a somewhat tender and prolapsed ovary upon the left side; a small bi-lateral tear of the cervix uteri, and the womb bound down to some extent by adhesions. Her general condition did not warrant operative interference, even had that step been deemed advisable. She was therefore, placed upon medicines of a tonic nature and kept at rest in bed. This treatment was kept up for some little time, and though it improved her condition somewhat, her progress toward health was not marked. About a month after her admittance into the hospital I noticed, in making my morning rounds, that patient was very stupid and drowsy, and unable to answer questions readily. This condition grew worse, and at night she was in a profound stupor from which it was impossible to arouse her. It was noticed at this time that the right pupil was markedly dilated and the left one about normal. At first it refused to contract to light, but about an hour later responded to light from a candle (though very sluggishly).

The next day she was quite rational and able to talk. It was at this time that specific trouble was suspected, and a careful examination to confirm this view was now made, resulting in finding marked tenderness along the crests of the tibiae, and the soft palate was found to be entirely ulcerated away. There was also evidence of pre-existing buboes. Tenderness was noted along the nerve trunks, especially of the arms; absent, however, along the spinal column.

The case was now turned over to Dr. Wood, and at his suggestion was placed upon the mixed specific treatment, consisting of potass. iodide, grs. xx, and hydrarg. bichlor. corros., gr. $\frac{1}{4}$ t. d.

It was now observed that the pupils were unequally dilated; that the tongue was drawn to the right side and that the corner of the mouth on that side was lower than the left. There was also distinct though not entire loss of sensation in both arms. Power was greatly diminished. Sensation was retarded on both sides of chest and abdomen. There was no loss of motor power or of sensation in the lower extremities. Ptosis was present on the right side. The potass. iodide was now increased to grs. xl, and the bichloride to a twelfth, t. d.

Examination of the urine resulted negatively. Patient still continued to improve. Headache grew better and the change was generally marked.

Ten days after the last increase was made in the potass. iodide, it was again increased to one dram t. d. This dose, together with the $\frac{1}{2}$ gr. bichlor., was kept up for some time until diarrhœa ensued, when they were both reduced.

After a month and a half of this treatment, patient was hardly recognizable as her former self. Had regained flesh and was mentally, as well as physically improved. The paralysis had long since disappeared, and she was able to be up and about. She was discharged and advised to pursue treatment for some time to come.

At last accounts she was doing well and had no return of previous attacks. Her head was also comparatively free from pain.

At the onset of the attack of coma, which occurred in the hospital, the patient was perfectly quiet and relaxed. There was no evidence of hemiplegia or of palsy, although after recovery of consciousness paralysis was noted.¹ That the diagnosis of cerebral syphilis

was correct in this case, I think the evidence upon the patient's body conclusively proved, and was further decided by the so-called therapeutic test, about which Prof. H. C. Wood speaks in the following terms:—"In all cases of doubtful diagnosis the so-called therapeutic test should be employed, and if sixty grains of iodide of potassium per day fail to produce iodism, for all practical purposes the person may be considered to be a syphilitic. No less an authority than Seguin has denied the validity of this, but I believe, myself, that some of his reported cases were suffering from unsuspected syphilis. I do not deny that there are rare individuals who, although untainted, can resist the action of iodide; but in ten years' practice in large hospitals, embracing probably some thousand of cases, I have not met with more than one or two instances which I believe to be of such character; of course in making these statements I leave out of sight persons who have by long custom become accustomed to the use of the iodide, for although in most cases such use begets increase of susceptibility, the contrary sometimes occurs. Of course the physician who should publicly assert that a patient who did not respond to the iodide, had syphilis, would be a great fool; but in my opinion the physician who did not act upon such a basis would be even more culpable."²

The symptoms which occurred soon after the attack of thermic fever, and which plainly pointed to a specific origin, evidently were prematurely induced by the sunstroke. The case is interesting on this account, as well as from its curious manifestation of disease which led to a correct interpretation of the true trouble and finally to, if not its cure, its amelioration.

EARLY DIAGNOSIS AND OPERATION IN A CASE OF ULCERATIVE APPENDICITIS.

BY BURNSIDE FOSTER, M.D., MINNEAPOLIS, MINN.

A BRIEF report of the following case, which recently came under my observation, will, I think, be of interest to the readers of the JOURNAL.

I was asked by my friend, Dr. Knut Hoegh, to see in consultation H. M., a Norwegian merchant, age 37. For the last six or seven years he had been subject to attacks of colic, at first of moderate intensity, but which, later, became more frequent and severe. These attacks were usually accompanied by diarrhœa, but the patient could not say whether this preceded or followed the attack. At first there would be intervals of six months or so between the attacks; but during the last fifteen months there have been five attacks, each one worse than the preceding; and he would be left weak and ill and unable to attend to his business for many weeks at a time. Sometimes the attacks would come on at night while he was asleep, and he would be waked up with an aching pain over the whole abdomen, which would always settle in the right iliac region. The pain would steadily increase, and would often be accompanied by chills and attacks of shaking. There was nausea and wrenching, but never vomiting. There was always extreme pain and tenderness in the ilio-cæcal region over a space the size of a silver dollar. There was sometimes difficulty in urination, but he never passed anything abnormal, and there have been no signs in the urine.

¹ Similar cases are recorded by Dr. J. Althaus. Medical News, vol. xlix, p. 428.

² Wood. *Pepper's System of Medicine*. Vol. v, p. 1013.

No blood or anything abnormal has been passed by rectum. Lungs and heart apparently healthy. He complains of a constant feeling of being bloated, — as if his bowels had not moved sufficiently. Appetite usually good, and he is never distressed by food.

The above history was obtained from him in June, and he was treated symptomatically, and sent back to Dakota, where he remained without any improvement until early in August.

I first saw the patient August 15th. A careful physical examination, both externally and by the rectum, failed to discover the slightest tumor or swelling in any part of the abdomen; but midway between the umbilicus and the spine of the ilium, over the ilio-cæcal region, there was a spot about the size of a silver dollar which was very tender on pressure. Dr. Hoegh and I arrived independently at the same conclusion, that there was some inflammatory trouble with the appendix vermiformis, and that the patient's condition justified an exploratory operation. The patient himself, an intelligent man, agreed to anything which offered a hope of relief.

August 19th, the patient having been kept for a couple of days on liquid diet, under chloroform anesthesia, Dr. Hoegh made an incision about four inches long in the right linea semilunaris. On opening the peritoneum, the cæcum and appendix were readily found, the latter pointing downwards and toward the median line. The process had a peculiar, firm, elastic feeling, and was about two inches long. At its base there were some not very fresh adhesions, which were easily separated. The process was ligated at its junction with the cæcum with stout silk, and amputated. The serous surfaces were stitched over the stump with fine silk. Dry gauze napkins, previously boiled, were used instead of sponges, and the wound was kept perfectly aseptic. The edges of the wound were united throughout and closed without drainage.

At the conclusion of the operation the appendix was examined, and presented the following condition: It was about two inches long and somewhat thickened in the centre; the opening into the cæcum was quite contracted, being smaller than the lumen of the process; on opening it, there escaped at once about half a drachm of dark brown pus, the odor of which was fetid rather than feculent; the mucous membrane was the seat of two ulcers, neither of them very deep; the largest one was near the centre, being about a quarter of an inch in length, and occupying nearly the circumference of the appendix; the other smaller one was near the apex, and was about the size of a split pea. The subsequent history of the case has been uneventful.

Reports of Societies.

NEW YORK COUNTY MEDICAL ASSOCIATION.

STATED MEETING, May 20, 1889. The President, CHARLES S. WOOD, M.D., in the chair.

Dr. T. H. MANLEY read a paper on

THE OPERATION FOR STRANGULATED HERNIA BY THE MCBURNEY METHOD, WITH REPORT OF THREE CASES.

Since January 1st of the present year, he said he had had in his hospital service three cases of strangulated inguinal hernia, all of which were operated on

as quickly as possible after admission, with a view not only to relieving the constriction, but also at the same time permanently curing the patient by means comparatively simple, and by all odds the safest yet devised. For the procedure adopted in these cases the profession was indebted to one of New York's most distinguished surgeons, Dr. Charles McBurney, who had thus added one more gem to the diadem of American surgery.

McBurney's operation was characterized by a few cardinal points which were decidedly original, and which, if well understood and skilfully applied, must always lead to successful results. These were: (1) An open wound; hence no septic infection or purulent infiltration. (2) The excision of the sac. (3) The suturing of the cutaneous and aponeurotic edges of the wound together. (4) The closing in of the breach by connective, scar or cicatricial tissue formation.

The difference in the character of the three cases in question rendered necessary some modifications in their management; but in all, there were followed out the fundamental points laid down by McBurney, whose operation was recommended for every variety of abdominal protrusion, wherever or whenever found.

The first case was that of a male forty-five years of age, whose hernia, on the left side, had existed as long as he could remember. From time to time the protrusion would disappear spontaneously, though he always wore a truss; and up to the day before he entered the hospital the patient had not noticed it for more than four months. On this day, after unusual straining at stool, the tumor reappeared larger than ever, and unusually tender to the touch. The man himself and his family physician both having failed in reducing it, he was sent to the hospital, where he was seen by Dr. Manley. At this time there were no signs of strangulation, and as his condition was very good, he refused to submit to an operation, which was strongly urged. Topical applications were applied for the purpose of favoring reduction, and these were followed by temporary relief; but, four days after the reappearance of the hernia, well-marked symptoms of strangulation declared themselves.

The patient was now eager for the operation, and an anæsthetic having been given, the skin was quickly opened by one bold stroke of the scalpel carried from a point just over the internal opening of the inguinal canal to an inch below the external ring, and then the coverings were divided until the sac was reached; the upper part or neck being first sought, and the body cut down later. The sac was found to be an old one, and bound down by very firm adhesions, which were separated only with the greatest difficulty. Within the sac was found a knuckle of intestine, with a large quantity of effused serum. It was calculated to leave the spermatic cord alone in operating; but in this case there was no spermatic cord, either within or without the sac. When the canal was opened the cause of all the trouble was found, viz., an undescended testis, which was normal in shape, but was not larger than a kidney bean. By making considerable traction it could be readily brought out of the canal, and Dr. Manley considered the fact that the inguinal opening was patent throughout its entire length, attributable to the defective development, the testis sometimes slipping down through the ring when there was much straining, and then