health, was not addicted to alcohol, but used tobacco to a moderate extent. He was a merchant and was able to live comfortably and without undue strain or exposure of any kind. His arteries were not sclerotic. Two years previously he had an attack of facial erysipelas of a severe type, from which he made a good recovery, and had had no sickness since that time.

September 19 the symptoms were about the same as on the previous day; the temperature was about 103 and pulse quickened but good. There was some distension of the abdomen, with pain, tenderness and rigidity of the right lower quadrant, evidently due to acute appendicitis. Blood count: Leucocytes 11,000. The urine contained many granular casts.

Treatment.—An ice bag was applied to the abdomen. No food was given by mouth and sufficient anodynes were given to relieve pain. Although there was no doubt in my mind that he was suffering with acute appendicitis, I refrained from operating on account of the condition of the urine, the patient's obesity, the previous attack of erysipelas, the low leucocyte count, and objections on the part of the patient and his wife.

Course of the Disease.—His symptoms rapidly subsided, and September 23, six days from the inception of the attack, he appeared convalescent. At 11 a. m. on that date he was free from pain, with diminished tenderness and rigidity, and felt very comfortable. Two hours later he was suddenly taken with pain in the left leg below the knee. The leg became numb, cold, white, and without appreciable pulsation in any accessible artery. No pulsation could be felt in the femoral or external iliac arteries. I do not remember having listened to the heart previous to this occurrence; afterward, however, I found a slight soft endocardial murmur, but there were absolutely no signs of any acute or serious heart complication. The foot became discolored, dark, cold, and of almost horny hardness, and this condition extended irregularly almost to the knee. Above the knee the skin continued warm. In a month an irregular line of demarcation had formed below the knee. The urine cleared up, the appendiceal symptoms disappeared, and the heart was performing its functions well. The patient was seen by the late Dr. I. E. Atkinson and by Dr. W. S. Thayer, and the condition of the left leg was recognized to be due either to an embolus, or to a thrombosis caused by a septic endarteritis of the left external iliac artery. He was removed to the University Hospital, where an amputation was done just above the knee, under ether anesthesia. The man made a good recovery, and has remained well until this time.

Among the complications of appendicitis, femoral phlebitis and thrombosis are not very rare and may occur on either the right or left side, or, as in a case recently under my care, on both sides, but I have not seen any account of a gangrene due to interruption of the arterial blood supply as a consequence of appendiceal disease. It is difficult to understand how a septic infection of the left external iliac artery could result from an appendicitis, apparently of mild type, and the question arises whether this gangrene was a consequence of the appendicitis or merely a coincidence. In the absence of any previous symptoms suggesting disturbance of the heart, and from the fact that there had been no cardiac distress before this attack, and has been none since, notwithstanding a slight endocardial bruit, I do not think it probable that an embolus large enough to block completely the external iliac artery could have been washed from the cardiac valves and lodged in this situation. I am of the opinion, therefore, that, from some cause, a point of least resistance was found in this artery and that organisms were conveyed by the blood stream to this point and there set up an endarteritis with thrombosis of this vessel, completely occluding its lumen.

The clinical symptoms, however, were strongly sug-

gestive of an embolism, as they came on suddenly without any premonition. In some cases of typhoid fever endarteritis of the femoral vessels has been observed, and this condition may have had a similar pathology.

Was the gangrene in this case due to the appendicitis, or would it have occurred spontaneously? I do not know, but I believe that it was the result of the appendicitis. Would the early removal of the appendix have prevented the gangrene? This is possible, but I am glad it did not follow an operation, as it certainly would have been attributed to the operation rather than to the disease. It seems to me that the case is of sufficient interest to be put on record, and I shall be pleased to know of any similar cases that may have been observed.

A CASE OF SCARLATINA WITH COMPLICATIONS.

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HIGHLAND PARK, ILL.

Scarlatinal arthritis, although a somewhat common complication is rarely so extensive as in the following case:

History.—June 24, 1906, I was called to see the patient, a girl, aged 15, well-developed and weighing about 125 pounds. She had a severe angina and headache with a temperature of 102 F., following a severe chill. The pulse was 118. The following morning her temperature was 101.3 F., pulse 114, and an exanthem was appearing on her chest. The tongue was typical of scarlet fever. For the first fifteen days the temperature varied between 102.6 F. and 105 F., after which it fell below 100 F., and gradually reached normal. On the fifth day albuminuria appeared and persisted during the period of high temperature. On the sixth day arthritis appeared, gradually involving all the joints, and disappeared by degrees. There was no suppuration, but there was an effusion in all the joints and the patient was unable to move the head owing to the severe pain such movement caused. From July 2 to July 10 the patient was delirious or in a state of coma at all times. The bowel movements and the voiding of urine were involuntary. The patient became deaf and was also troubled with amblyopia. Both these symptoms gradually disappeared.

Treatment.—The diet was milk until July 19, when egg-nog was added, followed by chicken broth, mutton broth, etc. The temperature was reduced by sponging. Liquor potassii acetatis and spiritus etheris nitrosi were given as diuretics. For the relief of pain and action on the arthritis sodium bicarbonate and sodium salicylate—making a fresh solution of sodium salicylate—were administered internally. Externally the affected joints were wrapped in cotton after applying unguentum Credé. Later the patient was given tincture of chlorid of iron for the resulting anemia.

Result.—The patient was under observation until September 19, and at no time could I detect any heart lesion. I saw the patient July 2, 1907, and she appeared to be in the best of health, not being troubled with any sequelae whatever.

RAPID RECOVERY FROM SYNCOPE.

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PHILADELPHIA.

For overcoming cerebral anemia it is the common practice to lower the head, according to the accepted theory, to permit the blood to reach the brain without working against gravity. To do this the patient is made to lie supine. In fact, the unconsciousness and fall of a fainting person is a natural provision to bring about the same end. In the absence of medicinal restoratives the treatment of unconsciousness caused by mental excitement or emotion, slight pain, excessive heat or

other nervous causes is deficient in that the end reaction, cerebral hyperemia, is usually not sufficiently sought.

In case of fainting from being in overcrowded rooms, from exciting surroundings, from slight concussion or other pain or discomfort, the most rapid relief comes from forcing the blood out of the abdomen, where it has largely collected. This is of more avail than to elevate or to compress the extremities, and should be practiced except where contraindicated by some abdominal condition. A patient found unconscious from an ordinary syncopal attack can be most rapidly resuscitated by laying him in supination with pressure on the abdomen by the hand or, better, by the flexed thighs. This much is commonly known, but the fact that better and more rapid results can be obtained by a slight variation does not seem to be known or the method adopted.

The patient should be made to sit on a chair or other high object and lean forward with as much flexion of the body as possible, even to bring the face between the knees. By this posture the head is brought to the level of the body, but what is of more importance, the flexed thighs pressing on the abdomen force the blood from the mesenteric vessels into the brain. If the patient cannot or will not voluntarily flex the body sufficiently he should be assisted by being pushed down and held in the position until long after all objectionable sensations have ceased. This leaning posture often gives instant relief or is a valuable prophylaxis for an oncoming syncopal attack. During minor operations where anesthetics are not employed, or during slight surgical dressings, by holding the patient in the flexed sitting position the pain, nausea, vertigo and discomfort may very largely be prevented. It is an especially valuable procedure for dispensary or office work, being convenient, rapid and effective.

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THE USE OF THYROID EXTRACT IN HENOCH'S PURPURA.

J. WIRT ROBINSON, M.D.

MACKAY, IDAHO.

History.—David P., white, American, was brought to me July 6, 1906. The following history was obtained from his father: He had always been a healthy boy, and, with the exception of measles at the age of 5, had no illness until the present illness. During February, 1906, the attack began. He was taken to a physician, who pronounced it eczema. His treatment did not help the child. He had pains in all the joints, but most marked in the knees. Attacks of pain in the abdomen, especially in the left hypogastrium. Vomiting had occurred twice. The bowels were somewhat constipated.

Examination.—This showed a well-nourished boy of fairly good size for his age. His eyes were clear and his tongue slightly coated. No abdominal tenderness, but slight tympanites. Temperature normal, pulse 80. There was an eruption, petechial in character, covering most of the legs and thighs, but most marked around the knees. There was a fairly well-marked edema of the legs, extending two inches above the knees. The knee joints were rather tender on pressure and manipulation. The urine was normal in every respect. Examination of the blood showed 60 per cent. hemoglobin. The cells were not counted, owing to lack of apparatus. As Rocky Mountain spotted fever was prevalent at that time and his symptoms much resembled those of that disease, I believed the eruption he had in February to be a different trouble and diagnosed the disease spotted fever.

Treatment.—I put him on the treatment that had given me good results in that disease, viz., sodium salicylate and a diuretic, usually potassium citrate. I might add here that the

treatment by quinin and ferric chlorid advocated by some has never given good results in my hands. My experience coincides with that of Major C. F. Kiefer.¹ Later I used arsenic with the best results. This relieved the joint pains and the edema, but the eruption remained unchanged. July 13 I added arsenic in the form of Fowler's solution and the peptonate of iron, on account of the anemia present. Appropriate diet and general measures also were used. On July 25 I saw him again. He was much improved generally, but the eruption was just the same. It was then that I changed my mind as to the diagnosis. Following Osler's suggestion, the arsenic was pushed to the limit. On August 24 the eruption was still unchanged. A blood examination showed 70 per cent. of hemoglobin. Each future examination showed improvement, the last one made being 85 per cent. Various drugs recommended for purpura were faithfully tried, but to no avail. Even the calcium salts were of little or no value. Considering the effect on general metabolism, I decided to try thyroid extract. So one grain was given morning and evening. In two weeks the eruption was entirely gone. The dose was then reduced to once a day, and kept up one month longer, when it was discontinued. I did not see the case for six weeks, when he returned suffering from a relapse. A second trial of the extract again gave speedy relief. My advice to discontinue its use gradually was not followed and a second relapse followed. This also was soon controlled by the extract. The dose was then reduced to once a day, once in two days, and so on, with directions to increase again if there were any suggestion of any return of the eruption. At the last report there had been no further return.

Whether or not this is a case much out of the ordinary I am not prepared to say. There were none of the usual manifestations of deficient thyroid function. Nor could any abnormality be found in the gland itself. Although I neglected to estimate the time required for coagulation of the blood, yet I noticed that the punctures made for the blood examinations readily stopped bleeding.

Symptoms besides those mentioned that sometimes occur in Henoch's purpura were noticeable by their absence. No hemorrhages from the mucous membranes were present at any time during the attack. The eruption was petechial throughout, no suggestion of an erythema multiforme being present. The heart remained absolutely normal, not even a hemic murmur being present when the anemia was most marked.

Whether thyroid extract will prove to be a specific for all cases of Henoch's purpura or for other forms of purpura remains to be seen. But the remarkable results in this one case warrant a further trial. So far as I know, this is the first report of the use of thyroid extract in this class of disorders.²

1. THE JOURNAL A. M. A., April 6, 1907, 1154.

2. NOTE.—July, 1907. Since this was written there has appeared the article by J. T. Rugh in *Annals of Surgery*, May, in which he used thyroid extract with success in a hemophilic knee joint.

Blood Examination for the Early Detection of Lead Poisoning.—Frey (*Deutsche medizinische Wochenschrift*, Feb. 7, 1907), finding that the presence of lead in the urine is not constant, suggests an examination of the blood in order to detect the red cells with basophile granules, described by Grawitz in 1899. These, it is true, are not pathognomonic of lead poisoning, since they are seen also in cancer, in pernicious anemia, and in certain septicemias. But in a mechanic free from these diseases, and handling the lead, the presence of these basophile granules becomes of great importance. The observations of Frey show that by examination of the blood we may find the first evidence of saturnine intoxication. The technic is simple. It is only necessary, after drying and fixing with absolute alcohol, to color the blood preparation with Loeffler's blue stain, in order to show, in a certain number of red corpuscles, the granules colored blue.—*New York Med. Jour.*, July 13, 1907.