DR. BENJAMIN R. SCHENCK, Detroit: The method we have followed at the Harper Hospital is to use large abdominal towels, using no sponges at all in abdominal operations. There is only one safe method, and this is the continuous attachment of the sponges, as described by Dr. Wakefield.

DR. FRANK T. ANDREWS, Chicago: I use small sponges, which are carefully counted and labeled. Sometimes I use a 6-foot strip with a nickel ring attached to the end of a 2-foot tape.

DR. BROOKE M. ANSPACH, Philadelphia: At the University Hospital, Philadelphia, we do all isolating by means of gauze taken from a long roll, using two or three thicknesses. The roll is probably 4 or 5 feet long, so that there is only one piece used to pack off the intestines and isolate the operative area. Twelve sponges are used for exposed bleeding points, and these are carefully counted, but as soon as bleeding ceases, they are removed.

Ptosia

DR. FRANKLIN H. MARTIN, Chicago: The treatment of ptosis which I employ consists of posture, temporary supports, exercise of the muscles and correction of postural habits, fresh air and feeding.

DISCUSSION

DR. W. FRANCIS B. WAKEFIELD, San Francisco: I have been using a course of treatment for the last two years almost identical with that described by Dr. Martin, and the results have been extremely satisfactory. Surgeons are short-sighted if they allow women who advertise physical culture treatment in the popular lay journals to treat such patients. One can take an intelligent nurse and train her to understand the principles of the application of such treatment and to make use of it intelligently, and it is better to take the necessary pains to do this and take these cases out of the hands of those outside of the profession. The means of cure will be found very useful.

DR. CLEMENT CLEVELAND, New York: The posture referred to by Dr. Martin is not the Trendelenburg, but merely an inclined posture with the head downward. The Trendelenburg posture requires relaxation not only of the abdominal muscles, but of the psoas muscles. In order to get this, it is necessary to flex the thighs on the pelvis with easy lifting. The only table which will do this is named after myself, and it has been in existence for years.

DR. RICHARD R. SMITH, Grand Rapids, Mich.: These women come to the gynecologist in the great majority of cases in a state of fatigue. A woman who is enteroptotic, who is leading a life within her strength, does not suffer at all, but goes about and does her work, and takes her part in society with other women. She has a certain amount of vitality, but she gives out more easily. The keynote of the situation is that she needs rest, both physical and mental. She needs to improve her nutrition, which means better food, fresh air, or whatever other means we may employ. Mechanical measures will help incidentally, and if one can employ them in conjunction with the other things, surprising results may be obtained.

DR. WILLIAM S. STONE, New York: I find walking to be one of the best forms of exercise. If the principles are carried out, it means exercise and rest. A specific way of doing that is to tell these patients to take a walk and walk a little further than they want to, and they should take the walk at such time, so that when they reach home, without doing any work, either physical or mental, they can lie down on the bed or sofa for the same length of time that is consumed in taking the walk. They should be trained to carry out regular exercises, which should be followed by rest. In addition to that, I rely on a good, brisk, careful rub.

The Torsion of Tubal Enlargements with Reference especially to Pyosalpinx

DR. BROOKE M. ANSPACH, Philadelphia: A woman, aged 26, entered the hospital with symptoms of acute appendicitis. Operation revealed torsion of the right tube and ovary. The

tube was distended and filled with pus. The ovary was closely applied to the tube. The mass was purplish-black in color, and almost entirely free of adhesions. Tuberculosis was suspected as the underlying cause of the pyosalpinx, but the histologic examination did not confirm the opinion. Two years later the patient returned for another operation and the left tube was found to be tuberculous. It was considerably enlarged and evidently represented the condition of the right tube before torsion had occurred. Histologic examination showed typical miliary tubercles.

The variety of tubal enlargement which most frequently undergoes torsion is a hydrosalpinx. Ectopic pregnancy and cysts originating in the tube itself and malignant tumors are other causes. There are twelve cases of twisted pyosalpinx reported in the literature. A considerable portion of these were proved to be tuberculous, and it is likely that tuberculosis is the cause of at least half of the reported cases.

(To be continued)

MISSOURI STATE MEDICAL ASSOCIATION

Fifty-Fifth Annual Meeting, held at Sedalia, May 21-23, 1912

The President, DR. ROBERT H. GOODIER, in the Chair

For a list of the officers elected see THE JOURNAL, June 8, p. 1763.

Recognition and Treatment of the Early Manifestations of Mental Diseases

DR. C. R. WOODSON, St. Joseph: If manifestations of mental diseases are recognized early the percentage of recoveries is increased, the mortality lessened, the cost of maintenance reduced and the terminal dementias fewer. Preventive medicine is as applicable to mental diseases as it is to any branch of medicine. The use of hypnotics to produce sleep in insomnia should be condemned, as they tend to increase nervousness and do not produce natural sleep, nor have the same effect on the same person in consecutive doses. Rest, diversion and proper up-building will give far better results.

Fractures of the Larynx

DR. W. E. SAUER, St. Louis: A laryngofissure is superior to a tracheotomy, not only as an immediate measure for saving life, but in preventing adhesions between the walls of the larynx which may result in a permanent stenosis. A boy of 14 was kicked on the neck by a horse. At the time of the accident the patient coughed up large quantities of blood, and soon noticed a difficulty in breathing, with hoarseness. These symptoms grew gradually worse, until he could speak only in a whisper and could breathe with difficulty. I did not see this boy until six weeks after the injury. He had lost considerable weight and presented the general appearance of a tuberculous patient. There was a marked stridor and he was compelled to walk very slowly in order to get sufficient air. There was a marked flattening over the pomum Adami, and a distinct depression could be felt over the left thyroid cartilage. The patient was absolutely aphonic. Examination with the laryngeal mirror revealed the interior of the larynx almost closed, with the exception of a small opening through which a small probe could be passed. A tracheotomy was done. Owing to the run-down condition of the patient it was thought advisable to wait before doing a laryngofissure. The latter was done a few weeks later. In the interior of the larynx there was a mass of scar tissue. The vocal cords could not be distinguished; some of this tissue was removed, and the skin was stitched to the mucous membrane.

A soft rubber tube was inserted into the larynx and the wound was packed with gauze; the dressing was changed daily, inserting a larger tube each time; by this means a gradual dilatation of the larynx was effected. At the end of two months the external wound was closed. The largest size O'Dwyer intubation tube could be inserted into the larynx with ease. The patient was able to breathe normally and

was able to make himself understood, although his voice was hoarse. His voice has been gradually improving with no evidence of a return of the stenosis.

Multiple Primary Carcinomas of the Jejunum

DR. F. W. BAILEY, St. Louis: My patient, 53 years old, complained of attacks simulating stomach ulcer. He gave a history of indigestion extending over twenty years, alternating with constipation and diarrhea. Stools were black and tarry. There were attacks of slight jaundice on a few occasions; pain was always high in epigastrium. Diet was necessarily limited. The attacks became more severe and frequent. Physical findings were negative, except for dilated stomach. No mass was palpable. Exploration was refused. Patient returned to hospital Feb. 18, 1912, with symptoms of complete pyloric stenosis, extreme emaciation and continuous vomiting. No tumor was palpable until patient was anesthetized. A movable tumor to left of the median line, posterior to the stomach was detected. The exploratory incision revealed the stomach and gall-tract to be free from adhesions and no signs of tumor or ulceration. Stomach was greatly distended. The pylorus admitted three fingers. The duodenum was 3 inches in diameter, the walls greatly thickened. This dilatation led to a point 18 inches below the ligament of Treitz, where an orange-sized mass was found and delivered. The jejunum being still dilated, it was traced to another tumor, slightly smaller, 4 feet below the first. No palpable evidence of any other visceral involvement. Rapid double resection was done using suture above and Murphy's button below, being careful to remove the large glands. Patient reacted nicely and left hospital in good condition twenty-two days later. Patient is steadily gaining, and is free from all intestinal symptoms. Pathologic diagnosis adenocarcinoma. Small intestine metastatic carcinoma.

Some Observations on Movable Kidney

DR. H. C. CROWELL, Kansas City: It is begging the question to attribute all the manifestations noted in connection with a movable kidney to neurasthenia, although most of these patients are neurasthenic, because of the disturbance produced by the position of the kidney, which can and should be corrected in the full confidence of very marked if not absolute relief of the symptoms, if no other agent is operating to defeat such a result. The claim that tight lacing acts to produce the condition is challenged as being far-fetched and incapable of demonstration. On the contrary, it can be demonstrated that properly fitted corsets serve better than bandages in holding the kidney in place, though I have no confidence in either as even a satisfactory factor in bringing relief. Neglect and temporizing treatment bring only reflection on those who employ either. Operative treatment by fixation has given reasonably satisfactory results. Patients so treated have regained their lost flesh, the thing most desired, but rarely realized, by those who palliate only. There are some patients who have not only a falling kidney, but a general enteroptosis. It must be admitted that in some of the long-standing cases the patients do not satisfactorily recover from the neurasthenic habit into which they have fallen, but so universally have I seen some benefit accruing that I have no apologies to offer for recommending a fixation.

Single Incisions in Vaccination

DR. GEORGE DOCK, St. Louis: Single incisions are made either with a scalpel or with a vaccine point. The operation should be as aseptic as possible. Antiseptics are not necessary and are very likely to interfere with the "take." Protective dressings are not necessary, but if the clothing and habits are such as favor accidental infection, a thin, dry, sterile gauze may be used.

Emphyema in Infancy

DR. JULES M. BRADY, St. Louis: Emphyema in early life, owing to its frequency and to the fact that it is often not recognized, assumes very great importance. Next to exploratory puncture, the sense of marked resistance imparted to the percussing finger and the displacement of the heart are the most valuable signs. The fact that the recognition of

the true condition followed by proper treatment almost invariably rescues the child, if over 2 years of age, from almost certain death, demands that physicians caring for children be on the watch for this complication. In the case of a breast-fed baby, aged 6 months, it was learned that the baby had been well up to six weeks before. At that time it took sick suddenly with pneumonia. After a desperate illness of nine days the fever abated. Ever since the baby has been losing weight; at the time of examination it presented the picture of marasmus. Of special interest was the presence of Brudzinski's neck sign, which in an acute disease is strong evidence in favor of meningitis. The fontanelle was level and there was no other sign pointing to this complication. Under local anesthesia the seventh intercostal space was incised in the posterior axillary line and two rubber drainage-tubes were inserted. Six days after operation the neck sign of Brudzinski could not be elicited. After four weeks there was still a profuse discharge from the chest wound, and the nutrition had not improved. A resort was then made to pneumococcus vaccine, 400 million being injected every other day for five doses. The result was as prompt as that following the use of staphylococcus vaccine in furunculosis. The problem then was to cope with the nutritional disturbance now that the empyema had been cured. Two feedings of Keller's malt soup, prepared with extract of malt, flour, carbonate of potash and cow's milk were resorted to with prompt improvement; these were later increased to five. In the course of two months the baby had recovered completely.

Acidosis

DR. O. H. BROWN, St. Louis: One certain cause of acidosis is carbohydrate starvation. This causes the body to depend on fat for its energy, and in the course of fat catabolism there result certain fatty acids that are only slowly oxidized, and hence there may accumulate therefrom a harmful quantity of acids, chiefly beta-oxybutyric and diacetic acids. A second cause of acidosis, one recently brought forth by Fischer, is the group of conditions at the basis of nephritis. These may be bacterial toxins, other poisons, cardiovascular disorders, or excessive exercise. The final result is the same in that there is a general interference with the oxidative processes of the cells of the body and an accumulation of waste which, in the main, consists of harmful acid products. Fischer sustains this theory with most convincing experiments and argument. A third cause of acidosis seems possibly to be based on injury of the liver or a perversion of the function of the body ferments. This, however, is mere speculation. So far, the extent of treatment is an administration of sodium carbonate or other alkali and some carbohydrate, if the lack of this has been the cause. Prophylactic treatment is to be aimed for.

Auto-Intoxication

J. M. BELL, St. Joseph: This condition is more frequent than usually credited. It is a concomitant of almost all digestive disturbances, particularly those of impaired motility. It arises from decomposition of animal food and from bacterial activity in the intestine. Indican should serve as an index to the digestibility of meat. When this is present in the urine, animal foods should be reduced until it disappears. Its constant presence creates a condition frequently called chronic malaria. Eczema, psoriasis and acne, unless very chronic and of long standing, may be disposed of by a change from an animal to a fruit and vegetable diet, plus liberal quantities of cold water. When its existence is the result merely of deficient peristalsis, change of diet, with colon irrigation with ichthyol and abdominal massage will dispose of it. When the result of distinct pockets arising from adhesions or ptosis of the intestinal tract, surgery is indicated. The relation between such toxic absorption and thyroid disease and, in fact, that of all the ductless glands is becoming appreciated. While indicanuria is not *per se* a dangerous condition, its persistence indicates a process within the intestinal tract which tends toward invalidism rather than health; a lack of harmony between diet and digestion which lowers resistance and prepares a soil which invites disease.

Chronic Recurrent Septic Endocarditis

DR. L. H. HEMPELMANN, St. Louis: Chronic recurrent septic endocarditis is an affection which develops in persons who have old valvular lesions. The predominating symptom is fever, which persists in spite of all treatment for weeks and even for months, cases lasting four to six months being not unusual and one case of eleven and another of thirteen months being reported by Osler. The course of the fever is usually not quite as regular as we usually see it in typhoid, and there are often occasional chills and sweats. The heart may show absolutely no change for months, there being no demonstrable change in the old murmur and no increase in the dullness or change in the rate of beat that can not be accounted for by the temperature. Emboli frequently occur, their most usual sites being the kidney, spleen, lung, brain or extremities. There is often an early anemia which when taken with the enlargement of the spleen, which is usually present, may lead to the erroneous diagnosis of splenic anemia. Blood cultures are of great value, the organisms most frequently isolated being the pneumococcus, streptococcus and gonococcus. The prognosis is always very grave, fully two-thirds of the patients dying, although recovery, of course with a damaged heart, has been reported even after an illness of six months' duration.

The treatment is mainly hygienic and dietetic, a liberal diet being indicated rather than the liquid or semisolid typhoid diet. Hexamethylenamin, Credé's ointment, quinin, and the like, while worthy of a trial, have in the main been useless. The serums and the vaccines, too, both the autogenous and the stock vaccines, have not given uniform results, most authors reporting unfavorably their use. I have had three cases, one a gonorrheal case, terminating in recovery after an illness of six months, and two fatal cases, lasting three and six months, respectively. The former case was due to a streptococcus but the antistreptococcus serum did not seem to be of any benefit. The last case due to the *Staphylococcus albus* (?) showed no improvement after an autogenous vaccine. In this case, too, there was an embolus of the tibial arteries of the right leg which led to gangrene of the foot extending up to midway between the ankle and the knee.

Experimental Work on Anti-Rabic Immunization with Desiccated Virus

DR. D. L. HARRIS, St. Louis: Employing a modification of the method of desiccation described by Shackell, I have been able to dry fixed virus so that from 30 to 50 per cent. of the infectivity remains after complete desiccation. The essential feature of this method is the freezing of the "virus" with carbon dioxide snow and drying this *in vacuo*, in the presence of sulphuric acid at a temperature of -15°C . The dried material, when kept in a cool dark place, free from moisture, loses its infectivity very slowly. After five months it still shows a virulence greater than the two-day cord of Pasteur. The relative permanence of this material has led to an attempt to "standardize" the virus and to determine the amount of infective "units" which will immunize animals. Experiments have shown that rapid and complete immunity may be established in dogs and rabbits by the injection of this material.

The Value of Beginning Passive Motion Very Early Following Fractures In or Near Joints

DR. CARROLL SMITH and DR. H. S. MCKAY, St. Louis: The after-treatment of fractures is often more important than the primary treatment. A good functional result after a fracture, even with some anatomic defect, is better surgery than a perfect anatomic result with poor function. Immobilized joints may ankylose in a very short time, and since forcible movements cannot be employed to break up joint adhesions for from two to three months after the injury, it is important to prevent adhesions from forming. The early and intelligent use of massage and passive motion is the best way to accomplish this end. The time at which massage should be begun and the amount of motion must be determined by the conditions present. The measures should not be used until primary pain, muscular spasm and swelling have subsided, for if they are used too early, hemorrhage may be kept up, fragments dis-

placed, muscular spasm made worse or fat embolism caused. Too early and too much motion may cause excessive callus or lead to non-union. Massage, properly used, aids absorption of periarticular and joint effusions, prevents atrophy and weakness, hastens healing and lessens joint and tendon-sheath adhesions and ligament contractures. When Lane's bone-plates are used one should remember that softening occurs about the screws used in applying the plate between the fifth and tenth days and that callus does not form so early nor in such amounts as in the older methods of treatment. After about fourteen days, however, the screws are again held firmly and then more or less motion is permissible. Early, careful massage in such cases does no harm and its use is to be recommended.

Several cases are reported to illustrate what may be accomplished by careful, personal attention to the details of after-treatment in fractures.

Thoracentesis as an Aid in the Diagnosis of Pleural and Pulmonary Diseases

DR. W. P. ELMER, St. Louis: I have had four cases in which the diagnosis was facilitated by thoracentesis. 1. Putrid bronchitis with emphysema bronchiectasis and thickened pleura in a child which might have been diagnosed empyema. 2. Lung abscess following amebic dysentery and complicated by enlarged and tender liver, which was first explored for liver abscess; would have had a better chance for recovery had the abscess been drained when it was demonstrated by thoracentesis. 3. Putrid bronchitis with bronchiectasis and acute pleurisy with effusion; would have been operated for empyema but for the result of the thoracentesis. 4. Putrid bronchitis with pleural thickening in an adult; was rendered more confusing by the x-ray which showed a shadow resembling a cavity which, however, could not be located with the needle and which did not change with improvement of the patient. It may be contended that the thoracentesis was in itself a therapeutic procedure in some of these cases and that in reality empyema was present in these cases with thickened pleura. The therapeutic effect of thoracentesis cannot be denied, but the thoroughness with which the explorations were performed, reduces the chances of mistake though it does not eliminate them.

AMERICAN PEDIATRIC SOCIETY

Annual Meeting, held at Hot Springs, Va., May 29-31, 1912

(Continued from page 2047)

Inclusion Bodies in the Blood of Scarlet Fever as a Means of Differential Diagnosis

DR. MATTHIAS NICOLL, JR., New York: With the purpose of testing Dohle's findings, I have studied blood-smears from fifty-one scarlet fever patients, together with twenty-five controls, with the result that forty-five scarlet fever patients showed inclusion bodies such as Dohle has described, and six failed to do so. In the great majority of the positive cases the patients had been sick a week or less. The inclusion bodies were found chiefly in the polymorphonuclear leukocytes and varied in size and shape from small coccus forms to large irregular masses one-fifth the size of a red blood-corpuscle. Bacillary forms were also seen. With Manson's stain the nuclei take on a deep blue color, the cytoplasm a faint blue, and the inclusions a tint between the two. With the Giemsa stain, the inclusions take on a clear delicate blue identical with that of plasmin, and the nuclei color magenta. For satisfactory examination it is essential to take a small drop of blood and spread it out evenly and thinly so that the leukocytes will not be distorted or cramped between red blood-cells or groups of other polymorphonuclears. The smear is fixed in methyl alcohol, thoroughly washed and stained with Manson's stain, for ten seconds to one-half a minute. It is then washed and examined with the oil immersion. It seems that we have in the blood examination of suspected scarlet fever patients an extremely valuable method of differential diagnosis between this disease and nearly all of the conditions which resemble it.