The division hospital, which is the logical unit for medical field service, and will survive the new criticism, has created for itself a picturesque reputation that is destined to make trouble. It has frames, floors, wire mattresses, much bedding, and many conveniences. The hospital of experience is a lean, though active thing, by the side of this opulent hotel. It is for nimble service, and often stripped to the simplest necessities, water-proofs, blankets, and a chance concession for empty bed sacks. It must often ignore tables of supply; it can not afford a superfluous ounce of flesh or anything else. Its transportation must go for its canvas, stores, clothing, utensils, and tools. Its intent is to cover barely, to receive the sick and wounded, but not to harbor them long; to be ready at an hour's notice to move. Furniture would be as impossible as melodeons or lawn mowers. Such a hospital must be manned. Its personnel are soldiers first, and nurses afterward; for it is for hard service, and meant for fatigue, privation, weathers and confusion. It may be idle sometimes, and acquire Spartan luxuries, but nothing but some overwhelming misery of the sick should intrude an unaccustomed and alien attendance.

May we hope that among the lessons of the Spanish War we may count this one, that the regimental and field hospitals are not the places for the treatment of typhoid cases or broken thighs, or for the best use of trained nurses.

Meanwhile questions of medical organization for war, which have, since the days of the Civil War, been in a condition of nebulous uncertainty, will in due time come before the General Staff for careful and systematic study, and although that body has, by a curious anomaly, no medical representative on it, it is probable that this defect will in time be remedied, and that the medical officer of the future will enjoy the heretofore unknown privilege of knowing beforehand what is to be the medical organization for the next war.

(To be continued.)

Clinical Reports.

EXTENSIVE PANCREATIC NECROSIS WITH RECOVERY.

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Introduction.—At this time, when the attention of the profession is directed so earnestly to the pancreas, the report of the following case, with the lessons to be derived from it, can not fail to be of much interest.

History.—W. J. G., a practicing physician of Columbus, Ohio, aged 52, had always enjoyed good health until the latter part of August, 1903. About thirty years before he had had some symptoms which led him to suspect the presence of gallstones, but he had been entirely free from the symptoms until six or eight years ago, when he became subject to occasional brief attacks of "indigestion." In August, after eating some ice cream, he had an attack of acute indigestion, with severe pain, vomiting, etc. More or less trouble in the region of the stomach persisted after that time, with several attacks similar to the one in August. During these attacks he vomited freely, and eructated a good deal of gas. The vomited material was never characteristic. Pain and soreness were at times present, which he referred to the pit of the stomach, the pain extending into the right shoulder. There was never any jaundice.

Present Condition.—Two days ago (Dec. 2, 1903), one of these exacerbations came on, but with more than usual severity. He vomited very freely the first day, but none since yesterday. Temperature at 10 a. m., 100; pulse, 100; at 4 p. m., temperature, 100.5; pulse, 108. He has had three movements of the bowels from calomel taken last night and Pluto water this morning.

Examination.—Patient has an offensive breath and some

coating of the tongue, is very tender over the entire abdomen, but most tender at the pit of the stomach, and to the right. Tenderness is so great as to render palpation and percussion entirely unsatisfactory. Some abdominal distension exists. What seems to be an indistinct tumor can be made out to the right of the median line, and just above the line of the umbilicus. Tenderness is too great for satisfactory examination.

The diagnosis of gallstones with acute cholecystitis was made, and palliative treatment advised.

Course.—December 6. Patient's condition has become very much worse in every way, and it is evident that the case is one of fulminant cholecystitis, or acute pancreatitis. The tumor previously mentioned is now more distinct, but the parts are too tender to enable its relationship to the liver to be determined. Operation was advised and promptly accepted, and the patient was at once removed to Grant Hospital for operation next morning.

Operation.—December 7. Assistant, Dr. Goodman; anesthetizer, Dr. Rice. Under the anesthetic I could determine a line of stomach tympany between the tumor and liver. This excluded the gall bladder as the site of the tumor, and left only the pancreas. Incision was made directly over the tumor. As soon as the peritoneum was opened, extensive fat necrosis was found, involving the omentum and peritoneum. The gall bladder was in easy reach, and was found to contain a number of medium-sized stones, which were removed in the usual way. No stones were present in the common duct, nor in the diverticulum of Vater. The omentum, which was unusually thick, was torn through, and the stomach lifted up, and after separating some light adhesions, the entire pancreas was explored by the hand without much difficulty. It was found considerably enlarged, the principal enlargement being in the region of the head. A large rubber tube wrapped in gauze was introduced down to the pancreas, drainage introduced into the gall bladder, which had previously been attached to the edges of the muscular incision, and the rest of the incision closed after protecting the field of operation by the introduction of washed iodoform gauze. Three of the gallstones were about the size of the end of the finger, and were very black. The rest (52 in number) were quite uniform in color and shape, being about the size of ordinary shot.

Recovery.—The patient made a somewhat slow but very satisfactory convalescence, and left the hospital, Jan. 13, 1904, with some discharge from the gall bladder and also through the sinus leading to the pancreas. January 23, patient telephoned me that he was having some trouble with the sinus, and on examining him I found the sinus plugged up with what on removal proved to be four large pieces of pancreas. February 7, he passed several other pieces, and minute bits have been passed from time to time since then, the last appearing about April 15. It is estimated that altogether from an ounce to an ounce and a half of pancreas have been thus discharged. The sinus has now practically closed.

The patient has for several weeks been steadily improving in health, and now regards himself as entirely well. At no time has there been any sugar in the urine, or fat in the stools, or other evidence of disturbed pancreatic function.

Comments.—The literature at my disposal and correspondence with Dr. Opie of Johns Hopkins Hospital, reveal no similar case. Cases are on record in which the necrotic pancreas has been discharged through the bowel, but none in which necrotic pancreatic tissue has been given exit by surgical means. The case is, therefore, of interest as being thus unique, and as showing the result of prompt intervention in a case of acute hemorrhagic pancreatitis.

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BILATERAL DUPLICATION OF THE URETERS.

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History.—G. F., male, aged 65, was admitted to the county hospital Feb. 15, 1904, presenting signs and symptoms of advanced pulmonary tuberculosis. He died Feb. 25, 1904.

Autopsy.—Both lungs were tubercular. Beside this condi-