case is such that, for want of accurate pathological report, the doctor would have right to believe that he had a case of ovarian pregnancy. I believe, of course, that those things happen, but they are very rare, and I am sorry he did not go into it more deeply and convince everybody that he had a case of that kind, instead of just stopping and saying he thought he had it. I want to ask the doctor what positive proof he had of pregnancy. Formerly it was thought that ovarian pregnancy was impossible, but it has been proved in late years that it may happen, although it is very rare, and generally, instead of being a true ovarian pregnancy, it is a tumor—an ovarian cyst with a ruptured vessel filled up full of blood. I would like to ask the doctor to state positively why he thought the patient was infected.

Dr. Elliott—Mr. President and Gentlemen: I appreciate the criticisms as well as the interest felt in the paper, and in response to any criticism as to our tapping that abdomen will say that you will notice that in three days' time that abdomen

had grown to assume the appearance of a seven-months' pregnancy as compared with an appearance of a three-months' pregnancy three days before. We were away off down there in a river swamp, five miles from the nearest railroad station, and the woman in no condition to go to a hospital and her abdomen still enlarging and she was growing worse all the time. With an increase in size that fast, we felt sure we had a good amount of some kind of fluid and we thought if we could get some of it out of her and afford the patient some relief it would be the proper thing. We knew if we had her in a hospital the simple thing would have been to open her and remove the tumor, but the circumstances were such that we could not. Operations of any nature, whether major or minor, are unsatisfactory if done in a negro house and under the circumstances existing there. We did it as a matter of relief to the patient. That abdomen was still growing and becoming more painful all the time; we catheterized her so as to be sure the bladder was out of the way. That is why we did the justly criticizable thing in tapping instead of opening the abdomen.

Now as to Dr. Crisler, who wanted to know what evidence we had of ovarian pregnancy, we had more evidence of that than anything else. We had an absence of menstruation for six months; she began to menstruate a little bit in November and in December, such as you usually find in ovarian pregnancies. She had profuse menstruation for about ten days; in February it appeared again, but just slightly. Those things all go along with ovarian pregnancies. That was the best conclusion we could arrive at without going into a microscopic examination of the tissues. We decided we had a case of ovarian pregnancy, which, we believed, took place only a very short while before the rupture happened, and when it did rupture, why, the foetus was small and it could have been overlooked in that mass or could have been possibly disintegrated. We had, from a medical point of view, more evidence of an ovarian pregnancy than of anything else that came into our minds.

While we flushed out there, the mass, when we went to remove it, broke and we had there in the abdominal cavity quite a number of blood clots, some of them old and very tough, and we washed them out. We thought it was the best way to get them out. Then, as some of the doctors said, we have good authority for flushing out and some against it. We washed it out simply because we thought it was the best thing to do under the circumstances—better than to wipe it out.

I believe I have nothing further to say.

THE FIRST BOOK ON PELLAGRA BY SOUTHERN AUTHOR.

PELLAGRA.

By George M. Niles, M.D., Professor of Gastroenterology and Therapeutics in the Atlanta School of Medicine, Atlanta, Ga. Octavo of 253 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1912. Cloth, \$3.00 net.

This volume of some 250 pages presents the subject of Pellagra in Dr. Niles' characteristic, clear

and concise style. His subdivisions of the subject matter, the splendid bibliographic and general index and the illustrative cuts make the reading of the subject facile and profitable.

The chapters on the History of Pellagra, its incidence in America, the Symptoms and Clinical Course of Pellagra and those on Treatment and Prophylaxis are especially interesting and valuable.

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