

stage by means of salines and depletion, and that it is much safer to operate in an interval; he also sews up without drainage, even those in which he finds an abscess.

In conclusion, I would say that it does not seem to me possible to lay down any definite rules as to when the operation should be done, but that each case must be considered separately. It seems to me that if it were possible to carry a patient through the acute stage without operation it should be done, since the operation in the interval by a skilful surgeon carries with it such a small mortality, and the abdominal wound can be sewed up tight, therefore minimizing the danger of a subsequent hernia.

Clinical Department.

A CASE OF MALIGNANT ENDOCARDITIS.¹

BY WILLIAM E. FAY, M.D.

THE early recognition of malignant endocarditis is so often difficult to the clinician that I desire to read this case. It is with the hope that it may be suggestive of discussion which will elucidate the way of diagnosis.

The patient was an Irish waiting-maid of twenty-two. Of her family there is little knowledge. Measles in early childhood; joints swollen and painful, with rheumatic fever lasting one month at the age of twelve; catamenia beginning three years later, always regular; occasional headaches; and a futile operation to find a needle she thought lost in her foot, comprises the known previous history.

On June 22d last, she is reported as standing in a china-closet, during a thunder storm of unusual severity, attending to her duties. Suddenly she was unable to speak. She understood what was said to her. She knew the words she ought to say, but could not utter them. From her own statement she thought she was all right in every other way, because she could move her hands and feet, and see and hear and eat. She experienced a chill some time during the next two days, when she was placed in the Newport Hospital. In a few days more she began to be able to say a word or two. Sometimes she was unable to repeat a word just spoken. She gradually acquired increasing power of speech during the six weeks of her treatment there.

On August 5th she was transferred to the Carney Hospital, and admitted to the service of Dr. James J. Minot. She had partial aphasia and huskiness of voice. Pain in left side, under costal border. Temperature 102.5° F. in the evening, subnormal in morning. A trace of albumen with a few blood and vaginal epithelial cells found at this time soon disappeared. Urine otherwise unimportant. No error detected in reaction of pupils to light or accommodation, nor in the protrusion of tongue. No paralysis. Throat and lungs normal. Apex beat of heart seen in fifth interspace, inside the mammary line. Pulse full, regular, compressible. Systolic murmur quite loud at apex, propagated into axilla, heard posteriorly at border of left scapula, anteriorly lightly over præcordia to base. Pulmonic second sound increased. Splenic area considerably increased, but limits indefinite on account of extreme

tenderness at this time. No tenderness elsewhere. No extreme tympany. Skin sensations normal.

During the following two weeks her speech became pretty natural, except for a certain hesitancy. She had a daily rise of temperature in the afternoon with morning remissions between the extreme limits of 96.4° and 104.8°.

Ten grains of quinine given at height of fever, caused gradual diminution of temperature, tinnitus and headache. Eight grains daily in divided doses was not well borne. However, during administration of quinine the variance in limits of pyrexia was somewhat lessened. Examination for plasmodium malarie was negative in results.

The patient came under my observation, during the absence of Dr. Minot, in the second half of August. She presented an aspect of anxiety, pale, eyes becoming slightly sunken. Tongue clean. No cough. No dyspnoea. No hæmorrhages. No abdominal tenderness except over area of splenic dulness. This area extended from the sixth interspace to the costal limit, where during inspiration the edge could be dimly felt. Dull pain here was more or less constant. No rose spots or petechiæ. Urine and dejections normal. Heart's murmur unchanged. Baffled in diagnosis, I asked Dr. J. J. Thomas to see the case with me and examine the blood. He found the red to the white as 100 to 1. Red normal. White in excess. Hæmoglobin 50 per cent. A condition more often pertaining to chronic, and after some acute diseases, as malaria and pneumonia, not typhoid fever.

About September 1st a small red spot appeared just below the trochanter of right femur, extending two or three centimetres. A small abscess developed at the centre, with infiltrated, uneven edge. Somewhat painful. Yielded a drop of pus. Healed in three weeks, under antiseptic dressings. Through this month patient gained a little strength. Splenic pain diminished. She sat up. A week more, and she was again in bed. Morning remissions of temperature are a degree or two less, and the evening rise higher. Pain recurs in the region of spleen. Urine becomes smoky; amount diminished; specific gravity 1.023; sugar absent; large trace of albumen; hyalin, fine, granular, fibrinous blood and epithelial casts; free blood and epithelial cells. It is five weeks since the urine was normal. In another fortnight there is one-eighth per cent. albumen; casts more numerous, of both large and small diameter. The spleen continues to be felt. Oedema of face appears. Semi-comatose condition supervenes.

On November 20th patient dies.

This illness extended over 122 days. In reviewing the time, it seems to divide itself somewhat into different periods. First aphasia is prominent, whether due to functional or organic cause? The kidneys showed no evidence to signify a causal relation to embolus. The mitral valve seemed responsible for a heart murmur, but this was thought to be an old chronic injury from an attack of rheumatism in childhood, and incidental to this illness. There had been no trauma. It was difficult to distinguish whether the trouble was motor aphasia or hysterical aphonia. There was no mind-blindness nor mind-deafness; and if Broca's region was impaired, lesion must have been extremely limited to be without some loss of function in the face, arm, or leg. In favor of the functional causation seemed to be the onset of the trouble coincident with her alarm from thunder and lightning, which frightened

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others about her; her age and sex. Also from the surgeon who sought the needle in her foot a year before, is learned her disposition then, which led him to suppose it might have been hysterically lost.

As this symptom passed, the question of malaria offers. There had been one chill reported. A suggestion of malaria accompanied her from the Newport Hospital. She had almost daily rises of temperature of four or five degrees, and an enlarged splenic area. But the lack of distinct periodicity, the tenderness disproportionate and extreme over a moderately enlarged spleen, the absence of plasmodium malariae in examinations made by the interne (Mr. Dewis), and the intolerance of moderate doses of quinine made this diagnosis improbable.

Typhoid fever was disregarded after observing that the peculiar temperature chart maintained its character constantly without any typhoidal curve, the tongue clean, no rose spots, and nothing abnormal with the bowels. In regard to tuberculosis, she had some hectic at times, progressive emaciation; and but for its rarity the skin lesion upon the thigh might have pointed to it, as it somewhat resembled the description in the books of such affections. Microscopic examination of scraping from same by Dr. Coggeshall discovered no tubercle bacillus. Examination of the choroids was not made. Tuberculosis of the spleen is always secondary, so far as I know. The lungs were repeatedly found quite normal, and no other origin of tubercular affection could be proved.

There was no condition of anæmia shown by examination of the blood to account for the patient's condition.

Some splenic or peri-splenic abscess could not be excluded by the symptoms; but the infectious source to which it might be secondary, and the source of the sudden severe nephritis did not appear. Cultures from the blood were not attempted during life. Had they been successfully made, inoculations in small animals might have given certainty, where clinical signs left us in doubt until facts were obtained by autopsy.

Autopsy eighteen hours after death, by Dr. F. Coggeshall: Small stature, emaciation. Rigor mortis marked. Scar, size of silver quarter, under right trochanter. Whole brain very soft. Left temporal lobe and adjacent portions especially softened and yellowish in color.

Organs were taken to Dr. W. F. Whitney, at the Harvard Medical School, who found the following: Heart of normal size. Right side normal. Left auricle slightly dilated. In it and on surface covered with small papillary fibrous projections which were also found on the edge of the mitral valve. With these were also associated soft, grayish, opaque small masses, especially abundant on the chordæ tendinæ. Left ventricle presented nothing abnormal, nor was anything abnormal noticed in the wall of the heart. Lungs, liver and stomach presented no marked deviations from normal. Beneath the mucous membrane in the lower part of the ilium were numerous small hæmorrhagic spots. At the root of the mesentery was a swelling, the size of an egg, composed of clotted blood, which seemed to be more or less extravasated into the tissues. The spleen was twice its normal size. Surface marked by several depressed cicatricial places, the base of which had a yellowish aspect. On section showed the pulp markedly increased; the cicatrized portions above mentioned corresponded to more or less wedge-shaped, yellow, opaque extensions into the sub-

stance of the spleen, and which were sharply differentiated from it. The kidneys were large, capsules slightly adherent. On section, found to be swollen, very moist surface, Malpighian bodies appearing as minute whitish bodies in the midst of grayish cortical substance, and with numerous small hæmorrhagic spots. There were several cicatricial places in the kidney similar in character to those in the spleen, and which in like manner were continued into yellowish, sharply differentiated, somewhat wedge-shaped nodules. Anatomical diagnosis: Softening of the brain; chronic verrucous endocarditis, associated with acute vegetative endocarditis; anæmic necrosis of spleen and kidneys, results of infarction; acute diffuse and glomerulo nephritis.

I am especially indebted to Drs. Minot and Temple for permitting me to report a case from their services at the Carney Hospital, and to Dr. Whitney for his examination of the organs.

Reports of Societies.

BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.

J. T. BOWEN, M.D., SECRETARY.

REGULAR Meeting, Monday, December 11, 1893, the President, Dr. C. F. FOLSOM, in the chair.

DR. J. J. PUTNAM made an oral communication concerning

A CASE OF MYXŒDEMA.

The patient, who was present, was a woman of forty-four, and of Irish parentage, though she had lived a great many years in America. It is interesting to note that her sister, who still lives in Ireland, also presents symptoms which strongly suggest myxœdema.

The patient's symptoms were of gradual onset, and date back perhaps a year. Previously to this she had been in good health, except that for four years past the menstruation had been irregular, and for two years she had had "hot flushes." A puffiness of the hands was noticed a year ago, but not much was thought of it until six months ago, when a swelling of the face and a slowness and huskiness of speech attracted her attention more forcibly. At this time, also, her eyelids began to droop, so that she had to drag them up by wrinkling the forehead. Soon afterwards the feet became swollen, and the hands were noticed to be dry and scaly.

These changes are said to have been gradually increasing, but even now there is nothing to attract the notice of a casual observer.

On close examination there is observed, besides the above-mentioned conditions, a slowness of the motions of the tongue, a marked trace of the characteristic alabaster appearance of the eyelids, a slightly sub-normal temperature (98° F.), slow pulse (69), and typical "supraclavicular fulness." The hair has been falling of late. The urine is normal. The diagnosis was confirmed by the fact that under treatment by feeding with desiccated sheep's thyroids (five to ten grains daily), which had been going on for two weeks, there had been a steady gain in all respects, except that the hair had continued to fall out.

[At the present time of writing this improvement