intense headache. The pain was terrific, absolutely unbearable, and was accompanied by a spasmodic twitching of both sterno-cleido mastoids. His favorite attitude was with his hands folded behind his head, or with his head and shoulders bent forward, lying curled up with his back very much rounded.

After etherization, I laid open the sinuses in the scrotum, perineum and buttocks. Two of them were symmetrical and were found to spread out beneath the skin, as tubercular abscesses do. None of the sinuses communicated with the urethra; they were curetted and packed with iodoform gauze. A small bougie was then passed into the bladder, and the urethra divulsed with Bigelow's divulsor. The points of most resistance were near the glans and in the membranous portion of the urethra. There was no bleeding. A large-sized elastic catheter was easily passed into the bladder, and was tied in and connected by a rubber tube with a bottle. But little urine was secreted after the operation. Eight hours later the patient died. The autopsy showed clearly the causes of the pallor, weakness and headache and the effects of the divulsion.

Dr. Whitney reports that the calvaria was thin and its inner ridges and markings extremely prominent, recalling the appearances in the skulls of very old people. In the right hemisphere of the cerebellum was an area of red softening occupying the central portion for its entire thickness. The area was rather pyramidal in shape, and its greatest area was about one inch square. The blood was dark red in color, and was evidently of quite recent origin (probably within a week). About six inches above the ileo-caecal valve was an irregular ulceration, about three-quarters of an inch in diameter, which was well into the muscular coat. The lymphatics were distended with an opaque cheesy material. The glands at the root of the mesentery were enlarged from the size of a pea to that of an orange, and on section contained abundant creamy pus with cheesy periphery. The intestine below the ulcer was filled with dark tarry blood. In the prostatic portion of the urethra were several holes, capable of admitting a sound, which passed into the prostate and from which yellow pus could be squeezed. The prostate was completely riddled with abscess formations. To sum up: Red softening of the cerebellum; tuberculosis of the mesenteric glands and tubercular ulcer of the intestine; abscesses in the prostate and about the perineum and anus; recent rupture of the urethra from divulsion. Any other changes in the viscera, if present, were masked by the fluid injected by the undertaker.

The appearances of the urethra in the recent state were as follows: At a point two and a half inches from the meatus, and extending two and five-eighths inches downwards, is a clean cut, or tear, parallel with the axis of the urethra. This cut or tear (linear) extends through the mucous membrane and through the submucous tissue, an eighth of an inch in depth. In the alcoholic specimen you see at the side of this cut, a shred of membrane (possibly mucous membrane, probably not), but I am not sure that this was there when the autopsy was made; it may have been made in the slitting open the urethra. In the membranous portion is a clean cut or tear on the floor of the urethra, one inch long and extending to the prostatic urethra, but not into it. The prostatic urethra and the prostate gland are riddled with holes and abscesses of long standing. At first sight this seemed to me

rather too extensive a splitting, as the result of the passage of the divulsors, but the more I have studied it and thought about it, the more I am convinced that it was a most excellent result and could not have been obtained in any other way. There was absolutely no hæmorrhage, nor an ecchymosis. The cuts were as straight and clean as if made by a knife and not ragged and there was no bleeding as there would have been with a knife. There were two strictures, one in the pendulous portion of the urethra, the tightest, and one in the membranous portion. If the urethrotome had been used there would have been considerable bleeding and the division of the stricture would have been no more satisfactory, though the incision in the urethra would probably have been shorter.

On the whole, I regard this linear splitting of the urethra, without hæmorrhage, almost the ideal treatment for stricture of the urethra, and if divulsion often effects such a bloodless and thorough division, I regard it as perhaps the best method of treating a stricture, at least a deep-seated one.

ŒSOPHAGOTOMY, WITH HEALING BY FIRST INTENTION.¹

BY ABNER POST, M.D.

THE following case of œsophagotomy presents some features of interest, especially in its recovery. The patient was a little girl twelve years of age who on her birthday received as a present a bright new silver twenty-five cent piece, which was a larger sum of money than she had had at her own disposal before. In her excitement she put it in her mouth, and accidentally swallowed it. For the first day after the accident she was unable to swallow anything. On the second day the coin evidently shifted, and she was able to swallow liquids. At the end of the second day she was brought to the hospital. I saw her late the next forenoon. She was evidently in pain; and when I approached her, she screamed, and grasped her throat by both hands. It was impossible even to touch her without anaesthesia, and the next day was appointed for the operation. The next morning she persuaded her nurse that she was able to swallow, that the coin had passed down; and I was so informed, so that I did not see her till late that forenoon, when I asked to see her swallow. She took but a single swallow, grabbed the throat with both hands, and made that characteristic painful deglutition which is so well-known with difficulty in the œsophagus. I was obliged again to postpone the operation until the next day, which was the fifth since she swallowed the coin.

When she was etherized an attempt was made with the coin-catcher to catch and extract the coin. I succeeded in locating it, but did not catch the coin. The bristle probang was then passed; it came up showing that the bristles had spread irregularly, and that the portion of the probang where the bristles had been thinnest had caught in the coin. The instrument was passed again, but no force that I dared apply would stir the coin. The probang came up with a little blood, and it was evident that œsophagotomy was necessary. The child being already on the table, the head turned to the right exposing the left side, which was made prominent by placing a rolled sheet beneath the

¹ Read before the Boston Society for Medical Improvement, November 13, 1893.

neck, it was then possible to feel the coin from the outside at a point midway between the cricoid cartilage and the sternum. An incision was made along the anterior border of the sterno-mastoid which was loosened, and with the vessels beneath was pulled outward with a spatula; the depressors of the hyoid, which were pretty wide, were loosened at the edges and pulled inward. The sterno-mastoid had been pulled to the outside, the trachea gently pulled to the inside, and the omohyoid depressed, so that there were three spatulae, one pulling in, one out and one down. Very little manipulation with the trachea in the region of the œsophagus liberated a few bubbles of gas, which were explained later by seeing that the coin had begun to penetrate the walls of the œsophagus so that it was just visible. The œsophagus was then incised by a small tenotome tracing the position of the coin, which could be made out very plainly. The coin was then seized with forceps and extracted. The coin was firmly grasped by the œsophagus, firmly held on two sides, if one may speak in that way of a circular object, and when it was extracted the median line was thoroughly discolored by sulphuretted hydrogen, while the two parts on the sides that had been grasped by the œsophagus were left comparatively bright. There had been practically no loss of blood. The record places the loss of blood at less than one-half drachm. The parts were then allowed to resume their natural positions, and the external wound was closed at the top and bottom, leaving the middle portion freely open, and the child was sent back to bed. There was no vomiting.

When I visited the ward the next day the child was up, dressed and playing about the ward. To my surprise I found that she had already been fed with cracker soaked in milk, and that none of the food had appeared through the wound. From that day until she was discharged there was absolutely no leaking. It was, then, an œsophagotomy which closed by first intention. So far as I have been able to find, this is the only case on record in which so successful an issue has been reached.

In trying to explain this good fortune, I think it lies in great measure with the child. She presented a neck which seemed to have been formed by nature for the operation. It was a little long, entirely devoid of fat, and the connective tissue very slight, so that the muscles were separated with a minimum of traumatism. No vessels were cut, so there was no blood to prevent immediate union.

I think this must be the only œsophagotomy that has been done with simple aseptic precautions. So far as I know, after the skin was cleansed there was nothing that should be called antiseptic that entered the wound. The instruments were sterilized by heat; the dressing put on afterwards was gauze that had been baked.

In the majority of cases the wound does not close under two weeks. This child must be one of the youngest on whom the operation has been performed. Dr. Leroy McLean, of Troy, N. Y., reports the case of a child of sixteen months. In that case the recovery is said to have been "rapid and complete." Dr. George W. Gay has operated on a child of three and a half years.

The little girl is here to-night. She has only the scar to show. She is good enough to let us see how slight a scar can result from so serious an operation. She now eats food of all descriptions without difficulty.

PREGNANCY IN THE LEFT HORN OF THE UTERUS, SIMULATING EXTRA-UTERINE PREGNANCY: LAPAROTOMY.

BY F. W. JOHNSON, M.D.,

Gynecologist at the Carney and St. Elizabeth Hospitals, Boston.

SOME months ago I saw in consultation Mrs. M., twenty-two years of age. Menstruation (which had always been regular) had been absent for three months. During this time she had had more or less pain in the left ovarian region. At times the pain was sharp and cutting, causing her to wince and cry out. I saw her about 12 M. The family physician was called the evening before. He got a history of flowing of only a few hours' duration. "Nothing" had passed from the vagina. Great pain, at times cutting like a knife, was complained of in the left ovarian region. There was marked sensitiveness on pressure over the left ovarian region. Patient was restless, and had an anxious expression. Pulse, 120; temperature, 101°. There had been no chill. Ether was administered, and nothing was detected by the finger inside the uterus. He told her it was probably a case of extra-uterine pregnancy. When I saw her the above-mentioned symptoms were present. She had flowed some during the night and forenoon, but had passed nothing except blood from the vagina. She was pale and restless, and vomiting was present. The abdomen was distended, and so sensitive that palpation revealed nothing. Vaginal examination revealed an enlarged uterus, with an ill-defined, sensitive swelling extending from the left horn. Pulse, 130; temperature, 103°. There had been no chill. Morphine had been necessary to relieve the severe pain.

At 2.30 the abdomen was opened. Nothing except an enlarged uterus, with the left horn enlarged, and an enlargement of the left tube close by the uterus was found. With the sharp curette, a quantity of placental tissue was removed from the left horn.

Convalescence was uneventful, and she was discharged in four weeks.

She is now four months pregnant. The symptoms in this case pointing to extra-uterine pregnancy were certainly as well marked as in some of the cases where I have removed a fœtus either from the tube or the abdominal cavity.

Medical Progress.

RECENT PROGRESS IN OPHTHALMOLOGY.

BY MYLES STANDISH, M.D., BOSTON.

ANATOMICAL CHANGES UNDERLYING OCULAR DISTURBANCES OF CEREBRAL SYPHILIS.

UHTHOFF¹ reports the anatomical changes of the eyes and optic nerves of 17 cases of cerebral syphilis which resulted fatally in the Berlin hospitals.

In two cases there were intra-ocular changes; in one, irido-choroiditis, with very noticeable vascular changes (peri-vasculitis) in the retina; in the other, a gummatous formation in the iris. The optic papillæ, nerves, chiasma and tracts were involved in 14 of the 17 cases; in several the anatomical changes found *post-mortem* had not given rise to any disturbances of function.

¹ Bericht über die 22te versam. der Ophthal. Gesell., Heidelberg, 1892.