possible. He probably arrived there within five minutes and I within ten minutes of the first alarm. When I saw the child he was completely exsanguinated and the radial pulse could not be felt nor could I be sure that I felt the carotid pulsation. The hemorrhage had been checked on Dr. Powers' arrival by digital pressure of the right tonsillar cavity. This was kept up until a tonsil clamp could be procured and placed on (perhaps half an hour) and it may be known that the child was in pretty bad condition when I say, there was absolutely no resistance made to putting a gag in the mouth and holding three fingers firmly against the side of the tonsil space during all this time. A pint of salt solution was given subcutaneously in the breast and two pints by rectum soon afterward. The child's pulse began to come back after the first subcutaneous infusion and could be counted at 160. Dr. Powers thought he had previously counted it at 200, but I could not be sure of this. Later on it fell to 140.

The tonsil clamp when applied was kept on about eight hours and when removed there was a large dark blood clot at the fossa. No further hemorrhage resulted. The child was completely prostrated and did not leave the hospital for ten days, during all of which time he ran a temperature from 100 to 102. He was extremely pallid and the throat was more septic than any throat I have ever seen. The child did not recover from the operation sufficiently to go to school for six weeks.

The nurse said that during the three hours between the operation and first alarm she had noticed no more than the usual hemorrhage until the child began to vomit and vomited fresh blood. The hospital where I performed the operation was within three blocks of my office. Had it been much further off, I do not question the case would have been dead before it could have been reached. It certainly was more exsanguinated than any case I have ever seen.

CASE II. About four months afterward, I operated on a twelve-year-old girl in Auburndale, again with large nonadherent tonsils and not having learned wisdom by experience began with the same technic of operation. Tonsils easily removed; pillars not wounded. The nurse in attendance said that the first sign of hemorrhage was observed about two hours after the operation. After a good deal of telephoning she succeeded in getting Dr. Hammond out about three hours after the operation, and I arrived about four hours after the operation. The hemorrhage, according to the physician who was one of large experience in throat cases, was very profuse, filled the throat so that she was unable to tell which tonsil it came from, consequently, it was impossible to apply the tonsil clamp. The family showed Dr. Hammond a basin which contained about a quart of blood, but they and the nurse said it did not equal all the girl had vomited. The hemorrhage had checked itself before Dr. Hammond arrived. The girl was pallid and the pulse was 130 to 140; she had sighing respiration and a good deal of faintness and complaint of thirst. A large clot of blood could be seen in the space of which one of the tonsils had been removed. The case was watched for about eight hours and then transferred in an ambulance to the Newton Hospital, not far away. She was unable to stand up and remained in bed for about eight days after the operation, but recovered perfectly.

It seems to me that these two cases which are being reported should be placed upon record.

One lesson which I certainly learned from them is that I should never again remove the tonsils under any consideration unless the case is willing to come in town and be near my office for twenty-four hours after the operation. The first case would undoubtedly have died had it been anywhere but near my office. The second case would unquestionably have died before help could have reached it, if it hadn't been that the hemorrhage ceased itself. In addition, I should advise No. 5 steel wire in threading the tonsil snare.

CONGENITAL DEXIOCARDIA.

BY W. F. DOOLITTLE, M.D., CLEVELAND, OHIO.
From the Cleveland City Hospital.

THE following described case of unusual anatomical interest has recently come under my observation.

Mr. F. N. G., aged forty-one, born in the United States, white, mechanic, applied for treatment on my service at the Cleveland City Hospital, May 31, 1907. He complained especially of "a swelling with pressure and distress" in the epigastrium, also of "swollen limbs below the knees, shortness of breath and loss of strength."

The routine physical examination showed among other things a very marked funnel-shaped breast, at whose apex at midsternum a loud diastolic murmur is

heard. By percussion and auscultation the heart was made out, lying entirely to the right of the sternum, which bounded it on the left, as shown in the accompanying diagram. The second rib marked its upper limit. The apex-impulse of the heart was located in the fifth interspace just inside the mammillary line, marking the heart's axis downwards and to the right. A movable dullness in the right axilla reaching to the third interspace obscured the outer border of the heart. Its lower bounds were also hidden by similar dullness fading into the liver flatness, which extended to within an inch of the umbilicus in the median line. The pulse

rate was irregular at 115 to 120 and quite arrhythmic. A capillary pulsation was easily demonstrated in the index finger, and the poorly sustained radial pulse on elevation aided in confirming the diagnosis of aortic insufficiency with broken compensation.

As it is not the purpose of this article to dwell on the pathology, it may be dismissed with the statement that rest in bed, moderate doses of digitalis and aspiration of 1100 cc. of serous fluid from the right side of the thorax brought prompt moderation of the symptoms. The orthopnea disappeared, the character of the pulse improved and its rate was at 80 in a few days. Following the tapping the lower border of the liver returned nearly to its normal limits and the epigastric distress then ceased.

However, the removal of the fluid did not alter the area of cardiac dullness. Inquiry of the patient revealed the following interesting facts relating to this transposed organ:

The position of the heart on his right side was noted at his birth by the physician, and the mother's attention was called to it. The patient has a twin sister whom, as a child, he very closely resembled in features, but her heart is normally located. Each of their parents was a twin, but their hearts are said to have been on the proper side. My patient has a wife and a twin son and daughter. The children are about four years old and look just alike. While the girl's heart is placed as usual, the boy's heart is, like the father's, on the wrong side of the chest. Some years ago the wife miscarried a pair of twins at the seventh month. Unfortunately no anatomical examination of the fetuses was made as to the heart's position.

It is of interest that the patient's twin sister also has a pair of twins (boy and girl), four years old, residing in a distant city, who are said to look just alike; but, in their case, my patient "thinks" their hearts are on the left side.

The patient is slightly under medium height, well nourished and claims unusual strength and health until recently. As a child he was naturally left-handed—a functional peculiarity noted in other cases of transposed heart. At school he was encouraged to use the right hand more and so became ambidextrous.

The percussion tone at the apex of the right lung is higher than that of the left—a fact which might be accounted for (in case the lungs are transposed) by the pressure of the right hydrothorax. Still, the character of the sign is but little altered since aspirating.

In conclusion, attention may be called to the following:

Dextrocardia, a local transposition, is comparatively rare and should not be confused with the not uncommon cardiac displacement due to disease. Blodgett states that in the examination of 20,000 recruits for the German army only two cases of dextrocardia were encountered.

The condition is said to have been very exceptionally noted at birth, and generally was not suspected during life.

Ballentyne, in his recent excellent work on "Antinatal Pathology and Hygiene" (1906), states that there had appeared no evidence of the transmission of this anomaly by heredity. He cites E. Rogi's cases of brother and sister as being quite unique as an instance of family tendency.

While dextrocardia is said to have been noted twice the number of times in males that it has in females, which may be accounted for by military and insurance examinations, yet many cases may

indicate a tendency for transmission, under certain circumstances, in the male line.

Aristotle was the first to describe transposed organs. It is of further historic interest that the wife of Henry IV of France (mother of Louis XIII) had the heart to the right of the sternum.

Several theories as to the cause of this anomaly have been advanced. However, Ballentyne states that the inverted position of single organs is not to be regarded as directly related to the causes of situs transversus viscerum (due to malformation of the germs, Winslow), but is ascribed to local anomalies in development, which belong to a later stage in embryological formation.

AN ABDOMINAL LESION SIMULATING CANCER.

BY BENJAMIN R. CATES, KNOXVILLE, TENN.

In the latter part of March, 1907, I was called in consultation by Dr. J. H. Wilkerson to see Mr. George Dunlap, who was suffering from some obscure trouble in the left lower quadrant of his abdomen.

I obtained the following history:

Mr. Dunlap is a merchant, fifty years old, large-boned, and inclined to be slightly obese. He relates he has always been healthy; but within the last six or seven years has been growing constipated to such an extent that he has had to use purgatives constantly.

Mr. Dunlap further says that on the twelfth of March, 1907, he retired at night as usual, remarking to his wife he "felt better than he had for months and months."

About 1 A.M. on the following morning he was awakened by a sharp pain in the left lower quadrant of his abdomen. The pain became so severe he sent for Dr. Wilkerson, who relieved him by a hypodermic of morphine and a purgative.

However, Mr. Dunlap did not feel inclined to go about his business, and was kept under the constant attention of Dr. Wilkerson.

After a few days of observation, Dr. Wilkerson suggested I be called in to consider the advisability of an operation.

When I saw Mr. Dunlap he was lying in bed, not suffering much pain; he had no inclination to move about. His pulse and temperature were normal, though Dr. Wilkerson said when he first saw Mr. Dunlap he was having fever. His abdomen was not distended.

Superficial palpation showed a slight degree of resistance on the left side, which on deep pressure in the left lower quadrant caused him to flinch and cry from pain.

From a digital examination of the rectum I could discover nothing abnormal, except, four or more inches from the anus I fancied there was a slight bulging of the bowel on the anterior surface. Anyhow, pressure against it caused pain.

With this history and examination I was not satisfied in my mind as to the pathology of the case and made arrangements to see Mr. Dunlap again in a few days. This I did without forming any well defined opinion other than that it was a case for operation.

I, therefore, suggested an exploratory operation, which was accepted.

Accordingly he was removed to the hospital of the Tennessee Medical College, and was operated upon April 4, 1907.

Thinking perhaps I might have an incipient cancer