four inches, stitched to the muscles and fascia with a continuous silver wire suture. The skin was closed by interrupted silkworm gut with the usual dressings. This patient was out of bed in three weeks and was allowed home in four.

In each case there were indications for this operation; namely, each of long standing, with atrophy and thinning of the muscles and fascia, large hernial openings and, in Case I, previous attempts at repair. These cases have been seen recently and are well. Case I, eighteen months after operation, is, with the assistance of a green Polish girl, caring for a large family. Case II, fifteen months after operation, is doing the housework for herself and husband with comfort, which she had been unable to do for several years before. A close examination of each case shows a firm, solid abdominal wall without suggestion of diastasis. These women claim to experience no discomfort or consciousness of a foreign body in the abdominal wall, and are both enjoying life thoroughly. The question naturally arises, Will they ever experience any trouble, and, if so, why, after more than a year of freedom? The operation is not difficult, and, with strict asepsis, should be successful.

I venture to suggest this operation as a remedial agent worthy of the trial in that class of cases where tissues already existing in the patient cannot be utilized to cure the defect.

Clinical Department.

A CASE OF MALIGNANT ENDOCARDITIS WITH RECOVERY.

BY CHARLES F. WITHINGTON, M.D., BOSTON,
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The following case, interesting from the etiology and as bearing upon the disputed question whether cases of this very grave disease ever recover, seems deserving of record.

The patient, a male, single, aged twenty-six, entered the City Hospital April 19, 1904. He had been usually healthy, but had had an attack of gonorrhea, his first, about March 8 of this year. Two weeks later he came down with measles, and two days after he began to sit up. Following this disease, he was taken with sudden and severe pain in the region of the heart, with dyspnea, lasting severely for four hours. There were chills and irregular fever with sweating and cough, which have persisted during the intervening time till his admission to the hospital. Four days before entrance he had pain in his left leg, which rapidly swelled and turned purple; sweating increased.

The physical examination showed a well-developed, but very sick-looking man. Temperature, 102-103; pulse, 160-170; orthopnea. The heart area as shown by percussion was 3 cm. to right and 16 cm. to left of the median line; a thrill, presystolic in time, was felt below the nipple; gallop rhythm; no murmur was heard at the apex, but a short systolic was heard in the fourth space to the left of the sternum. There were limited areas of consolidation in both backs, toward the bases, not involving the whole of either lower lobe. There was marked phlebitis of the left leg throughout its whole extent. The left calf meas-

ured three inches more than its fellow, and the thigh was only a little less swollen. Marked tenderness over the popliteal and femoral veins. Leucocytosis, 16,200.

During the next few days the heart action grew less tumultuous, the murmur became more distinct. Pulmonic second increased; no pericardial friction. The fever ran from 103 to 101, but showed a tendency to lowering of the curve. On April 25, six days after entrance, and about thirty-eight days after the onset of the gonorrhea, blood was taken from the vein at the elbow with antiseptic precautions and was reported by the pathologist of the hospital to show in the culture gonococci. This confirmed the opinion already held that the endocardial trouble was of gonorrheal origin. Soon after this the fever curve reached normal, and after April 28 the temperature never again rose much above the normal line. The phlebitis was distinctly less on April 30.

May 8 he began to sit in a wheel chair. The systolic murmur is still present, as before, but there are no cardiac symptoms, and the heart area is less than before. There is no dyspnea. On May 19 the limits of heart dullness were 2.5 cm. to right and 11 to left of the median line. A white count on May 28 showed 9,400 leucocytes.

In early June the patient was practically well, walking about and having no symptoms. The murmur is still heard, loudest in the second left interspace, less distinctly at the apex. The areas of consolidation in the back, which were considered to be pulmonary infarcts or embolic pneumonia, were nearly resolved.

Of course, the rôle of gonorrhea in the production of some cases of ulcerative endocarditis is now established by numerous post-mortem observations, but I believe few cases have occurred in which pathologists have been able to demonstrate this organism *intra vitam* in the blood current.

Medical Progress.

RECENT PROGRESS IN NEUROLOGY.

BY PHILIP COOMBS KNAPP, A.M., M.D., BOSTON.

PLANTAR REFLEX.

BARNES¹ has examined the plantar reflex in about 2,500 cases, fifty per cent of whom were suffering from organic nervous disease and twenty per cent from "functional" nervous disease. He concludes that in adults an extensor response (Babinski's sign) never occurs in health; it is always indicative of organic disease. The pyramidal system need not be so injured as to show post-mortem lesions. An extensor response may be produced in any condition which greatly raises intracranial pressure, even if that condition does not cause a demonstrable lesion of the pyramidal system. For instance, an extensor response may occur in hydrocephalus, meningitis, cerebral tumor, etc.; in such cases the extensor response usually occurs only in comatose or semi-comatose states. It also occurs in convulsive conditions of organic origin; *e. g.*, in epilepsy, uremia, infantile convulsions, strychnine poisoning, etc. It never occurs in hysteria and allied conditions, unless some organic disease is also present. A flexor

¹ Review of Neurology and Psychiatry, May, 1904.