Year	Student candidates examined.	QUALIFYING EXAMINATION.					
		Approved.		Physically disqualified		Rejected.	
		Num.	Per ct.	Num.	Per ct.	Num.	Per ct.
1904	4	4	100.				
1905	16	11	68.75	2	12.5	3	18.75
1906							
Totals	20	15	75.	2	10.	3	15.

NOTE: The percentage of candidates admitted to the medical department has progressively increased, as shown by the table. This is undoubtedly due to improved educational requirements by many medical colleges throughout the country. The admissions for 1905 and 1906 are very large on account of the requirement of a second examination for admission after an attendance of nine months at the Army Medical School in Washington.

Clinical Notes

BILATERAL TUBAL PREGNANCY.

HARRY GREENBERG, M.D.

MILWAUKEE, WIS.

History.—Mrs. M. B., aged 29, married 6 years, has one child 3 years old, no miscarriages, menses always regular and normal. The last menstruation occurred as usual after 28 days, but was accompanied by considerable pain, which necessitated her taking to bed. A piece of membrane was passed on the third day, after which the pain and flow ceased. The physician consulted diagnosed miscarriage and advised removal to a hospital for curettement. I saw her for the first time on the following day at the hospital.

Examination.—Patient a medium-sized woman, poorly nourished, very anemic, mucous membranes almost white and skin of a dirty sallow color. She said she was always pale. She complained of feeling weak, loss of appetite, restlessness and sleeplessness. No pain. Temperature 101.8 F., pulse 109. Thoracic and abdominal organs negative. Uterus slightly enlarged and somewhat tender at the fundus. Uterine adnexa somewhat thickened. A waiting course was advised. After a few days her temperature and pulse came down to normal and her general condition improved markedly. This condition continued unchanged for six weeks. At the end of that period while resting comfortably in bed she suddenly developed a chill, her temperature rose to 102.8 F. and she appeared in general considerably depressed. On micturition passed dark red blood along with the urine. Under stimulations her general condition improved, while the bladder symptoms continued unabated; blood was passed in large quantities at frequent intervals. Local applications to the interior of the bladder seemed to aggravate the condition. A pelvic examination three days later revealed the uterus enlarged, tender to the touch and situated high up in the pelvic cavity. On either side of the uterus was a soft, semi-fluctuating mass of about the size of a hen's egg; these masses having evidently developed during the past six weeks, and from the fact that she has not again menstruated a diagnosis of ectopic gestation with the possibility of the rupture of the ectopic sac into the bladder was made. Surgical intervention was advised and consented to.

Operation.—Fluid and clotted blood was found in lower abdomen. Several coils of intestines firmly adherent to pelvic organs. On separating the adhesions a sausage-shaped mass, bleeding from its distal extremity and continuous with the left horn of the uterus was found and removed. This proved to be the left Fallopian tube filled with clotted blood and membrane and ruptured at its fimbriated end. On the right side a similar but larger mass was found. This mass rested slightly on the interior uterine wall, but mainly on the bladder wall between its peritoneal attachment to the uterus and the symphysis pubis, and was firmly adherent to that viscus. On

separating it from the bladder, a rent about $\frac{1}{8}$ inch in diameter was disclosed in the bladder wall, corresponding to a similar rent in the removed mass. This mass, like the first, proved to be an ectopic tube.

This case is reported because of the rarity and significance of the bladder complication. There seems to be no adequate reason for the rupture of the bladder to have taken place. No history of bladder trouble that might have weakened its walls could be elicited. Ocular and manual examination revealed no diseased condition there. The path of least resistance could certainly not be considered in this instance. I can only explain it as one of Nature's freaks which can not generally be accounted for, but for which the surgeon need always be on his guard.

A CASE OF INDURATING EDEMA OF THE PENIS.

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ST. LOUIS.

Attracted by the paper of Dr. Taylor on indurating edema in *THE JOURNAL*, July 13, I am led to report the following case. I agree with him as to the extreme rarity of this condition, having encountered but this single case in seven years of private and dispensary practice, the latter comprising a clinic of from one hundred and fifty to two hundred cases of syphilis monthly. In my available text-books I find indurating edema mentioned specifically in but two, Mracek and Gottheil, the latter classifying it as a variety of the initial lesion, the former supplementing a short description of the condition with an excellent water color reproduction depicting the condition in a labium majus. In the light of my present information I believe I have observed a few such cases in the secondary period in women, but I was unable at the time to place them in their proper category.

History.—My case began in no unusual manner, the initial lesion being quite ordinary, small, exulcerated, situated in the sulcus, imbedded in an induration very moderate in extent and hardness and fairly well defined. The patient had a prepuce which entirely covered the glans and which was easily retracted, but in the second week of the evolution of the chancre it began to assume the indurating edema which finally entirely prevented its retraction. The induration extended gradually over the skin of the entire penis back to a point near its root.

Examination.—On palpation the condition feels in no way like the ordinary edema of lymphangitis, which is a complication of many venereal cases, being firm and elastic and violaceous in color, nor yet was it hardly as firm as the sclerosis surrounding an ordinary chancre, this difference being noticeable at the margin of the site of infection, where it merged into the indurative edema of the contiguous skin. The condition was very obstinate and remained long after the chancre had healed. In proper time he developed an ordinary macular eruption interspersed here and there with a few papules.

Subsequent History.—I lost sight of him, but at the time of his disappearance, although his other symptoms were on the wane, there was but little, if any difference in the size or consistency of the penis. There was a sufficient subsidence in the acute inflammatory condition of the chancre and its immediate vicinity to permit me to separate the prepuce from the glans sufficiently to see that it was healed. I can not say, however, what the ultimate results of prolonged and proper treatment would have been.

The Physician's Remuneration.—A poorly supported doctor is generally one who can not keep up-to-date in mental equipment or in instrumental armamentarium and the patients of that man will suffer.—*California State Journal of Medicine.*