fore the American Neurological Association at Washington, D. C., 1913, and at the International Medical Congress at London, Eng., 1913, and will be shortly published in this series of medical contributions.²¹ An extension of the work to manic-depressive insanity, and other obvious extensions, will be carried out as time permits.

SUMMARY AND REMARKS.

A general picture is offered of the medical scientific activities of the State Board of Insanity of Massachusetts. The duty of investigation and publication as prescribed by law, and the special duties of the pathologist to the board are summarized.

A general summary of the various pieces of investigation before and after the special appropriation was made is given. It is estimated that over twenty-five workers have contributed to various aspects of the different investigations. The investigations are listed under fourteen heads, of which eight relate to work done subsequent to the special appropriation.

It is impossible that studies of this particular type and range shall be carried out without special funds, such as the New York Lunacy Commission and the Massachusetts Board of Insanity provide. It is hoped that other states will be prevailed on to establish a similar policy. The amount of money necessary for such investigations is negligible as compared with the money spent on maintenance; the results, however insignificant they may appear at a given moment, are bound to be some day of importance.

It is planned in future to publish various medical contributions from the State Board of Insanity in various appropriate journals with serial numbers such that readers may readily refer back to earlier contributions.

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- ²⁰ Especially see publications mentioned under notes 13 and 14.
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OUR LITTLE BALLOONS. SOME OBSERVATIONS ON GAS AND PTOSIS.

BY E. A. CODMAN, M.D., BOSTON,

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ALMOST every medical journal one takes up nowadays has an article on ptosis. There is much discussion of the "ligamentous supports" of the abdominal viscera, of "muscular relaxation" of the abdominal walls, of "congenital adhesions", of "non rotation of the colon", of variations in the "poise of the skeleton", and of alterations of the normal "pear shape" of the abdominal cavity. According to Goldthwait all our organs are hung on a peg by the cervical fascia, and by lines of traction through the pericardium and mediastinum.

So far every theory seems based on the idea of the weight of the viscera producing a downward drag. The writer wishes to emphasize another neglected element—the balloon effect of the gas in the hollow viscera. The x-ray shows us that we have at least four little abdominal balloons which are constant in all individuals.

1. The stomach.
2. The hepatic flexure.
3. The splenic flexure.
4. The small intestine.

The last mentioned is a coiled compound balloon. The sigmoid and rectum might also be included and doubtless are the safety valves of the system since their gaseous content is more or less under our voluntary control.

Consider the viscera from below upward. Suppose a ptotic cadaver with the stomach, ascending colon, transverse colon and descending colon left *in situ*, and the rectum, sigmoid and small intestine removed, and each of these latter inflated with gas and tied off at both ends.

While some one carefully holds up the transverse colon by the omentum we will now pack into the empty lower half of the abdomen the organs which we have removed and inflated.

First, our little rectal balloon very nearly fills the bottom of the pelvis; over that the sigmoid fits quite naturally and almost fills the remainder of the pelvis. Now with much difficulty and crowding the distended small intestine is forced in under the transverse colon and the omentum nicely tucked down in front of it. The abdominal wall is then closed.

Set the cadaver upon his feet. Has he got ptosis now?

The transverse mesocolon is held up like a shelf by the compound balloons underneath it. On top of this shelf rests the stomach. It cannot drop down, and if the omentum is long and nicely tucked in it keeps the small intestine from bobbing up in front of the colon.

Now this change does not demand the strengthening of "ligamentous supports" in the neck or elsewhere—in fact, all the natural supports were cut when the viscera were removed to be blown up individually.

Diagram of our little balloons with their uplifting tendencies. N. B. If you wish to send a fragile liver by express, pack the bottom of a barrel with inflated small intestines; put in the liver; tack down a rubber apron over it and fill the remaining space with inflated lungs.

The healthy individual whose normal appetite furnishes fermentation to his intestine so that there is always plenty of gas in the small bowel to hold his transverse meso-colon up.

The ptotic individual whose sensitive intestine is irritable to the normal amount of gas and who does not eat enough fermenting food to cause natural distension. These patients complain of gas but they are not distended.

When we add to the picture by putting a toy balloon in the top of the stomach and other smaller ones in each of the colonic flexures we can readily see that the hollow viscera are likely

to fly away with the liver! And by the way, the liver has an easy time of it riding on an air cushion all day!

Looking at ptosis from this point of view many interesting questions come up.

Should we not feed ptotic individuals with gas-producing foods, and teach them to endure temporary distress from distention for the sake of crowding their organs up into place?

Should we not urge these poor collapsed individuals to retain the gas which they seem impelled to eruct or expel?

What are the effects in the standing patient of inflation of the colon as seen by the x-ray?

Do different articles of food produce different kinds of intestinal gas?

Are different kinds of gas equally agreeable to the intestine?

What are the toxic effects of the absorption of different gases?

Why is it that some patients who are obviously not distended complain of distress from gas?

What are the laws governing the manufacture and absorption of intestinal gas?

Do individual coils rise and fall in the abdomen according to the weight of their contents?

And many more!

Clinical Department.

REPORT OF A FEW CASES WHERE SUTURES INSTEAD OF PACKING HAVE BEEN USED AFTER SUBMUCOUS RESECTION OF THE NASAL SEPTUM.

BY MARGARET L. NOYES, M.D., BOSTON.

In ten cases of submucous resection of the nasal septum, in which through and through sutures have been placed to hold the flaps, instead of using the packing, the report is favorable.

The method according to Lothrop¹ has been used. It is in brief, as now used, as follows: Pass the needle threaded, from above down, into the left nares, carrying it as far back as the bone and cartilage has been removed. Pass through both flaps of septum, withdrawing the free end of suture from right nares. Attach a hemostat, then withdraw needle, without unthreading, to anterior edge of septum, just posterior to incision; pass as before through both septal flaps, withdrawing the loop through the right nares. Pass the free end of suture first withdrawn through the loop and draw back the needle and suture through left nares, making a quilting stitch. After taking as many as necessary for firm splinting, perhaps five, tie all the sutures at once lightly under the columella of

¹ Oliver A. Lothrop: BOSTON MED. AND SURG. JOUR., Mar. 28, 1912.

nose. In the cases reported here the results were good in all but one. In that one, on the fourth day a swelling came between the flaps and pus was found upon making an incision for drainage. There resulted a small perforation near the floor and just posterior to primary incision, which was due no doubt to the poor placing of sutures and so drawing the flap back and exposing a tear on opposite flap. The abscess healed after a few days' treatment. It did not seem to be due to the sutures, but to faulty technic of a clinic operation.

Advantages:—

1. Does away with discomfort of nasal packing.
2. Allows free breathing through nose at all times following operation.
3. Results in less trauma to turbinates and thus a quicker healing and restoration to normal, the functions of the nasal mucous membrane.

Disadvantages:—

1. Five to ten minutes necessary to place sutures.

Reports of Societies.

ASSOCIATION OF AMERICAN PHYSICIANS.

TWENTY-EIGHTH ANNUAL MEETING HELD IN WASHINGTON, D. C., ON MAY 6, 7 AND 8, 1913.

(Continued from page 508.)

THE PROBLEM OF TYPHUS FEVER IN THE UNITED STATES.

DR. JOHN F. ANDERSON, Washington, D. C.: Except for isolated cases of typhus fever at our largest seaports, it had generally been believed that the disease had disappeared from the United States. The determination of the identity of the disease, described by Dr. Nathan E. Brill, of New York, with typhus fever has, however, led to the recognition and report of cases from widely separated sections of the United States. The disease apparently has a very low mortality. It is possible, however, that it may assume virulence and become even more widespread.

DISCUSSION.

DR. WM. H. THOMPSON, New York: In 1859 and 1860, I was physician to the New York Quarantine Hospital, and in that service I was constantly seeing typhus fever among immigrants coming into that port. The typhus fever I saw at that time was as different from Brill's disease as smallpox is from measles. That disease was particularly contagious, and I had several friends who contracted the disease and died of it. I think it is very unfortunate to attempt to identify Brill's disease with typhus fever.

DR. W. H. PARK, New York: We had the interesting experience of finding a family consisting of the father and three children; the father had the symptoms of typical typhus, the children those of Brill's disease. Guinea-pigs and monkeys showed the usual reactions for typhus when inoculated from all these patients.