was continued during that time. One week after operation she developed cellulitis starting from the point of rupture in the os. The temperature ranged about 102 F., but never got above that point. In the course of the cellulitis she suffered a severe attack of acute nephritis, which induced persistent vomiting.

On the third day of July, I discharged her comparatively well. I have not seen her since that time until to-day, September 11, 1886, I find her looking well and robust. She considers herself in very good health, and complains of nothing but a slight yet continuous oozing of dark blood. The fact that she is menstruating precludes a vaginal examination.

Yours very truly, A. E. McDONALD, M.D.

FRACTURED TRACHEA.

BY E. C. NORTON, M.D.,
Assistant Resident Physician, Tewksbury Almshouse.

JANUARY 31, 1887, a robust Irish-American, aged twenty-eight, a bricklayer, was admitted to State Almshouse Hospital, at Tewksbury, complaining of pain and soreness in the throat.

When first seen, his throat was considerably bound up with flannels, but the portion exposed indicated great swelling and redness. On being questioned, the patient said he had fallen, two days before, through a staging, striking his throat on a portion of the staging that did not break.

Placing my fingers on his neck, I easily detected emphysema, which, I found, on further examination, extended to border of the lower ribs in front and sides, and down the back as far as lower borders of the scapulæ. The pupils were considerably dilated, though the patient claimed he had taken no medicine that day; the slightest handling of the trachea caused spasmodic breathing for a moment, although, at all times, breathing was slightly hurried and difficult; the voice was clear, but not strong.

When asked to locate the seat of injury, the patient placed his finger just below the cricoid cartilage. External digital examination proved that the hyoid bone was still intact; and the ability to articulate distinctly eliminated from my mind any possibility of injury, either to the thyroid or cricoid cartilages, and compelled me to believe that either one of the upper rings of the trachea was fractured; or the membranous structure between the rings, or the muscular tissue behind, was ruptured. No examination which the patient's condition would allow me to make, owing to the excessive amount of air in the tissues about the neck, enabled me to locate just where, in the upper part of the trachea, the injury took place; but we know that when a hoop is pressed together at two opposite points, the other two opposite points, that is, the sides, are the places where the hoop breaks; and, inasmuch as the emphysema was about equal on both sides of the neck, it is easy for me to conclude, since the blow in this case was on the front of the tracheal rings, that the upper ring, or first two rings, perhaps, was broken at the sides, so as to allow air to escape into both sides of the neck.

Patient related that, for the first twenty-four hours after the injury, his struggle for breath was very trying; swallowing of liquids, even, caused a great deal of pain; and that he bled freely for several hours after injury. There was considerable bronchitis present at the time of admission, and his sputa were quite bloody; both bronchitis and blood-sputa lasted for seventy-two hours. There was, at no time, oedema of the glottis.

Treatment. Patient was put to bed, and enjoined

to keep his head as quiet as possible; given ten grains of calomel, which was followed, in six hours, by an enema of suds, free movement of the bowels resulting. The cold-pack was applied to the neck, and maintained for forty-eight hours. Other medication consisted in relieving the bronchitis, and a few doses of morphine, at night, to insure sleep.

The following I quote from my clinical book: February 2d. Patient more comfortable; less emphysema, less cough. February 4th. Emphysema diminishing; also soreness in the throat; swallowed liquids without much pain. February 8th. Only slight emphysema, which is at top of sternum. February 12th. Since last record no emphysema could be detected, and there is now no difficulty in swallowing solid food. Patient had apparently made a complete recovery.

PERSISTENT PUPILLARY MEMBRANE.¹

BY CHARLES S. TURNBULL, M.D., OF PHILADELPHIA.

I HAVE brought before you to-night a case of unusual interest to ophthalmologists and to medical men in general. The patient has in his right eye what is known as a "persistent pupillary membrane." This is a remnant of foetal life, but its exact structure has not been ascertained. Some consider it to be made up of atrophied bloodvessels, which have served their purpose. Other authorities hold that it consists of the remains of connective tissue through which bloodvessels pass. In this man's right eye there is a network of hair-like fibres occupying the outer half of the pupil. These fibres originate from the anterior surface of the iris, and interfere in no way with the constrictor muscle of the pupil. This form of congenital anomaly was first observed about 1735, and on an average about one case has been reported every five years since that time. I am indebted to Dr. P. H. Bailhache, of the U. S. Marine Hospital Service, for the opportunity of exhibiting this patient.

[In the subsequent discussion, Dr. E. Jackson said: This case is notable for the clearness with which it shows the relation between the membrane and the iris. In all the cases I have seen heretofore, as in this, the pupillary membrane has seemed to arise from the anterior surface of the iris; but in no other instance has the connection been so obvious, the membrane here appearing to be simply an extension of the anterior layer of the iris, and similar to it in structure.

¹ Read before the Philadelphia County Medical Society, at the Stated Meeting, February 23, 1887.

Dr. Turnbull said that the point referred to by Dr. Jackson is well illustrated in this case, and it settles the disputed question as regards the origin of these fibres. It is distinctly seen that the sphincter muscle is in no way involved. The membrane has no connection with the muscle nor with the inner pupillary margin.]

Reports of Societies.

BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.

E. M. BUCKINGHAM, M.D., SECRETARY.

FEBRUARY 14, 1887. The President, Dr. O. F. WADSWORTH in the chair.

OVARIAN CYSTOMA OF RAPID GROWTH, CAUSING SEVERE PERITONITIS AND INTESTINAL OBSTRUCTION.

DR. JAMES B. AYER reported the case:

Mrs. B., forty-two years; fifteen weeks before was suddenly seized with severe pain in each groin. Examination next day showed a prominent swelling corresponding to the transverse colon, together with peritonitis; pain most marked in inguinal regions. Morphia prescribed.

The bowels gradually became obstructed. At the end of four weeks, there were marked tympanites, delirium, nausea with vomiting, and severe pain, requiring two grains or more of morphia daily. There was no defecation for eight days.

These symptoms strongly suggested obstruction from malignant disease.

By Dr. Warren's advice, he having seen her in consultation at different stages, the transverse colon was punctured with a fine trocar, and croton oil and enemata were freely used. The distension was much relieved by puncture and the bowels were opened on the ninth day — the pressing symptoms were relieved, and there was no serious trouble afterward from obstruction. Peritoneal inflammation gradually subsided until the abdomen could be examined to better advantage.

A small lump of stone-like hardness could be made out just above Poupart's ligament on the left side, and this grew rapidly upward. On the right side, after a while, a limited area of fluctuation was made out. When this was evacuated a hard lump remained.

Dr. Whitney examined the fluid and stated that it probably came from an ovarian cyst. As the cyst rapidly refilled after aspiration, and had become purulent it seemed to Drs. Warren and Elliot, as well as to Dr. James Ayer and the speaker that the danger from this source could not much longer be averted. Moreover, both lumps were growing rapidly, that on the left had passed the umbilicus.

As peritonitis had disappeared, and as she had gained a very little strength from the large amount of nourishment, stimulants and tonics which she had taken, being able to sit up a few moments daily, it was thought proper to insert a drainage tube, and while under ether to remove the tumor if possible.

February 9th. Dr. Warren, assisted by Dr. Elliot, performed ovariectomy skilfully and speedily, and the patient rallied from the operation. For twenty-four hours there were good hopes of recovery, but she sank from septicæmia on the fourth day.

One of the most important among the many inter-

esting points connected with this case according to Dr. Elliot, is the fact that this dense tumor while *clinically* as malignant as possible, was found by Dr. Whitney not to be *pathologically* malignant.

Dr. WARREN remarked that the condition of the patient when first seen by him was one of typical chronic obstruction. The distension of the abdomen was excessive and the point of constriction appeared to be above the cæcum, as enemata could be made to ascend to nearly that point. It was evident that an attempt made to open the bowel above this region, had such an operation been thought advisable, would not have been successful, owing to the presence of the tumor.

The cyst was tapped the first time for the purpose of relieving pressure. After suppuration had set in, laparotomy was performed, primarily to drain the pus cavity; but it was found impossible to attach the cyst wall to the abdominal wound, owing to its friable character. Notwithstanding the suppurating cyst, the condition of the patient was more favorable at the time of operation than at any moment during treatment.

POISONING BY CARBOLIC ACID.

DR. MINOT reported the case of a young married woman who was brought to the Massachusetts General Hospital, February 4th, nine hours after having swallowed, with suicidal intent, about seven fluid-drachms of liquid carbolic acid, stated by the apothecary of whom it was bought to be of the strength of from 90 to 95 per cent. Soon after swallowing the poison she became unconscious, with cold clammy extremities. In about three hours violent vomiting set in; two hours later she became able to speak and to swallow. Small quantities of saturated solution of carbonate of sodium, were administered, but were not retained; eight hours after taking the poison she passed a pint of "black" urine. She was brought to the hospital at 4 P.M., in the following condition: great prostration, urgent vomiting, cold extremities, pallor, intellect confused, no recollection of what had occurred, pulse 114, small and compressible, temperature 99.6°, respiration rapid, shallow, with a few tracheal râles. There was no carbolic odor to the breath, no white streaks about the lips, tongue moist, with white coat, fauces and posterior wall of pharynx somewhat dry, with a white surface. The patient could talk and swallow. Some castor oil which was given was soon vomited. Two ounces of greenish-black urine were drawn off, containing a very slight trace of albumen.

In a few hours the general condition improved, but the patient complained of dryness of the throat and of a burning sensation along the œsophagus; there was much vomiting and retching, with intense thirst, and she was unable to speak above a whisper. The next day there was marked tenderness of the epigastrium and left hypochondrium, and the vomiting persisted; she also coughed and raised mucus. The vomitus was not remarkable except on one occasion, when it contained specks of blood. The patient was very hoarse, and the intense thirst and dryness of the mouth continued. During the following night vomiting gradually ceased, and she could retain iced milk. After this there was progressive improvement, but she was still unable to speak above a whisper on the fourth day, and had some difficulty in breathing. The urine gradually returned to its natural color. On the sixth