high temperature as showing the presence of a serious constitutional disturbance, a "tuberculous fever," which should not be lost sight of in treating the local disease. In fact, the treatment of the local disease becomes all the more important because the fever is undoubtedly due, in part, to the intense muscular irritability and the persistent irritation of the diseased joints in walking.

Rest and protection to the joint are, therefore, imperatively indicated on theoretical, as well as practical grounds, and the observations have shown clearly enough that the temperature subsides somewhat under suitable treatment although not reaching the normal level except in cases of exceptional mildness.

A further inference which might be reasonably drawn from these data is, the fact that a certain amount of general quiet is indicated for these patients and that while out-of-door air is essential to their well-being, the amount of exercise, as in any febrile condition, should be moderate and somewhat restricted. In short, the general condition needs most carefully to be looked after in view of the increased tissue waste incidental to the continued high temperature.

The prognostic value of high temperature in individual cases early in the history of the disease has yet to be determined. It may prove ultimately to be as valuable as in phthisis. So far as these observations have gone they have shown that very high temperature was associated with an exceptionally severe form of the disease, but, of course, cases must be watched for a longer time to be able to say that high temperature in the early stages means an unusually protracted or severe form of the disease. It can be said, however, that high temperature coming on in late convalescent cases is a matter of much significance, as probably indicating a relapse and that a rise of temperature occurring in the first year or two of the disease means an increase of joint symptoms and not necessarily the formation of pus.

The diagnostic value of high temperature in these conditions is not to be left out of sight. It has many times proved of service to the writer in making, for example, the diagnosis between lateral curvature and early Pott's disease and it seems reasonable to allow a certain weight to the presence or absence of this sign in view of the fact that high temperature seems so commonly to be associated with early hip-disease and Pott's disease.

The observations, however, have been simply enough to suggest, rather than to formulate, the diagnostic and prognostic value of high temperature in these conditions and the object of this paper has been simply to call attention to the fact that high temperature exists in hip-disease and spinal caries from an early stage.

Clinical Department.

NOTES ON A CASE OF HYDROPHOBIA.

SERVICE OF DR. H. H. A. BEACH, AT THE MASSACHUSETTS GENERAL HOSPITAL.

BY J. G. MUMFORD, House-Officer.

THE patient, W. J. M., of Quincy, was referred, as a case of neuritis from a dog bite, to Dr. M. H. Richardson, by whom he was sent to the Massachusetts General Hospital.

The patient presented himself at the hospital on the morning of April 9th, at 8 o'clock, with his father,

who gave the following history: Three weeks before, his son was bitten by a sick puppy, which died the next day "in fits." The wound was a mere scratch on the left forefinger, and healed in two or three days. The patient thought no more of the accident. Seventeen days later he began to have acute pain in the scar, shooting up the arm, for which he sought medical treatment without relief. The next day the patient's "throat began to contract"; in a few hours he was able to swallow nothing. This state of affairs, with increasing weakness and anxiety, had persisted up to the time of entering the hospital, four days after the first symptoms. The son himself added that water was especially distasteful to him, and that at times he had great difficulty in breathing, but for the past twenty-four hours he had no pain in the hand or arm.

Such was the alarming appearance of the patient, that on his presenting himself at the hospital, the porter sent word to the house-officer that he thought the case was one calling for immediate tracheotomy.

Examination: Man, thirty-five years of age, very restless, with staring eyes, who started back in apparent fright when approached. The least stir in his neighborhood caused convulsive movements of the pharynx. He would wave his arms, start back violently, and the spasms of the pharynx would soon become accompanied by expulsive movements of the chest and abdominal muscles. He kept appealing eagerly for assistance. His voice was gasping and sobbing in character. Pulse 108 and of good strength; respiration 27. He told a connected story and seemed quite rational. There was a small, soundly healed scar on the left forefinger. He was kept quiet long enough to have a stomach tube passed; and four ounces of milk with one ounce of brandy was poured in. This slightly steadied him for a few minutes. He was then given morph. sulph., gr. $\frac{1}{4}$; potass. brom., 3i; chloral hydrate, gr. xx; by enema, with but little subsequent relief. The same dose was repeated three hours later; and at 5 p. m., the patient appeared somewhat quieter.

About 5.30 in the afternoon he became suddenly violent, without any warning, though all day he had been perfectly rational and willing to submit to treatment. He had the fixed idea that the consulting physicians intended him some bodily harm, attempted to escape out of window, then furiously attacked two attendants, and after a struggle of ten minutes was secured in bed in a camisole. Dr. George F. Jelly saw the patient in consultation, and agreed that hysteria and mania should be eliminated from the diagnosis. He then continued muttering and irrational, but no longer violent.

At 7 p. m., he broke out into a profuse sweat, and began expectorating vigorously at intervals of three or four minutes. Was given an enema of morph., gr. $\frac{1}{4}$; potass. brom., 3i; chloral, gr. xx; sulphonal, gr. xi; brandy, 3iss; with slight effect. An order was given for an enema of brandy, 3iss; peptonized milk, 3iii; every four hours. A note was made at this time, that the pupils, which, during the day had been widely dilated, but reacted to the slightest stimulus, were contracted to a normal size, but not an "opium pupil."

At eight o'clock general convulsions began to increase rapidly in intensity and number, especially flexions of arms and legs with clonic contractions of temporals, masseters, buccinators and muscles of pharynx. The patient was violently maniacal at times, quiet for about five minutes, then began rapid mutter-

ing delirium, gradually becoming more violent for three or four minutes; from this state he would again relapse into silence, from exhaustion. When violent he spat constantly and accurately at surrounding objects. Up to 10.30 P. M., he refused all liquids, as he had done all day.

These symptoms continued, without cessation and with little change, up to half-past ten in the evening of the day of admission, when, in one of his moments of quiet, he suddenly died without premonition.

Unfortunately, owing to the violence of the patient, the temperature during life could not be taken. The temperature by mouth immediately after death was 107° F.

No autopsy was allowed by the friends.

Reports of Societies.

BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.

G. G. SEARS, M.D., SECRETARY.

REGULAR meeting, Monday, February 24, 1890.
DR. W. L. RICHARDSON in the chair.

ANATOMICAL SPECIMENS.

DR. W. W. GANNETT showed an

AORTA WITH THE BEGINNING OF THE AXILLARY ARTERY WHICH WERE THE SEAT OF THREE ANEURISMS.

The following is a brief statement of the case: The patient was a man of sixty-six years of age, who died in an insane asylum. He had been originally a lawyer in good repute and had held an office of trust, but owing to alcoholic habits had lost his position, all his practice and had gone down in the scale until finally he became a drunkard. He was found last fall wandering about the streets in an aimless way and taken to the City Hospital and found to be insane. He was kept there four or five weeks, and a diagnosis of tuberculosis, which at the autopsy was found to be the condition, was made; and also an aneurism in the axilla was discovered. He was sent to the asylum and remained three months. His condition there was practically one of senile insanity, there being nothing in his condition to attract attention to his chest beyond the signs which represented his tuberculosis. At the examination made at the hospital there was found dullness on percussion but nothing else. One of the remarkable things about the case is that it should have showed no signs referable to the pressure produced by three aneurisms. At the autopsy there was abundant evidence that the left bronchus had been completely compressed by one of these aneurisms, both in the appearance of the bronchus itself and in the entire atelectasis of the left lung, no air having entered for some time. There was also compression of the œsophagus.

The specimen consists of these three aneurisms. The first of these involves the ascending and just the beginning of the transverse portion of the arch. The second involves the transverse and just the beginning of the descending portion. The aneurism extended backward and caused erosion of four of the dorsal vertebræ. The left bronchus is completely compressed by it. The œsophagus extends over the back of it and is also compressed by it. There is no history of paral-

ysis of the vocal cord and probably the recurrent laryngeals were not involved. There is a spindle-shaped aneurism of the axillary artery involving that portion of the artery which lies deep in the axilla. It was really at the point where the subclavian joins the axillary. This is a circular aneurism about two and one-half inches long and an inch or inch and a half in diameter and contains a large thrombus partially filling it. The rest of the aorta shows a chronic inflammation of the intima, and his alcoholic habits may have had something to do with this. The matter of particular interest is the fact that, although there were three aneurisms, there were no symptoms referable to them. The patient died of exhaustion, there being no rupture of either of these sacs. There was tuberculosis of both lungs with atelectasis of the left lung. The tubercular process was much more extensive on the right. There was, on the left side, tuberculosis and also quite marked dilatation of the bronchi and the intervening portions were simply like mottled flesh. It seemed quite extraordinary that there was no alteration of the shape of the thorax by external examination. In aneurisms of the ascending arch it is common to see some alteration, but there was no bulging and no pulsation.

DR. B. CUSHING read

THE REPORT OF A CASE OF OBSTRUCTION OF THE COLON.¹

DR. R. H. FITZ: Dr. Cushing and I considered the expediency of any surgical measures, radical measures so-called, being undertaken, and it seemed to us that the evidence was very strong in favor of the case being one of annular stricture. We supposed from the capacity of the rectum and the fact that a tube was not to be passed for any considerable length, the absence of any tumor and the gradual progress of the trouble that the stricture was likely to be malignant. An obstruction of the intestine found at the point suspected is much more likely to be a malignant or a syphilitic stricture than any other form of obstruction. There was no question of any syphilitic stricture in this case and by exclusion the view was held which the autopsy confirmed.

With reference to the manner of death, it was quite like that which occurred in a case reported by Dr. Homans not very long ago, where, after prolonged symptoms of stricture, death took place very suddenly, apparently from peritonitis, and there was found a fistulous tract which extended from the ulcer of the intestine, undermining the wall, to the peritoneal cavity.

As Dr. Cushing says, in the treatment of this affection, each case has to be judged by itself. I have recently been seeing a case of intestinal obstruction, where, after complete stoppage for two or three weeks, there was the spontaneous evacuation of semi-fluid feces and for some weeks or months afterward no further symptoms of obstruction till another acute attack which went on some two weeks or more, when, after repeated punctures of the intestine (the abdomen being very much distended) a large amount of gas escaped. In the course of some hours about six quarts of frothy, fecal matter came from the rectum. Such a case illustrates what is very well recognized, that in order to overcome even a complete obstruction it is not absolutely necessary that a colotomy should be performed.

¹ See page 371 of the Journal.