head after pubic separation. To illustrate my meaning: If the right half of the pelvis is contracted but not the left, and the fetal head presents in a left occiput transverse, when the pubes separate the occiput moves snugly into the left half, slightly rotating posteriorly, with the right brow pressing into the inter-pubic space. In this way what might be called the normally inutilized space just to the side of the promontory is taken up and offsets the loss in caliber of the right half of the pelvis to some extent.

The narrow, funnel-shaped pelvis requires the least separation relatively, as the separation of the pubic bones, which is like the swinging open of double gates set somewhat out of the perpendicular, secures the fullest effect in increasing the transverse diameter. One-inch separation of the pubes increases the middle transverse diameter at the brim a fraction over one-half inch. The flat, rachitic pelvis, with its projecting promontory and narrow conjugata vera, occupies a place midway between the justo-minor and the narrow-transverse pelvis. The contracted outlet pelvis likewise occupies a middle place.

As symphysiotomy is an operation that should never be determined upon until a patient is in active labor, and as it requires but a few minutes to properly prepare for it, the actual test of the question of its adaptability for securing passage of the head is and should be made during labor and while the patient is anesthetized. Due regard must be given to the previous history in multiparæ and to palpation, pelvimetry, Müller's test, and, if we like, to cephalometry by Perret's method in both primiparæ and multiparæ; but one is neither justified in making a final decision nor required to do so previous to the stage of fair cervical dilatation and moderate test of both automatic engagement of the head and artificial effort with the forceps. An exception might be made to this that it would not be desirable conduct in view of the selection of Cesarean section when it was found that too much separation would be required to justify symphysiotomy. My answer to this would be that pelvic contractions to such degree as demand Cesarean section constitute an exception, as they can be determined before labor.

2. Symphysiotomy is justifiable in certain mal-presentations: Impacted posterior occipital, and chin presentations, in which the fetal pulse is good and delivery is not possible without mutilation.

The operation should give place to premature delivery when the forecast of impossible delivery without major operation is sure and the patient prefers it, or the physician is not accustomed to major operative work. It should give place to Cesarean section in cases in which there are obstructions to vaginal delivery by tumors, exostoses, cancer and pelvic contractions greater than the rule given above allows for symphysiotomy.

The great majority of cases of pelvic contraction beyond the scope of forceps delivery lie within the range of symphysiotomy. In some forty cases of such contractions occurring in my clinical experience, and observation of others' work, there was not one which could not have been delivered by symphysiotomy; and in only one case was Cesarean section positively indicated.

23 West Fifty-third Street.

Novel Post-graduate Course.—The medical officials in the duchy of Hesse were taken on a trip to Hamburg instead of having the usual course of post-graduate lectures. All the sanitary and hospital arrangements of the city were inspected under the guidance of experts.

Clinical Report.

FEVER OF HODGKIN'S DISEASE.

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The "Note on the Fever of Hodgkin's Disease," by Dr. J. H. Musser,¹ has led me to report a case that, while it does not conform rigidly to a definite type of Rückfall fever, presents many characteristic points.

The case is that of a lady, 30 years of age, married, mother of three healthy children. Up to the present illness she had enjoyed good health. Her family history was negative. In the fall of 1898 she complained of weakness, malaise and swelling of the cervical glands. She was treated for malaria and spent the winter of 1898-9 in Florida. She stated that she had fever "off and on." Early in 1899 she had a febrile attack that persisted for some weeks. During that time the cervical glands on the left side and the inguinal glands on both sides became enlarged and tender. Upon subsidence of the fever the glands became reduced in size and less tender. In May there was another lighting up of the fever accompanied by growth and induration of the glands, but under Fowler's solution the pyrexia again subsided and the glands softened and diminished in size. All medication was suspended June 19. The temperature remained normal until June 26. The duration of the apyrexial period was about 16 days. From June 26 until July 30 there was a pyrexial wave reaching its fastigium about July 15, when the systematic record of temperature was begun.

From July 30 to August 10 the temperature hovered about normal with slight daily elevations and intermissions. Then followed an afebrile stage lasting three days. During the decline of the paroxysm the patient improved rapidly, the glands diminished in size, the color improved, the appetite became urgent and she was out of bed and going about the house. On August 14 the fever returned, and during the time between that date and the date of her death, September 30, there occurred three distinct paroxysms but with remissions only between. The temperature curve showed morning remissions and evening exacerbations as a rule, but there were observed scattered instances of a reversed type.

The record of the temperature and the amount and distribution of the glandular involvement may be seen in the accompanying diagrams. This case illustrated fairly well the tendency of the fever to recur in waves separated by an interval of calm. With the progress of the disease the waves increased in frequency, with lulls more brief between them. Repeated blood examinations showed no variation from the normal beyond a slight leucocytosis, noted but once, and oligocythemia toward the close. Late in the progress of the case there was considerable pain in the left arm, chest, right side of the abdomen and in the right hip and thigh, all easily accounted for by pressure effects. The liver and spleen were moderately enlarged. An autopsy could not be obtained.

Dr. Musser's paper is an important and valuable communication. The writer has seen four cases of Hodgkin's disease in Nashville during the past four years; in two the course was characterized by fever and two were seen for a brief period only and subsequently were lost sight of. Only in the case reported were there opportunities affording a partial study of the temperature.

1. American Medicine, Jan. 4, 1902.

Fecal Matters in Urine.—Desesquelle writes to the *Bulletin des Sciences Pharmacologiques* that the discovery of fecal matters when urine is being examined in case of cystitis, should not always be attributed to contamination of the receptacle, but should suggest the possibility of vesico-intestinal fistula. He mentions three cases in his experience in which the etiology of a rebellious cystitis was explained by the discovery of traces of fecal matters in the urine, when nothing previously had indicated such a possibility.