nia were absent and, as his mental condition had also improved slightly, he was, after a few weeks, taken home on parole. The scar seemed strong, and the probability is that he will not again suffer from a hernia in the same place.

DIAGNOSIS.

Some of the symptoms which have been observed in cases of inguinal hernia of the bladder are:

1. A difficulty in passing the urine.
2. A change in the size of the hernia, depending on the amount of urine in the bladder.
3. A desire to urinate following pressure on the hernia.
4. A catheter may at times be passed through the urethra and into the hernia.
5. Injection of air or water into the empty bladder may cause an enlargement of the hernia.
6. On reduction of such a hernia the accompanying omentum or intestine may quite easily be pushed back into the abdomen, but there frequently remains a small, doughy mass which represents the extruded part of the bladder.
7. In the case here reported the tumor mass was much harder than most ordinary cases of inguinal hernia.
8. In some cases there is fluctuation in the tumor mass.

During the operations for relief of this condition the following facts have been observed by several writers:

1. The difficulty of identifying the structure of the hernia, when seen for the first time. There is consequently danger of cutting into the bladder, mistaking it for other tissue.
2. An unusual amount of fat in the inguinal canal.
3. The large size of the external inguinal opening.
4. The difficulty in separating the true hernial sac from the tumor mass.
5. The recognition of the muscular tissue in the wall of the bladder.
6. The possibility of passing a urethral catheter into the hernia.
7. The frequent difficulty in finding the neck of the true hernial sac.
8. The fact that hernia of the bladder is found nearer the median line than the true hernial sac.
9. The fact that when normal, the wall of the bladder is thick and firm.
10. When the extruded part of the bladder is ruptured or incised, urine frequently flows out, and, in such case, a small catheter can occasionally be passed into the bladder through this artificial opening.
11. The frequency with which intestinal and omental hernias accompany the hernia of the bladder.

Radical operation is the only rational treatment.

A CASE OF BLACK TONGUE.*

HUGO A. KIEFER, M.D.,
LOS ANGELES.

Patient.—J. G., aged 21, a Servian by birth, and a cook by profession, was admitted to the hospital Feb. 6, 1906, suffering from a severe attack of quinsy, which had set in six days previously.

Examination.—On the day of admission, examination showed the entire dorsum of the tongue to be covered by a thick, tough, grayish-white membrane, which was closely adherent. It was possible to remove only small particles, which left no

raw surface. The entire surface of the soft palate, the pillars of the fauces, and the tonsils were covered with minute patches of grayish-white membrane easily removable and leaving no erosions. A very large peritonsillar abscess on the left, together with the swelling of the fauces on the right, shut off a view of the oropharynx.

Treatment.—The abscess was incised and evacuated, yielding over one-half ounce of pus not differing in gross appearance from that usually found in such cases.

Course of Disease.—February 7, the entire dorsum of the tongue had turned jet black, as if it had been stained. There was no more of the white membrane anywhere, and the black color was confined to the tongue. Vigorous curetting brought away very minute quantities of the black material. The patient had taken absolutely nothing that could produce such a stain. His general condition was much better than on the day previous, and on reopening the peri-tonsillar abscess only a very small quantity of pus was found. The black color remained on the tongue four days, disappearing gradually.

The general condition of the patient was such as is usually found in cases of quinsy, except that there was a marked suppression of urine.

Date.	Temperature.	Pulse.	Urine, oz.
February 6.....	102.8	89	1
February 7.....	98.6	72-70	2
February 8.....	97.6-99.2	60-64	3
February 9.....	97.2-97.8	64-74	2
February 10.....	97.2-98.2	64-68	8
February 11.....	97	60	not measured.
February 12.....	97	60	not measured.

It will be noted that the excretion of urine did not increase until the last day of the black growth on the tongue, when it had nearly disappeared. The urine, unfortunately, was lost, except on the tenth, when he passed eight ounces, and the results, which were as follows, showed nothing unusual: Reaction alkaline; sp. gr. 1012; color, amber; no albumin nor sugar. Was the suppression due to the black fungus?

Remarks.—A specimen of the black scrapings from the tongue was submitted to Dr. Stanley P. Black, who succeeded in making a culture on potato and reinoculating on bread crumbs, but it is questionable whether this mold is the one causing the black coloration of the tongue. The culture does not show any mold that approaches the black color found on the tongue.

What was the organism causing it?

Probably *Mucornigra*, one of the zygomycetes. I have frequently seen dark growths of the aspergillus that invades the external auditory canal, but never anything so black as in the case reported.

A CASE OF ANEURISM OPERATED ON BY THE MATAS METHOD.

ISRAEL BROWN, M.D.
NORFOLK, VA.

Patient.—C. I., colored, aged 51, native of North Carolina.

History.—Family history was negative. Personal history showed usual diseases of childhood and gonorrhea 8 years ago. Formerly, patient was a heavy drinker and used tobacco in moderation for a number of years.

In January, 1906, he was taken with pain in right leg extending from knee to ankle, which was treated for some time as rheumatism. Pain was worse at night and unrelieved by posture or pressure. There was a pulsating tumor in the right popliteal space, supposed to have been caused by pressure and irritation produced by wearing high rubber boots. Patient was admitted to St. Vincent's Hospital, May 22, 1906.

Examination.—Heart, lungs, etc., were normal; there was very little hardening of the arteries. The tumor was hard, slightly elastic, and very painful. There was considerable edema of the leg.

Operation.—May 25, 1906, incision was made over tumor about 7 inches long, clots were turned out and interior sac was well cleansed. Groove between ends of artery, about one inch in length, were sutured with Lembert-sutures to preserve lumen of vessel; this layer was reinforced. Openings of other vessels were closed with catgut, tourniquet was loosened, and

* Read before the Eye, Ear, Nose and Throat Section of the Los Angeles County Medical Association, April 9, 1906.

where vessel leaked reinforcing sutures were used. The sac was obliterated as far as possible, it being rather large. Four deep sutures were then used to enfold sac from bottom and sides coming through skin and tied over pads to complete obliteration of sac. The skin was not turned in but sutured in the ordinary way with silk. There was no infection and the swelling very gradually disappeared.

CONGENITAL MALFORMATION OF HEART, WITH MALPOSITION OF CERTAIN VIS- CERA AND ABSENCE OF SPLEEN.*

G. W. POTTER, M.D.

REDFIELD, S. D.

The case in question was that of an infant which lived but four and one-half hours and was in the service of my colleague, Dr. H. C. Burch.

The mother, Mrs. A. J. O., was a primipara; pregnancy was normal and the child, a female, was born at full term, March 4, 1906. Labor was difficult, instrumental, but was not allowed to be overprolonged. The head was right occipital anterior.

The child at birth was feeble; there was difficulty in establishing respiration, and throughout the four and one-half hours of life the cry was weak and fretful. The attendant's attention was first attracted to the apex beat, which was situated three-fourths of an inch directly below the right nipple.

On the death of the child an autopsy was requested and granted. Our findings were as follows: An infant of nine and one-half pounds and perfectly normal on external examination. When we opened the thorax and abdomen an unexpected and interesting condition presented itself. The heart was placed in a corresponding position in the right side, which would have been normal in the left. It was one and three-quarter inches in length and one and one-quarter inches in diameter at the base. The external appearance was normal, but section showed the left heart defective in that the auricle was made up of a small thin sac about the size of a two-grain capsule. The left ventricle and entire right heart were normal. The pulmonary veins emptied into the left ventricle, there being no opening from the left auricle to or from any other part.

The right lung consisted of three lobes, the lower one being pressed upward by the position of the heart. The lung was normal in size and all portions were crepitant on pressure, showing that it functionated fully during this short life.

The left lung had no lobes and was greatly atrophied, being one inch in length, one-half inch in width in the widest diameter and one-fourth inch thick. A small area at the junction of the bronchi was slightly crepitant, all the other portions being non-crepitant, dark in color and bloody on section.

The left chest cavity was normal in size, and the space which should have been occupied by the heart and a normal lung was filled by the stomach, pancreas, small intestine and the greater part of the large intestine. These structures had apparently gained access to their unusual location by an opening caused by a complete absence of the left half of the diaphragm, excepting a narrow strip anteriorly three-eighths of an inch in width. All these parts were normal in size and appearance. The appendix, also misplaced, was two and three-fourths inches in length and about the diameter of a slate pencil.

Passing to the abdominal cavity, we found the liver and gall bladder normal in size, location and macroscopic appearance. The same was true of the urinary bladder, the uterus, tubes and ovaries. The colon, descending from the left chest cavity, passed diagonally across the abdominal cavity to the right side and reached the rectum to the right of the uterus and posteriorly to the right tube and ovary. Diligent and repeated search failed to reveal a spleen. The kidneys were both normal in appearance and size. They were both found to be floating; the right was resting on the pelvic brim and close to the colon as it descended on the right. The left was less freely movable.

In looking up the literature at hand on this subject I find that J. M. Van Cott, Jr., says that absence of entire organs is

common, absence of lungs with absence of diaphragm occurs, and that cases of partial absence of one lung with compensatory hypertrophy of the other lung have been observed. Further, he noted absence of one or more chambers of the heart.

Dittel reported unilateral defect in the diaphragm of an infant that died soon after birth. The stomach, small intestines and part of the large omentum lay in the left pleural cavity. Instances in which the spleen has been found wanting are reported. More frequently the spleen is doubled.

There are several cases of complete transposition of the viscera on record. This was probably first observed by Riola¹ in 1650.

Absence of the heart, Gould says, has never been reported, except in monsters. The absence of one ventricle has been recorded. Jurgens, in Berlin, in 1882, reported an autopsy on a child who had lived some days after birth, in which the left ventricle of the heart was found to be completely absent. Many cases of displacement of the heart are reported.

I report this case in the hope that it will be as much interest to the members of the Association as it has been to me.

A PECULIAR CONGENITAL MALFORMATION.*

F. RUSSELL DAME, M.D.

BEDFORD, MASS.

In July, 1905, I attended M. D. in confinement, the labor being in every respect normal. The woman gave birth to a healthy, robust boy, which gave a lusty cry before fully born and seemed to be normal in every way. I cut the cord and laid the child by while the mother was being attended to. In about fifteen minutes from the time of birth I found the child's respiration extremely slow and irregular; after waiting a few minutes I commenced to stimulate respiration, first by sprinkling with water and then by artificial respiration, but in spite of my efforts it shortly ceased to breathe.

At birth the child showed absolutely no malformation or abnormal condition; its first cry and respiration were strong and forceful, and having had a short labor I paid little attention to the child, thinking there could be nothing needed, and it seemed to do well for ten or fifteen minutes.

The case was so unusual that I obtained the parents' consent for an autopsy. On opening the chest cavity I discovered in the left pleural cavity a mass of coils of intestines, which had escaped from the abdomen through the small opening in the posterior portion of the diaphragm.

On further examination I found the stomach, duodenum and the small intestine, also the greater part of the large intestine, except the descending colon, and the rectum, and a small lobe of liver which was adhered to the stomach all above the diaphragm. The esophagus and the aorta passed through the diaphragm through a normal opening, and the esophagus wound up around through the diaphragm to the stomach. The appendix was between four and five inches in length. The liver was of about the normal size for a baby, but its right border posteriorly was curved inward and forward on itself. The left kidney was somewhat large and displaced downward, probably because of lack of other organs in the abdomen, which was practically empty. The left lung was very small and had not been distended; the right lung was distended. The heart was wholly to the right of the sternum. The pericardium was closely adherent to the diaphragm. The auricles of the heart were extremely large and thin-walled. The thymus gland was two and one-half inches long and thick. The mediastinal septum was only partially developed.

It was a question at the autopsy what caused the immediate death of the child, as it seemed that the abnormal position of the organs would not of itself terminate life in so short a time. My supposition was that the opening in the diaphragm did not allow sufficient suction in the chest to draw enough air through one lung properly to aerate the blood.

1. See Gould and Pyle on "Anomalies and Curiosities of Medicine," page 291, 1897 edition.

* By a curious coincidence these two unusual reports, one from Massachusetts and the other from South Dakota, were received by us on the same day.—EDITOR.

*Read before the Aberdeen (S. D.) Dist. Med. Soc., May 15, 1906.