a most extensive thrombus, which was not removed, the recovery was rapid, the neck wound healed by first intention and following the operation there were no symptoms suggestive of pyemia.

The main thing is that we have learned to diagnose this condition when present and what to do to save our patients' lives.

LYMPHOSARCOMA OF THE TONSIL.*

BY J. L. GOODALE, M.D., BOSTON.

THE patient, a woman thirty-five years of age, was seen in April in consultation with Dr. Sawyer, of West Roxbury. She gave a history of having had, several weeks previous, pain in the left tonsil and adenitis. The condition at that time suggested a severe type of diphtheria of one tonsil, with swelling and exudate.

When I saw her, on the fifteenth of April, the left tonsil was transformed into a firm, reddened mass about the size of a hickory nut, with deep extensive ulceration. The glands on that side, below the angle of the jaw, were enlarged, firm and slightly tender. Examination of the blood was negative.

The clinical diagnosis was sarcoma; we excluded diphtheria and other acute infectious diseases, together with tuberculosis and syphilis.

A portion of the growth was removed and examined by Dr. J. H. Wright, who reported lymphosarcoma of a rapidly proliferating type.

The patient was sent to the Faulkner Hospital, on April 22, where she was attended by Dr. Sawyer and Dr. F. G. Balch. On May 4 the growth had rapidly increased in size and the glands were very much enlarged. The patient was breathing with difficulty. The question arose whether it would not be wise to excise the tonsil and the glands. I therefore examined her under ether with the object of taking out what I could of the growth. Dr. F. G. Balch planned to take out subsequently the glands in the neck. It was found, however, at this time that the growth had extended to the soft palate, infiltrating it, together with the base of the tongue, so that we simply allowed her to come out of the ether, expecting that there would be nothing to do except a later tracheotomy.

I will digress a moment to say why I followed the treatment that was now adopted. A young man had been under my observation for two years with Hodgkins' disease and had been getting slowly worse, losing about forty pounds. He developed, in February of 1907, a series of boils about the groin and came to me in April, after recovery from the boils, with very marked improvement in his general condition and in the lymph nodes all over the body. It seemed possible that there was some connection between the staphylococcus infection and the improvement in his Hodgkins' disease.

Recognizing the very close relationship between the Hodgkins' disease and lymphosarcoma, it seemed to me we might utilize this idea in the treatment of the case under consideration. Turpentine was therefore injected by Dr. Sawyer into the legs with the object of making abscesses. Two minims were injected on May 25 and 27, without result except that the sites of injection became rather red and painful. At the same time injections of staphylococcus aureus vaccine were given every three days. The turpentine was increased every two days up to twelve minims at each injection. About the first of June the patient began to show improvement. The swallowing was easier and the whole condition was better, so that on the first of June she could take beefsteak, potato, etc., and every day after

* Read at a meeting of the New England Otological and Laryngological Society, March 13, 1908.

that solid food was taken. On June 8 she was out of doors. On June 10 she was talking easily, while the growth in the throat steadily diminished in size. About the middle of June it had nearly disappeared. The turpentine injections, which up to that time had been borne without great discomfort, became very painful, and on the 14th she began to have for the first time localized necrosis of the skin from the turpentine injections.

On the 29th of June she was taken home. I saw her on the 10th of July, when she had on the site of the tonsil a large stellate cicatrix and absolutely no sign of new growth. The infiltration at the base of the tongue and soft palate had disappeared. The lymph nodes on the outside of the neck had become so small that only one about the size of a hickory nut was at all palpable.

In September I saw her again and found no change, while the cervical nodes had entirely disappeared. At Christmas time I heard that she was as well as she had ever been in her life.

In making deductions from the results of treatment in this case, we must discriminate between the turpentine and the vaccine. On theoretical grounds, I am inclined to attribute the result to the vaccine. This is chiefly for the reason that the boils and abscesses which we expected to excite by the turpentine did not appear until after the growth had nearly disappeared.

We have also an analogous effect observed in the treatment of other types of sarcoma by the vaccines of streptococcus and bacillus prodigiosus. The case is presented for your consideration without attempt to theorize, but with the hope that you will be led to give it a trial in this ordinarily fatal disease.

TWO PALATAL ANOMALIES.

BY CARLETON R. METCALF, M.D., STATE HOSPITAL, TEWKSBURY, MASS.

THE two anomalies in question are, first, a double uvula, and second, an unusual cleft of the hard palate.

McKenzie, in his article on double uvula, says that this condition is "one of the rarest of embryological curiosities." Such a declaration is perhaps too forcible, for patients thus afflicted occasionally appear at hospitals. Yet reports of cases of double uvula have been very infrequent.

Of the reported cases, the least common are those in which there are two distinct uvulae, hanging side by side in the median line. McKenzie has collated 5 cases of this sort. Recent literature yields no others. More frequently one finds a rudimentary and a normal uvula in the median line; or two distinct uvulae, widely separated. The incidence of these latter varieties has been noted by Shufeldt, Foster, Somers, Coues, Ohmann-Dumesnil, Gould, McKenzie and others.

The following case exemplifies the rare form of double uvula:

G. H., male, age forty-one. Entered State Hospital April 1, 1908. History of cystitis. Had had no throat symptoms nor had he ever noticed anything unusual in his voice.

Physically the patient was sound. No evidence of cystitis existed. His voice was normal. His tonsils

were slightly red and hypertrophied. He had two distinct uvulae, one on either side of the median line, their bases about one eighth of an inch apart. The uvula on the right was slightly anterior to that on the left. Each uvula was perfectly formed and a little larger than average size. The patient was unaware of the abnormality.

The case illustrates Meckel's remark that we have in these deformities an excellent illustration of the law that each half of an organ, when it develops, reaches the same size that the whole organ would have reached had the embryological process gone on in the natural manner.

The second case is one of congenital defect in the hard palate:

R. G., born April 2, 1908. Well-developed child at full term. The infant was nursed by the mother but did not gain. The mother had comparatively little milk, but the infant seemed unable to obtain even the small amount present.

An examination of the child's mouth showed an aperture in the median line, between the palate processes of the inferior maxilla, about 1 cm. posterior to the anterior palatine fossa and about 3 mm. in diameter. The suggestion was made that the defect in the palate might be partly responsible for the inability of the child to nurse successfully. The infant was put on artificial feeding one week after birth. Various modifications were tried, administered for the greater part of the time with a dropper. Despite this change, the child continued to fail, became marantic and died on April 29.

Autopsy showed a patent foramen ovale, a moderate ileocolitis and the cleft in the palate described above. The hard and soft palates and the uvula were otherwise normal.

Von Bergmann says of this abnormality:

"The partial cleft, the uranocolobom of the hard palate, is subject to the most numerous variations.

"The rarest of all, according to von Langenbeck, is where the cleft is present between the palatine processes of the superior maxilla only, while the horizontal processes of the palate bones, the velum and the alveolar arch are normally developed."

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CASE OF TWIN INTRA- AND EXTRA-UTERINE PREGNANCY. OPERATION WITHOUT INTERRUPTION OF PREGNANCY.

BY EDWARD L. PEIRSON, M.D., NALHEM, MASS.

Mrs. B., aged thirty-eight years, sent for me Oct. 2. On arrival at her home, three miles from my house, on a farm, I found her in a very weak state, with all the symptoms and signs of a ruptured extra-uterine pregnancy. I had her immediately removed to the hospital, and operation showed the abdominal cavity full of blood and a ruptured right tube due to ectopic pregnancy of about two months. A later history showed that she menstruated the last

time early in August, had been having sharp pains in her right side for about a week, and in the early morning of Oct. 2 had very severe pain and became very faint and weak. She left the hospital on Nov. 4, and I delivered her of a full-term, mature and perfectly developed male child on May 4. I did not see her from the time of her discharge from the hospital, Nov. 4, until summoned for the labor. The child weighed over nine pounds and was the twelfth child born to her at full time, and according to her statement was as large or even larger than the majority of her children at birth. There is no doubt the child was the full nine-months. She states no intercourse took place with her husband before December.

It seems this is undoubtedly a twin pregnancy occurring in August, one child in the tube and one in the uterus. The former ruptured and she was operated upon without disturbing the uterine pregnancy. Unfortunately in the hurry of operating on a desperate case no note was made of the size of the uterus at that time.

Reports of Societies.

NEW ENGLAND OTOLOGICAL AND LARYNGOLOGICAL SOCIETY.

A MEETING of the society was held March 13, 1908, at the Massachusetts Charitable Eye and Ear Infirmary, Dr. A. COOLIDGE, JR., in the chair; Dr. W. F. KNOWLES Secretary.

Dr. J. L. GOODALE read a paper on

LYMPHOSARCOMA OF THE TONSIL.¹

Dr. J. PAYSON CLARK read a paper

RESULTS IN ADENOID AND TONSIL OPERATIONS. A STUDY OF A SERIES OF CASES.²

Dr. D. A. HEFFERNAN read a paper on

REMOVAL OF THE TONSIL IN CAPSULE.

(Published in this JOURNAL, April 16, 1908.)

DISCUSSION.

Dr. H. P. MOSHER: In connection with this question of dissecting out the tonsils I have done a certain amount of work upon the anatomy of the tonsil at the medical school. I have brought here to-night a number of specimens illustrating certain important points. I will state briefly what these points are. The readers have spoken of most of them in their papers.

Dr. Barnes dwelt on the thinness of the capsule of the tonsil. It is hard, of course, to get tonsils of any size in the dissecting room. In all the specimens which I have examined the capsule is extremely thin. One of the speakers spoke as if the capsule was thick. It is not, and I feel that it would be very easy in using the finger to dissect out the tonsil to tear into or through the superior constrictor muscle.

Perhaps the most important point about the applied anatomy of the tonsil is the fact that the upper part of the tonsil is attached to the superior constrictor muscle very lightly. If an incision is made through the upper inner edge of the anterior pillar, and the plica and the anterior pillar turned outward, the upper pole of the tonsil is easily dissected free so that the tonsil can be turned inward and downward. About half way down the outer surface of the tonsil, however, the attach-

¹ See JOURNAL, p. 409.

² See JOURNAL, p. 403.