cult and its adherents are many. Drawing the attention of man from the realities of this world to the frictions of an imaginary one, has resulted in religious doctrines entailing much misery to mankind.

So far as civilization has any definite aim, that aim must be the increase of human happiness. The means to the attainment of this object are material comfort and prosperity. The removal of ignorance and the growth of knowledge are, therefore, necessary to the development of happiness.

A system of dogmatic religion of any kind, such as "chasing the spirits," depraves morality, benumbs the mind of man and debases human nature.

Where in the realm of science has a discarnate intelligence been found? Is there any reason why we should not apply the same methods of investigation in studying the unknown that we use in studying the known?

Has science ever demonstrated any dualistic nature of man, any separate entity apart from the matter of which the body consists? Mind is looked upon as the functioning power of the brain, but how can a mind or intelligence exist apart from the brain, a material product?

In 1916, the Open Court Publishing Company, of Chicago, brought out a book entitled, "Behind the Scenes with the Mediums," by D. P. Abbott. Any physician who wishes to become a "medium," a message-reading, slate-writing, and table-tipping expert, is referred to this work.

It is the duty of the physician to combat all cults that are not based on scientific facts. And furthermore, it is time that all medical men place themselves on record as *defenders of science* and as opponents of those things which impede progress, impair the mind of man, and subjugate his mentality to a parasitic class.

Go to the Psychopathic Hospital and tell the physicians there that you have had messages from the dead, that you are in communication with spirits, and that you have "psychic" powers and see what will happen. You will at once be classified as one who is suffering from delusions, hallucinations or illusions, according to your story, and the chances are that you will be detained for further observation, as to your sanity. "Who ever heard of a psychiatrist who believed in spirits?"

Modern medical science has fought its way

from the primitive belief in exorcism and magic, to the rational administration of various remedies for the cure and prevention of disease.

Every step in its advancement has been met with opposition by organizations claiming divine authority, and the office of mediator between the known and the unknown world. Without the use of incantations, prayers, holy bones, holy relics or blessed shirts, medical science has become one of the true and actual saviors of the human race.

The realm of spiritualistic phenomena is largely "bunk or fake" and sleight-of-hand. It is the sum total of all the superstitions of the past, the destruction of which has always been the chief purpose of science. The science of psychology and psychiatry gives a natural and sane explanation of spiritual phenomena.

Let the medical profession unite for further victories in the interest of humanity.

Clinical Department.

PERFORATION OF THE CECUM. A CASE REPORT.

BY EDWARD H. RISLEY, M.D., F.A.C.S., BOSTON.

It is desired to report the following case because of interesting points in postoperative findings and because of the several postoperative complications with eventual complete recovery.

M. M. C. was seen at 4 A.M., December 23, 1918, after having been in bed one week with an attack of epigastric pain, nausea, and vomiting, and obstinate constipation accompanied by temperature varying from 97.2° to 100.4°. Because of a previous history of a chronic "stomach trouble," with acute exacerbations, the present attack was diagnosed, in the absence of lower abdominal signs, as probable gall stone colic, by the attending physician. Not until 1 A.M. of the day I was called in had there been any signs or symptoms of a possible lower abdominal lesion. At this time, however, the temperature had gone to 102°, there was violent pain in the whole lower abdomen, and rigidity in the right lower quadrant.

Examination showed an abdomen typical of acute, ruptured appendicitis with beginning general peritonitis. The upper abdomen was soft and only very slightly tender to palpation. There was no evidence of obstruction. Immediate operation was advised and accepted. The

patient was brought to Boston and was operated on at 6 A.M., ether being administered by Dr. Freeman Allen.

On opening the abdomen, a large amount of foul, colon-smelling, yellowish-green fluid and pus escaped, which also carried with it a strong odor of turpentine, and, when an entirely sloughed-off, gangrenous appendix with a perforation of the cecum $1\frac{3}{4}$ cm. in diameter was found, it was taken as undoubted evidence that the fluid free in the peritoneal cavity was none other than the turpentine enema given a few hours before the sudden onset of right lower quadrant pain. This apparently marked the time of perforation of the very necrotic appendix and cecum.

The cecal opening was closed with a zero gut stitch, three cigarette wicks placed; one to the stump, one to the right flank, and one to the pelvis and the wound closed in the usual manner. The patient was returned to bed in very good condition but because of the general peritoneal involvement a bad prognosis was given.

He had a stormy convalescence, septic petechiae developing over the chest on the fifth day. On the eighth, seventeenth, and twenty-first days there occurred profuse secondary hemorrhages from deep in the wound. The patient was fortunately reached by me very soon after the onset of each hemorrhage, gas was given, the wound inspected—no bleeder found—and the wound packed. After the second hemorrhage the patient's condition was so precarious that Dr. G. W. W. Brewster was called in consultation but advised against any operative interference. Patient made uninterrupted and satisfactory recovery without transfusion, after the third hemorrhage, and was discharged February 14, 1919, in excellent condition.

He remained well until about August 1, 1919, when he began to have sudden severe attacks of acute epigastric pain, without nausea, vomiting or distention. Attacks were often relieved by enemata, but might come on shortly after an unaided stool in the morning. Attacks thought to be due to adhesions involving colon,—probably the transverse portion. Attacks continued at rather regular intervals in spite of careful diet, mild laxatives and occasional enemata.

September 4, 1919, entered Deaconess Hospital to be under observation while gastrointestinal x-rays were being taken and so that patient could be watched during an attack.

Patient previously seen by Dr. C. H. Lawrence, who considered condition probably due to adhesions and spasm. Dr. Morrison's report showed absolutely no evidence of adhesions or obstruction and no pathology in relation to the stomach. In conversation with me regarding this case, Dr. Morrison stated that had he not known that the patient had had a previous general peritonitis, he should never

have known from the x-ray findings that the peritoneum had ever contained any adhesions.

Patient had no attack during a week's hospital observation but on the night following his arrival home he experienced the worst attack he had ever had. No relief was obtained from atropin or several doses of morphia. The temperature was reported by the attending physician as 101° and the patient was advised to return to Boston for further study. He was seen by Dr. C. H. Lawrence and myself at 7 P.M., on the day of his attack. Temperature was 100° . There was mild pain, but the physical examination was absolutely negative. There was no distention. Even deep palpation could elicit no tenderness, rigidity or spasm anywhere in the abdomen. Operative interference did not seem indicated and it was thought best to see the patient in an attack if possible. However, on September 11, 1919, the temperature went to $102\frac{1}{2}^{\circ}$, the white count previously 18,000 to 28,000 and the patient looked sick for the first time, and a very slight amount of tenderness was found in the epigastrium, more to the left than to the right of the median line. This corresponded to the site of most of the previous pain complained of. Operation was advised and accepted. Ether was given by Dr. William L. Dodge. The abdomen was opened through a median epigastric incision. Much to my surprise, the whole peritoneum, as far as could be inspected and palpated, showed absolutely no signs of past or present inflammation. It looked like a virgin peritoneum everywhere; even at the site of the old infection there were only a few fine adhesions of the cecum to the abdominal wall. The total absence of any sign of the old diffuse and virulent peritonitis was a very surprising revelation. No pathology was found in the stomach, colon, pancreas, or intestine. Finally, a small tongue of omentum was seen pointing downward toward the right kidney region, and, tucked far underneath the costal margin and very deep in the flank, a gall bladder distended to the size of the fist was found. A cholecystectomy was easily done and on section the bladder was found distended with thick, foul pus, whose drainage was prevented by the impaction in the cystic duct of one small mulberry stone. Three cigarette drains were placed and the abdomen closed.

The patient made an uneventful and satisfactory recovery with flat, normal temperature. All wicks were out and the patient was preparing to go home in a few days, when on the eighteenth day the temperature rose to 101° , patient had a chill, and a diffuse, deep red rash appeared on chest and abdomen. The abdomen was soft and there was no tenderness. There was a little serum from the wound. The next day temperature went to $103\frac{1}{2}^{\circ}$ and the patient was lobster-red all over. In Dr. Lawrence's absence, was seen by Dr. William

B. Robbins, who could find no evidence of scarlet fever and a diagnosis of toxic erythema was made. That night the temperature went to 105° and the white count to 32,000. The patient's condition seemed desperate. Suddenly at 1 A.M., he began to perspire and did so so profusely that his bed had to be changed three times during the night. At 9 A.M., the temperature was normal and remained so until discharge twelve days later. Patient has remained perfectly well ever since, has gained weight, and shows no ill effects from his almost overwhelming but fortunately short-lived toxemia.

The points of especial interest in this case are the following:

a. Finding of a recently given turpentine enema free in the abdominal cavity, its entrance being through perforation in the cecum where a completely gangrenous appendix had been sloughed off. The question may, of course, be raised as to whether or not the turpentine enema did not actually produce the perforation or at least hasten it by several hours.

b. Recovery from general peritonitis and three secondary hemorrhages occurring as late as the eighth, seventeenth, and twenty-first days after operation.

c. Later finding of "virgin" peritoneum with no adhesions even after so severe a peritonitis.

d. Unusually late, overwhelming, but short toxic erythema with sudden onset and equally sudden recovery.

A third theory is that the condition is due to the failure of the developing tubules to unite with the corresponding glomeruli or an excess of either glomeruli or tubules and cyst formation in the supernumerary structures.¹

If the kidneys are of normal size, as they may be, there will be no symptoms. If the kidneys are large the condition will be considered among the abdominal tumors of infancy. The prognosis depends on the amount of parenchyma involved. In the tumor type death usually occurs in early infancy.²

Report of Case: E. C., two years old. Came to the Out-Patient Department of the Children's Hospital.

Family History. Only child of healthy parents. No exposure to T. B. or contagious disease. One miscarriage before child was born.

Past History. Full term, normal delivery. Birth weight, 6½ pounds. Breast fed six months. Since that time was fed on mixtures of proprietary foods and condensed milks.

Present Illness. Past eight months child has had spells of "getting blue," coming usually in the morning. Has had them every day for the past week. Usually last fifteen minutes. Mother has also noticed a yellowish-white discharge on the diaper. Urine has been dirty white. Eyes have been puffed, but mother has not noticed that the body was swollen. Appetite good. Cough for past two weeks.

CONGENITAL CYSTIC KIDNEY: REPORT OF CASE.

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[From the Medical Service of the Children's Hospital.]

IN looking over the records of the Children's Hospital I have found only three cases of congenital cystic kidney. It is a rare condition in infancy. The condition is usually found bilateral. The contents of the cyst are usually clear but may be tinged with blood pigment. Virchow believed that the condition was one of retention cysts due to fetal nephritis. Another theory is that the condition represents a true developmental anomaly, with the formation of cysts instead of normal renal tissue (Ranvier).

FIG. 1.