rensic Medicine, state that the symptoms of shock are usually immediate, but there may be an interval between the accident and the symptoms. In this case we may perhaps assume that the lighter blows were first delivered, and that only as the officers came up stairs and the increasing probability that he would be taken alive was forced upon him did he deliver the heavier and more fatal blows.

I think, then, we may say that while it would be more natural to expect immediate insensibility, it is not impossible that the power of locomotion may remain for a brief period, and yet the patient die of shock.

(4.) Could the wounds on the head have been self-inflicted? The announcement of the result of the autopsy, that Cate had committed suicide, was received with considerable incredulity not only by the laity but also by some of the profession. Leaving out the evidence, however, there were some things in the character of the injuries themselves that looked like suicide. That the wounds were all either on, or to the right of, the median line, looks as if they were given chiefly with the right hand of the person himself. The nine convex cuts, all crowded into a comparatively small place, show that the head must have been kept quiet while the blows were delivered. In any personal conflict it would be almost impossible that nine wounds should be received in a space of two square inches unless we assume that the receiver was insensible. Moreover, these wounds were all shallow, evidently given with feeble force, characteristic of suicidal rather than homicidal violence. "Contused wounds," says Taylor, "are rarely seen in cases of suicide, but there are exceptions to this remark. When persons laboring under insanity commit suicide they often inflict upon themselves wounds of an extraordinary kind, such as would at first view lead to the suspicion that they had been produced by the hand of a murderer. In one instance which is reported, a lunatic in committing suicide inflicted thirty wounds on the head." I think we can say, then, that it was perfectly possible that the wounds were self-inflicted, and yet in the death and in the whole story there remains sufficient mystery to make it what I have styled my paper, *A Strange Case*.

A CASE OF TWO-HORNED UTERUS (UTERUS BICORNIS).

THE LEFT HORN NOT COMMUNICATING WITH THE VAGINA AND DISTENDED BY MENSTRUAL BLOOD, FORMING A LARGE TUMOR. SUPRA-VAGINAL REMOVAL OF UTERUS, OVARIES, AND FALLOPIAN TUBES. CURE.¹

BY JOHN HOMANS, M. D., BOSTON,
Surgeon to the Massachusetts General Hospital.

Miss L. S., a farmer's daughter in Vermont, eighteen years old, was sent to me in April, 1883, by Dr. Ellis, of Poultney, Vt. She was a healthy girl, but had a worn look as if she had suffered much from pain. The girth at the umbilical level was thirty and a half inches, and there was a globular tumor with thick walls filling the lower middle part of the abdomen and pelvis. The tumor was movable, it had no adhesions; fluctuation and impulse were both distinct. Tenderness of the abdomen was universal. The dullness extended an inch above the umbilicus. On auscultation no sounds were transmitted through the tumor. The right lumbar re-

gion was resonant, the left was dull. The uterus could not be found. The vagina was filled with a tightly distended elastic tumor which pushed the rectum forcibly backwards. Menstruation had begun at fourteen years of age. It had been irregular and deficient. Her appetite was poor and also her sleep. Her pulse was 100. She had dull pain in the pubic region, and suffered almost constantly from pain and tenderness. Formerly her left leg was swollen, but is now normal in size. One year ago she noticed that she was increasing in size, and the tumor has risen up and spread out. She thinks that there has been some periodical increase and diminution in the tumor. This somewhat detached account of the case does not make sufficiently prominent the principal factor, and the one that induced me to operate, namely, the agonizing pain. The patient said she was willing to die of any operation that promised the least hope of amelioration. On April 11, 1883, I operated at the Carney Hospital. I made an incision from the umbilicus to the pubes, and on cutting through the parietes the marks of an old hæmorrhage (hæmatocele) were met with in the cellular tissue of the pubic region. On getting through this confusing mass of old blood clot and muscular tissue the peritonæum was opened. The tumor was found to have an adhesion to the omentum and to be semiglobular in shape, and to be incorporated with the floor of the pelvis, the rectum, and the bladder, and, in short, to be the uterus filled with fluid and distended to about the size of a small foot-ball or a large cocoanut. The right ovary and Fallopian tube were tied and burnt off. The left ovary was tied, and it was found that a mass of irregular sausage-shape was connected with the left broad ligament and Fallopian tube. This mass puzzled me at first, and I could not tell whether it was intestine or tube, or a mass of hæmatocele, or an old aneurism. The anterior and lower pelvic region were more or less filled with shreddy remains of old hæmatoceles. The globular swelling was now punctured, and the cavity of the uterus emptied. Its wall, at the seat of puncture, was an inch or more in thickness. Several pounds of dark fluid blood without clots ran out and welled out. The cut surfaces of the uterus bled pretty freely and were clamped. The uterus immediately began to contract in size, and was much smaller at the close of the operation than when the abdomen was opened. It seemed impossible to remove the whole uterus, as its lower pelvic portions could not be raised. A wire was passed around the uterus just above the bladder and as low as possible, but it broke. One of Mr. Wells' large ovariotomy clamps was then put on, and a large portion of the uterus and the left Fallopian tube and ovary were removed. An elastic catheter was passed into the cavity of the uterus (between the jaws of the clamp). The operation was done under the carbolic spray, and the wound was dressed antiseptically. It seemed at first as if the os uteri might have been found and the uterus drained through it, but the cavity I opened did not communicate with the vagina, and from the state of the pelvic organs it seemed to me that menstruation would go on, and perhaps the same state of things would be reëstablished as existed before the operation, or even a more serious one, for it would have been difficult to have kept the artificial cervix open, and there was a large wound in the roof of the uterus through which blood was constantly oozing; consequently I decided to remove all of the

¹ Read before the Boston Society for Medical Improvement, October 22, 1883.

uterus that I could clamp, and also both ovaries and tubes, so that menstruation would be done away with. The patient suffered from considerable pain for two days, and thirty-six hours after the operation had a smart hæmorrhage. I was called at one A. M., and found the clamp loose, the uterine tissue having shrunk away from it. I tied beneath the clamp with carbolized silk, but the hæmorrhage had already ceased. Twelve hours later another slighter hæmorrhage took place. No more hæmorrhage occurred after this, but much black fluid blood was discharged upon the dressings and syringed out. The wound was syringed once or twice a day, under the spray, as was necessary, and the tube was gradually shortened. The temperature during recovery varied from 98° F. to 101.4° F. on the second day, but averaged very nearly normal, and the pulse was never over 100.

She left the hospital on the thirtieth day after the operation, and soon afterwards returned to the country, having gained flesh and strength and color in her cheeks, and being wholly free from pain. There was a small granulating surface at the site of the wound which was depressed and looked like a second navel which had been pulled inwards. The os uteri could be felt in the upper part of the right side of the vagina, but a sound was not inquisitively pushed through it, as I preferred to let well enough alone for the present. I hope to see the patient at some future time, and shall perhaps be bolder in my investigations. The specimen was handed to Dr. A. N. Blodgett, and the following is his account of it:—

The specimen consists of the fundus and body of the uterus, which has been amputated at the cervix. Attached is the left broad ligament, the left Fallopian tube, the left ovary, and a sac, the size of a large orange, situated at the pelvic extremity of the broad ligament. The right ovary is present, but is detached from the other organs. The right Fallopian tube and broad ligament are not apparent. Upon the peritoneal surfaces of the uterus and the entire surfaces of the broad ligament are adherent remains of partially organized blood coagula, which hang as shreddy tufts from every part of the serous surface. Upon the posterior aspect of the broad ligament is a sac, the walls of which are composed of dense shreddy coagulum, but which has no present contents.

The uterus is deformed, the left horn being greatly distended, forming an oblong conical pocket which is impervious at its superior extremity, there being complete atresia of the left Fallopian tube. The right horn of the uterus is apparently normal in size and relatively very short. The section by which the amputation of the organ was effected passed through the body of the uterus at a point in which the left Fallopian tube still constitutes a separate cavity in the wall and body of the uterus, thus presenting two openings upon the amputated surface, one the cavity of the uterus proper, or perhaps better described as that of the right horn of the uterus, and the other the canal of the left Fallopian tube and left horn of the uterus. The wall of the uterus is very thick and dense; on the right side it is much thinner, and the thickness constantly diminishes toward the region of the Fallopian orifice. The tissues are at present everywhere wrinkled and contracted, but the uterus is said to have been the size of a child's head at the time of the operation.

The present appearances are as follows: From the seat of amputation to the top of the right cavity in the

middle line five centimetres. From the same point to the extreme end of the cavity in the left horn eleven centimetres. Thickness antero-posteriorly through both walls 4.5 centimetres. From side to side six centimetres. The lining of the right uterine cavity is apparently normal in every respect, and is everywhere thrown into numerous minute folds. The lining of the left cavity differs from that of the right only in respect to the more natural arrangement and condition of the glandular structures of the mucous membrane, which are very striking in this particular specimen. Both canals are everywhere surrounded by normal uterine muscular tissue.

The ovaries are of nearly equal size, and measure each 4.5 centimetres in length by two centimetres in breadth, and 1.5 centimetres in thickness. Their surfaces are covered by shreds of coagulum, and they are softened and elongated. Upon section of the right ovary a corpus luteum is found in the stage of grayish yellow absorption, the cavity being linear and almost entirely obliterated. The contents was a mass of finely granular fatty detritus. No other corpora lutea were here observed.

In the left ovary a number of firm, rounded bodies were felt, some of which bulge slightly above the surface and have the size of a pea. There are also small superficial depressions of some parts of the surface covering the ovary. These being incised led to sacs the size of a pea, containing a bloody fluid. The lining membrane of these small sacs was covered with columnar epithelium, the cells of which are often in a state of more or less advanced fatty degeneration. The interstitial tissue of the ovary consists of a loose, long, spindle-celled connective-tissue structure, soft in feeling and easily separated. In the left ovary no corpora lutea were observed.

The left Fallopian tube was found and its canal followed as far as the junction of the tube with the body of the uterus, where there is complete atresia of its lumen. Its canal is pervious for a distance of eleven centimetres from the body of the uterus to its point of attachment to the before-mentioned sac contained in the broad ligament, at which situation the Fallopian tube is lost. Nothing like a fimbriated extremity can be found. The mucous membrane lining the tube is atrophied, and no ciliated epithelium can be anywhere discovered. The sac in the broad ligament is a cavity consisting of a membrana propria quite thick and elastic, which is at present thrown into loose folds, and an outer layer of peritonæum covered with fringes of organized blood coagula-like adhesions. The lining of the sac was everywhere covered with a layer of pasty matter of a dull red color, which proved to be grumous blood. Upon the posterior wall of the sac were found two distinct perforations in the lining membrane which extended through the entire thickness of the membrana propria and peritonæum, and communicated by free orifices with the abdominal cavity. Other small perforations of the lining of the sac led down to deposits of grumous blood in the tissues, varying in size from that of a shot to that of a Lima bean. Upon the peritoneal surface of the broad ligament near the perforations is a large mass of blood coagulum, a portion of the hæmatocele below alluded to. No connection between the sac in the broad ligament and the ovary is apparent, and no afferent blood-vessel can be discerned.

The pathological condition, so far as this can be determined from the specimen, is the following: There

is essentially a double uterus, the two Fallopian tubes being prolonged toward the cervix so that in amputating the body of the organ two distinct canals are found. The orifice of the right tube communicated with the vagina, while there was complete atresia of the lower extremity of the left canal. The secretions of this cavity had gradually accumulated so as to cause a great distention of this portion of the uterine body. There is a distinct sacculated cavity within the outer portion of the broad ligament which at present contains a considerable amount of grumous blood, and which communicates by two separate and independent openings with the peritoneal cavity, and which had evidently given rise to the large amount of shreddy coagulum at the seat of the peritoneal openings upon the broad ligament, and formed the source of the blood found in the pelvis as an old hæmatocele at the time of the operation. Several other openings of the *membrana propria* of the sac led to small isolated hæmorrhagic deposits in the tissues beneath, after the manner of a dissecting aneurism. In some of these small sacs the blood has the consistency of putty, in others the absorption of the blood has progressed to such an extent as to leave only a small deposit of coloring matter in the part. At the seat of the perforations above mentioned the interior of the large sac is lined with a firm reddish-brown layer, similar to that seen in the cavity of a true aneurism when healing by obliteration.

THE TREATMENT OF PSORIASIS.¹

BY ARTHUR VAN HARLINGEN, M. D.

PSORIASIS is one of the commoner skin diseases met with in this country. The statistics of the American Dermatological Association show that it occurs in the proportion of about six per cent. in all diseases of the skin encountered. Daily experience would seem to indicate a still more frequent occurrence, because the affection is a disfiguring and annoying one, and therefore patients are more inclined to seek relief, and also because it is a stubborn disease and greatly prone to relapse. The history of a single case will often extend over many years, and bring it under the observation of a number of different physicians.

It is because of the comparative frequency with which psoriasis is met and its stubbornness to treatment, that I have selected it as the subject of my remarks this evening. Having had a good deal of experience in the treatment of the commoner forms of the disease, it is my intention to confine myself chiefly to the consideration of such remedies as have come under my own observation and use, only touching incidentally on others.

The object of treatment in psoriasis is the removal of the eruption as it exists upon the skin. We cannot hope with any degree of certainty in any given case to prevent a recurrence of the disease, or, if you please, a relapse. For the drug has not yet been discovered which will surely take away all tendency to the recurrence of psoriasis, and whoever promises a cure, in the wider sense of the word, to his patient, will, in a very great number of cases, find that he has been too sanguine. Fortunately, however, a certain number of patients do seem to recover. I do not know what has

been the experience of others in this respect, but I have patients who have been under observation three, five, even eight and ten years without relapse. Such cases are, unfortunately, few.

Preëminent among the internal remedies which are useful in the treatment of psoriasis is arsenic, which may be justly called a specific in this disease. I think I am not asserting too much when I say that eight out of ten cases of psoriasis of average character and severity will do better under the use of arsenic than with any other remedy. I prefer Fowler's solution given in the average dose of four minims thrice daily. I think this solution is often prescribed in too large doses, and I am sure the dose of five to ten minims, as given in the books, is too large for ordinary use. Most patients bear a four-minim dose very well, but there are idiosyncrasies. I have sometimes been obliged to limit the dose at the beginning to one minim in cases where subsequently such toleration has been established that twelve minims have been taken with impunity. However, four minims is a good dose to begin with, and if the effect does not begin to show itself within ten days or two weeks, the amount may be gradually increased. Fowler's solution should never be given to the patient in a vial with directions to drop out the requisite number of drops. The patient is apt to make a mistake, vials of different sizes may pour out more or less in each drop, and there is always danger in leaving a half-empty vial of poison about the house. The solution is better given mixed with water, or with wine of iron or other convenient vehicle.

The effect produced by arsenic upon the eruption of psoriasis is, first, in diminishing the quantity of epidermic scales thrown off, and then in preventing the appearance of new lesions. The patches gradually lose their scaliness, begin to heal in the middle, and disappear little by little. It must be remembered, however, that arsenic is a slowly acting remedy, and its use should be continued through many months to get the best security against relapse.

The other liquid preparations of arsenic used in psoriasis are Pearson's solution of the arseniate of sodium, and Donovan's solution of the iodide of mercury and arsenic. I have used the former in a few cases without noticing any perceptible difference as regards efficiency between it and Fowler's solution. The solution of mercury and arsenic (Donovan's) I have employed in certain stubborn cases with good effect where Fowler's solution has seemed to fail. The existence of syphilis as the cause of the eruption in these cases having been excluded, I am at a loss to account for the apparently greater efficacy of the mixed treatment. The dose given was as much as ten drops, and although this solution is weaker in arsenic than Fowler's, yet I am inclined to the opinion that the conjoint administration of the two drugs, mercury and arsenic, was the cause of the good result rather than the increased dose. I should be inclined to use Donovan's solution in cases where Fowler's solution shall have failed.

The mixture of arsenious acid, black pepper, and sugar of milk, known as Asiatic powder, and recently placed in the *Pharmacopœia* with the pepper left out, among the triturations, is of no particular value above the other preparations, and is not so convenient of administration.

Hypodermic injections of solutions of arsenic have been employed in the treatment of psoriasis, but I have had no experience in their use.

¹ Read before the Philadelphia County Medical Society, October 17, 1883.