which is partially indicated in the photograph (Fig. 4).

No attempt has been made to present the literature on the subject, as it has been quite recently and fully reported by Rager,¹ but a case illustrating each type of the condition treated by operation seemed of enough interest for special report.

TUBAL PREGNANCY WITH DOUBLE PYOSALPINX.*

BY C. H. HARE, M.D., BOSTON,

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INQUIRIES made of several surgeons with large opportunities to see and hear of the various varieties and conditions of extra-uterine pregnancy have failed to find any case just like the one now reported; nor, by a moderate, though not exhaustive, search of the literature upon ectopic gestation, has the writer been able to find a like case.

Miss —, 2,232, was sent into St. Elizabeth's Hospital because of prolonged flowing, and for the correction of a backward displacement. She was 26 years old, single, never pregnant; menstrual life had been of the normal type. Flowing began Jan. 18, being a few days late, and continued to the amount of 1 or 2 napkins almost daily until operation on March 1. For this she had been packed several times, with temporary relief. There was marked pallor and a systolic murmur, probably hemic. There had been no severe or alarming symptoms, but simply those of the ordinary pelvic inflammation. The urine showed an acute cystitis. From the clinical story she undoubtedly had gonorrhea, though unfortunately no microscopic examination was made.

Under ether the uterine canal was $3\frac{3}{4}$ inches deep. Dilating and curetting caused free bleeding, but only a very slight amount of curettings were obtained.

Up to this time the writer supposed that he was most likely dealing with a double salpingitis resulting from a neglected abortion, and the first suspicion of an extra-uterine pregnancy arose when the peritoneum was reached in doing the celiotomy, and dark fluid was observed bulging up the peritoneum. By guess there was a good pint of bright blood in the abdominal cavity. There was extreme retroflexion, with the fundus tubes and ovaries firmly adherent to everything they touched. Each ovary was the size of a large English walnut, with small cysts containing bloody fluid. The left Fallopian tube was the size of a forefinger, and pus leaked from its fimbriated end on freeing it from the surface to which it had adhered. The outer two-thirds of the right tube was thumb size and was bleeding freely from the fimbriated end.

¹ Zeitschr. f. Arthropäd. Chir. Bdix, H. I.

* Read before the Obstetrical Society of Boston, Oct. 15, 1901.

In view of her age both ovaries were resected, leaving a rather poor looking portion of ovary on either side, about one-third the size of a normal ovary. The left tube was entirely removed. The right tube was resected, leaving an inch of the uterine end, to which was attached the remaining portion of the right ovary. The appendix, being mixed up in the adhesions, was freed and removed. The retroflexion was corrected by suspension to the peritoneum, and the belly closed by the usual layer method.

The pathological examination was made by Dr. R. M. Pearce, who reported: The uterine scrapings negative; pus in each tube; and a tubal pregnancy in the fimbriated end of the right tube, which must have preceded the infection and pus formation in this right tube—the pus pocket being on the uterine side of the pregnancy.

After operation the pulse remained high but of fair quality. The temperature was not above 102° until the eighth day, when a pulmonary embolus occurred. Up to this time she had been a very sick woman, but was gaining, taking plenty of nourishment, and was thought to be on the road to recovery. With the embolus the pulse went to 150, the temperature to 105.8°, and the respirations to 50 or 60, where they remained with the right chest the chief source of discomfort until another embolus, followed by death within 5 minutes on the eleventh day after operation.

Autopsy was not allowed, but the house officer opened the celiotomy wound within an hour after death. Pus was present in the abdominal incision. There was a pint, by estimate, of fluid in the abdominal cavity, and general intestinal adhesions. A small piece of the right lung was obtained, upon which Dr. Pearce reported an acute fibrinous pleuritis, with streptococci in the pleura and lung tissue. Smears from the celiotomy wound and from the abdominal cavity were unfortunately placed upon culture media so old that nothing grew.

In my search for similar cases many most unique cases were found, a few of which the writer will briefly recall to you.

Warthin¹ reported a case of extra-uterine pregnancy with tuberculosis of the placenta and fetus in a patient aged 38; married 13 years, without any pregnancy. From the history, rupture occurred in October and was followed by peritonitis. Both ovaries were cystic at the operation the following April. The right tube was tortuous and large. The left tube thickened and ending in a cocoanut-size mass containing a male fetus 7 inches in length.

Jordan² reported a case of right pyosalpinx, ending in a general abscess, which was opened above the right Poupert's ligament. A vesicovaginal fistula followed childbirth 2 years later, which was cured after 5 operations, 1 being suprapubic. Menstruation continued regular until about 4 years later, when she sought advice, having been 51 days without menstruating and the last one very scanty. Examination was not sat-

isfactory, and she was told to return in a month; but violent pains, vomiting and collapse occurred at noon of the same day, and she was operated at once. There was a small hernia in the scar on the right side and an apple-size hernia through the left inguinal ring, involving the scar of the suprapubic operation. This left-sided hernia had adherent to the sac the left fallopian tube with ruptured pregnancy, the fetus being about 11 or 12 weeks old.

Wendler³ reported a most unique case following vaginal hysterectomy, where the right tube and ovary were not removed, one end of the tube being drawn down into the vagina. Menstruation continued, until on cessation for a time a 6 to 8 weeks' fetus was found in the vaginal end of the tube, and on dilating and curetting the fetal membranes and chorionic villi were obtained.

Coe⁴ reported a case where he removed a 3 to 4 months' live fetus, following rupture, from the right tube, and also found a mummified fetus in the right broad ligament which, from the history, was from a ruptured tubal pregnancy 12 years previously. The right tube was closed at the uterine end, but opened at the fimbriated end. The left ovary had a corpus luteum, but the right none, hence the theory that an impregnated ovum wandered over from the left side to the right, where it entered and developed in the end of the right tube.

Sänger⁵ did Cæsarean section, finding both fimbriated ends closed from inflammatory processes 2 years previously, following extra-uterine pregnancy, but there was an accessory ostium near the left ovary.

Williams⁶ reported the case of a woman 29 years old, with 1 child 8 years old. Menstruation had been irregular after childbirth, with the last one in December. In the latter part of April there was a sudden gush of water, which continued to dribble for a day, with some sharp, shooting abdominal pains. In July the breasts were filled with milk for 2 weeks, then gradually diminished to normal size. In August for 2 days she had pains resembling labor pains, followed in a few days by a normal catamenia. In September he opened the abdomen and removed a shrunken and mascerated fetus about the size of a 5 months' normal gestation. A good-sized placenta was near the uterus in the enlarged right tube, with the cord going to the fetus through an opening in the tube, while the tube near the placenta was sacculated with several ounces of pus. Both ovaries and the left tube were normal.

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REGISTRATION OF COLUMBIA UNIVERSITY.—

There is this year at Columbia a total registration of over 5,000 in all departments. Of this number 800 are in the medical department.

A PLEA FOR PAIN AND PATIENT.

BY EDMOND R. MORAS, M.D., CHICAGO, ILL.

FIRST, as to the meaning of words.

By pain I do not mean that which is conceived by the biased or unconceiving brain of a self-appointed judge-physician or other—but I mean that sensation which is felt by the individual who resents it or expresses it (the pain). And that sensation is never, and in no way can ever be, imaginary or unreal or anything else than pain, physical and real.

Sensations are essentially physical; not psychical, nor psycho-physical, and pain is the most frequent, the most universal, the most logical and the most natural of sensations. Without pain the human race—mind and body—would rot in one generation.

By patient I mean not what ails him, not his social or financial position or condition, not what he may or may not bring to the realm of my reputation, etc., etc., but I do mean the human individual. I mean that one parcel of humanity—the being afflicted—and what that being is to relatives, friends, society and God.

Now let us plead for the patient and his pain. Is pain a cry or a warning from disease? Is a frost-bite a cry or a warning from cold? Or is not pain a cry or warning from health, as a frost-bite is a cry or warning (of the lack of heat) from the healthy remnant of the affected part or tissues? Is that the same thing? Of course that's the same thing, but just the reverse, or upside down, which is why we've been treating pain, or rather nature or humanity, upside down.

Strange, isn't it, that our eye-retinas so soon set things right side up when centuries have failed to teach our brain-retinas to do so? As there is no better way of showing this than by citing a case now under my care, I shall do so. Not because it is interesting, not because it is unique, not because medical societies would be entertained by it, but because it illustrates an everyday blunder committed under the guise of medicine; but because it outlines the easy, uneventful recovery of one of those everyday "hopeless" cases made hopeless not by the sickness, not by the nursing, not by the unexpressed though understood and manifested wishes of the relatives, but by the direct ignorance and malpractice of the attending physician. Yet, he is not altogether to blame, as he is tracking the footsteps of authors and professors. Let him who runs follow.

(1) A well man overexerts to the degree of getting an inguinal hernia on each side. Nature or health utters its cry-pain. Seeing, he runs to the physician, just as on sight of fire one calls upon the fire department.

(2) The doctor prescribes opiates, and together they fail to reduce the ruptures. More pain from the patient fetches more opiates from the physician. But fortunately the opiates produce a condition of rest in bed and starvation. So, some days later, one rupture vanishes and the other is in part relieved.