

pale and blue around the nose; the pulse was weak and rapid; the child refused to nurse after vomiting blood, the nursing being discontinued after hemorrhage was reported. For two days vomiting of blood and hemorrhage from the bowels occurred, the latter profuse and passed in masses of clots.

Treatment.—After treatment with subcutaneous injection of gelatin solution, 2 per cent., described below, the child made a good recovery; at the end of the second week it had regained its birth weight and continued to thrive.

TREATMENT.

Different methods of treatment have been suggested by various authors. Koplik suggests the cold coil; ergotin, $\frac{1}{2}$ to $\frac{3}{4}$ grain subcutaneously; Hensch suggests one drop of liquor ferri sesquichloridi in barley water, every hour; Williams suggests gallic acid, gr. 1, every three hours, oil of turpentine, m. 1, in mucilage every hour; extract of krameria, grains 2, every two or three hours, or an injection into the bowel of an infusion 4 to 5 ounces, and calcium chlorid to increase the coagulability of the blood.

The subcutaneous injection of gelatin employed in the case reported was followed by very prompt recovery. The English gelatin was used in this case, as the ordinary commercial gelatin has been found contaminated with the tetanus bacillus.

Two sterilizations of the gelatin are made in order to be sure that this organism is destroyed. An ordinary antitoxin syringe or aspirator, without too large a needle, can be used for the injection. The cellular tissue of the back can be used, the solution warmed and 20 c.c. can be slowly injected.

Weil² of Paris experimented in patients with hemophilia, in whom he was able to control the tendency to bleed for a certain time with the injections of fresh serum. He states that the "sera of man, the rabbit, horse and cattle have been found equally efficacious, although *in vitro*, the action of the human serum is more evident in correcting the disorder." He injects 30 c.c. under the skin, and suggests the use of diphtheritic serum, if fresh.

As long as there is any bleeding from the stomach food can not be given in this way, but it can be given by nutrient enemata.

After writing this paper I saw another case, very similar to the one reported, except that the hemorrhages began on the second day and were more profuse and frequent. The gelatin solution was used subcutaneously every three hours and this child recovered, although a very grave prognosis was given.

This treatment was advised in a third case, the attending physician consulting with me in regard to it over the telephone, and this patient also recovered, though the physician thought that the child would die.

2. Internat. Clin., series 17, iv.

Tuberculosis and Discharged Prisoners.—Dr. J. B. Ranson, physician at Clinton Prison, at the recent meeting of the New York state conference of charities and correction, spoke of the danger of discharged prisoners infecting others with tuberculosis. He says that there are annually discharged from the penal institutions of the United States over 100,000 prisoners, and from the penal institutions of the State of New York 12,000. Of this number a large percentage are in some degree infected. These become scattered throughout the country, living under unsanitary conditions, regardless of the care of their person, and often indulging a feeling of hostility to society. The possibility of infection which this vast army may possess and its responsibility for the prevalence of this disease in our large cities and towns can not be estimated.

Clinical Notes

DOUBLE SUPPURATIVE PAROTITIS COMPLICATING TYPHOID IN A BOY ELEVEN YEARS OLD.*

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Patient.—T. P., aged 11, an Italian, was admitted to the University Hospital on Aug. 15, 1908. His father, mother and one brother were living and well. One sister had died, aged 15, cause unknown. The patient had never been sick before his present illness.

Present Illness.—He had been sick ten days, and in bed seven days before coming to the hospital. At first it was noticed that he stopped playing and would lie around the house most of the day. Later he complained of headache and general pains all through his body. He developed a severe diarrhea and became so weak he could scarcely move. He had no hemorrhage from the nose.

Physical Examination.—General: The patient was a well-developed boy with moderate wasting of the muscles and subcutaneous adipose tissue. The bony skeleton was well proportioned and the chest normal in shape. The patient's mental condition was decidedly dull; he was semistuporous but could be roused with some difficulty. His eyes were sunken and surrounded by dark rings. There was some ptosis of the upper lids, and the conjunctivæ were somewhat dry. The pupils were slightly dilated, equal, and reacted to light. The lips were dry and cracked; the mouth was kept open and the teeth were dry. The tongue was thickened, dry, fissured with a brownish-yellow coating, and the breath was offensive. The external lymphatic glands were not enlarged. There were no rose spots on arms, chest or abdomen. A slight Kernig's sign was present on both sides. The knee-jerks were absent. There was no ankle clonus, or Babinski. The leucocyte count was 9,600.

Heart: The apex beat was visible in the fourth interspace, 0.5 cm. to the right of the midclavicular line; there was also a diffuse impulse seen all over the precordium. Cardiac dullness extended from the right parasternal line to the left midclavicular line, and began above at the lower border of the second rib. The first sound at the apex was feeble. The heart's action was regular and slightly rapid, but no murmurs were audible. The second sound at the pulmonary area was moderately accentuated.

Lungs: The type of breathing was principally thoracic. Expansion was good, and slightly more marked on the right side than the left. Tactile fremitus could be felt normally over both lungs, and was more marked on the right side. Over both lungs breath sounds were normal, and vocal resonance was heard well everywhere. No râles were present. There was normal pulmonary resonance both anteriorly and posteriorly.

Abdomen: The abdomen was distended, particularly the lower half. There was some resistance to palpation, more on the right side than on the left. Slight tenderness was present in the region of the gall bladder. To percussion the abdomen was everywhere tympanitic. The spleen extended above from the eighth rib in the mid-axillary line to the edge of the ribs; and anteriorly as far as the anterior axillary line. It was not palpable. The liver reached from the fourth rib to the costal margin, in the mid-clavicular line. It could not be palpated.

Clinical Course.—Thirteenth day of illness: Forty-eight hours after admission there was no change in the patient's condition except in the right upper quadrant of the abdomen. Here there was localized rigidity of the abdominal walls, with marked tenderness. There was a palpable mass, dull on percussion, in the region of the gall bladder, extending in length 6 cm. beyond the edge of the ribs in the mid-clavicular line,

* Presented at the Philadelphia Pediatric Society, Oct. 13, 1908.
* From the Service of Dr. J. P. Crozer Griffith.

and in width from the right parasternal line to just beyond the right mid-clavicular line.

Fourteenth Day: The mass had disappeared, but rigidity and tenderness still remained. The leucocyte count had increased to 22,000.

Fifteenth Day: The mass in the region of the gall bladder returned, and seemed even a little larger than it was before. Rigidity became more marked, and the mass was very tender to the lightest palpation. The leucocyte count was 20,600.

Seventeenth Day: The patient developed a swelling below, extending up slightly in front of the left ear, which was tender to palpation. There was no tenderness over the mastoid, and the auricle, which was red, did not stand out any more than the right. The leucocyte count was 28,800. The patient's general condition had improved. His spleen now extended 2.5 cm. below the edge of the ribs in the anterior axillary line. The abdomen was flat. The gall bladder was not palpable, and tenderness and rigidity in the right upper quadrant was subsiding.

Eighteenth Day: In twenty-four hours the left parotid became very large, the swelling extended upward as far as the top of the ear, and as far forward as the eye. There was comparatively little swelling posteriorly, but the swelling extended downward beneath the jaw. The swelling was very firm, tender, pitted on pressure, and showed elevation of temperature on palpation.

Nineteenth Day: In twenty-four hours after we had first observed the swelling of the left parotid, the gland on the right side became involved. The right parotid appeared similar to the left gland twenty-four hours previous. The leucocytes were 21,800.

Twentieth Day: There was enormous swelling of both sides of the face, largest on the left side, where it was most prominent in front of the ear; here the skin was shiny and very tense. There was some ecchymosis below the left auricle. The lobe of the ear was swollen, and had on it a large blister. The swelling and edema extended upward 1 cm. above the auricle; and below it was beginning to extend down the neck. Posteriorly the edema almost reached the middle of the occiput. There was no fluctuation. On the right side the swelling was almost entirely in front and below the ear. On both sides there was extensive inflammation of the tissues surrounding the parotids. The leucocytes were 21,400.

Twenty-first Day: The parotid on the left side appeared to be pointing just in front and below the ear. On the right side deep fluctuation could be felt below in front of the ear. Both abscesses were opened by Dr. C. C. Rush. From the left side two drams of pus were removed, and almost a dram from the right. This pus was examined bacteriologically and contained *Bacillus typhosus* and *Micrococcus pyogenes aureus*.

Thirtieth Day: The notes state that the patient was rapidly improving. His abdomen was soft and flat, the spleen could not be felt, and there was no tenderness or rigidity in the region of the gall bladder. He looked much brighter and talked intelligently. His pulse was very small and compressible, but regular and not rapid. His temperature had shown a daily range between normal and 102. It was almost invariably elevated after his dressing was changed. The swellings in front and above the ears had almost entirely subsided, but the abscesses were not much improved. The one on the left was very deep, extending more than an inch into the deep structures of the neck, uncomfortably near the deep vessels. The pus was thick and cream-colored and very offensive; about half an ounce was daily removed from the left side, and a dram from the right. The leucocytes had dropped to 7,000.

Thirty-first Day: The openings in both abscesses were enlarged on account of the retention of pus; the one on the left side, by an incision an inch long downward and forward; the one on the right by an incision half an inch long, posteriorly.

Thirty-third Day: Two sores about two and one-half inches were discovered behind each ear. The one on the right side was a necrotic ring the size of a quarter. Cultures made from this area on bile medium in an endeavor to isolate the typhoid bacillus were negative. On the right side, although

there was no break in the surface of the skin, the area was reddened, indurated, and had a softened center. A small incision was made, but no pus obtained. Leucocytes, 6,500.

Thirty-ninth Day: An area of swelling and induration was noticed to have developed below the outer angle of the left eye, about one and a half inches in diameter, with swelling of the left eyelid. In two days the inflammation of the left cheek had subsided.

Forty-fourth Day: The parotid abscesses were doing splendidly. The sore over the occipital region on the right side continued to deepen until the bone on this side was exposed. The edges of the wound were healthy. An air-cushion was kept constantly under the patient's head, and he slept on his side, so that there was little pressure brought on that region. The same day an abscess on the side of his right hip was opened and quite a little pus removed.

Fifty-first Day: The openings of the parotid abscesses were completely healed. The sore in the left occipital region was almost well and the one in the right occipital region was healing rapidly; there was no longer any exposed bone.

Urine: On the twelfth and twenty-ninth days the urine contained a trace of albumin and a few hyaline and pale granular tube casts. The Diazo reaction was positive. On the twenty-ninth day the urine contained a large number of pus cells. On the forty-fifth and sixty-seventh days the urine examination was normal.

Blood: On the thirteenth day the blood gave a strongly positive Widal reaction. On the thirteenth day the hemoglobin was 81 per cent. On the thirty-ninth day the hemoglobin had dropped to 48 per cent. and the red blood corpuscles were 3,040,000. On the seventieth day the hemoglobin was 55 per cent. and there were 4,140,000 red blood corpuscles.

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DERMOID OVARIAN CYSTS OF UNUSUAL SIZE.*

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The following cases of dermoid ovarian cyst are of interest, not alone because of their enormous size (they weighed, respectively, 42, 39 and 32 pounds), but because of the singular fact that all three were of the left ovary.

Usually cysts of this character are small in size and of slow growth. Not infrequently they develop rapidly, attaining enormous size; rarely they become purulent, with associated fever, as instanced in one of my cases. Dr. T. Gaillard Thomas, in his "Diseases of Women," says that "dermoid cysts rarely grow larger than an adult head."

As to the genesis of these growths, the fact that they have been discovered in fetal life shows that the ovum possesses all the requisites for the development of the many structures present in dermoids, such as bone, cartilage, skin, membrane, hair, teeth, etc. Furthermore, as other ovarian cysts are almost invariably multilocular in character, it might be suggested here that dermoid ovarian cysts are perhaps originally multilocular also, the walls of smaller cysts being eventually compressed into the wall of the common cyst. Regarding the teeth, one text-book on surgery ventures the assertion that these are never perfect and can not be absolutely identified as incisors or molars. The specimen obtained in Case 1 proves the contrary.

The history, in brief, of these three cases is as follows:

* Read before the Southern Medical Association Section on Surgery, Atlanta, Ga., Nov. 10-12, 1908.