with two or three needles or a trocar electrode, using them as the negative pole, and a large pad for the positive on the abdomen; the clay pad is the best except from the fact of being more or less dirty.

MULTIPLE FIBROIDS OF THE UTERUS.¹

BY SAMUEL BRECK, M.D., BOSTON.

The specimen illustrated by the accompanying photograph is one obtained by autopsy from a negress, forty-seven, single. I first saw her forty-eight hours before death; she was then evi-

dently suffering from peritonitis, and any active interference was not to be thought of. She had had the abdominal enlargement for many years, but was in dread of an operation.

Examination post-mortem showed multiple fibroids of the uterus — the largest of which, the size of a small watermelon, had become cystic and had ruptured into the peritoneum in its upper and posterior portion. The opening was sealed by exudate at the time of the autopsy. The tumor and the abdomen were full of rather thin greenish pus, in quantity about half a pailful. The tumors

and the peritoneum were covered with a recent fibrinous exudate. In addition to the main tumor, which was pedunculated and rose to the epigastrium, were numerous small ones, varying from the size of a cherry stone to that of an orange. They were subserous, the uterus being but little enlarged. The tubes and ovaries were healthy. As a rather rare complication there was complete prolapse of the vagina, with elongation of the supravaginal cervix. The prolapse has evidently been of long standing, as the vaginal wall is much thickened and shows ulceration.

The kidney and liver are fatty in a marked degree. The heart of normal size, the muscular substance probably somewhat fatty. Lungs and spleen healthy.

The life history of these tumors seems to have been this: Beginning as small subserous masses, their weight led to the prolapse of the vagina. As they enlarged they gradually rose out of the pelvis, drawing the uterus with them and thus causing elongation of the supravaginal cervix. Finally, cystic degeneration of the largest tumor; rupture into the peritoneum; general purulent peritonitis; death.

A SELF-RETAINING TONGUE DEPRESSOR.

BY HARRIS PEYTON MOSHER, M.D., BOSTON.

It is often necessary, in mouth operations, especially in the operation of snaring off the tonsils, to have the tongue depressor held by an assistant. This method is generally only half satisfactory, because in transferring the tongue depressor to another the grip of the inner end is altered, and the exposure of the tonsil, which the instrument gave while it was in the operator's hand, is partly or wholly lost. In addition, while the snare is being tightened home, both hands of the operator are engaged, so that the tongue has to be left to itself, with the result that the view of the tonsil is lost again. In the latter case it does not matter; in the former it does. As the tonsil is being drawn into the loop by the double hooks, and the wire fitted about it, a clear view is absolutely essential. A simple self-retaining tongue depressor would be a great help. There have been many complicated self-retaining tongue depressors, but they have never attained any popularity.

I have found the tongue depressor, which is illustrated here (Fig. 1), to meet my wants. It is simple — a spring merely, one end of which catches on the tongue and the other under the chin. It is applied and taken off by pressing on the two sides, just as is customary in working any spring clasp.

The original of this tongue depressor I bought in a Boston shop. I could not learn the inventor's name. On trying the instrument it worked nicely for holding the tongue down in the middle line, but it would not stay in place on the side of the tongue. This was necessary in order to make it of general use. By pivoting

¹ Read before the Suffolk District Medical Society, Section for Obstetrics and Diseases of Women, March 26, 1902.

the chin piece (Fig. II) so that it could swing on a horizontal axis and catch on the side of the chin, I found that this improvement was accomplished. In addition, the length of the blade was made changeable. Other minor modifications were made. These two are the essential ones, especially the pivoting of the chin piece. Owing to this, the depressor will lie on the side of the tongue and expose the tonsil to its base.

The illustrations explain themselves. The blade of the tongue depressor is controlled by a thumb-screw, so that it is possible to take the blade out and to substitute a blade of any size or shape that the operator may prefer. This would not be called for in the majority of cases, because as the depressor is now made the blade can be shortened one-half inch.

I have found this instrument in operating to be what I have claimed for it. With the tongue controlled by it, and with the etherization carried on by the Fillebrown ether vapor apparatus, throat operating is made much easier.

Clinical Department.

A VARIETY OF SKIN LESIONS TREATED BY X-RAY.

BY EDITH R. MEEK, M.D., BOSTON.

CASE I. Mrs. R. S., age 25; Russian. Lupus vulgaris. Duration of disease, seventeen years. The patient was first seen by me at the Pope Dispensary on Nov. 30, 1901. The skin of the entire left cheek was reddened, thickened, and in places covered with yellowish white crusts. Beneath the left eye was a reddish-brown nodule about the size of a French pea. Near this was an ulcer, which was freely discharging. Scattered here and there on the cheek were areas of cicatricial tissue. Directly beneath the lower lip were three brownish-red nodules; under the chin were three similar ones; on the chin was another ulcerating area.

After the first few treatments the discharge from the ulcers ceased, the nodule on the cheek flattened out and showed a small scale. At the close of the treatments the nodule on the cheek had entirely disappeared, the ulcerating areas had completely healed, and the skin of the cicatricial parts had become softer and more vascular. The nodules under the lip were somewhat flattened and had scales attached to them. A similar condition existed under the chin, except that the nodules were much more flattened.

Unfortunately, at this time the patient was unable to return for more treatments; she had never at any time been able to come regularly. The exposures were scattered over a period of five months' time, a treatment being given when possible. In spite of all these disadvantages, the condition was very much improved, and if more time could have been given, the disease would

undoubtedly have entirely yielded to the treatment.

CASE II. Miss A. R., American, thirty-one years old. The patient had a large growth of hair on each side of the chin; the hairs were rather coarse, long, and very disfiguring.

X-ray treatments were given her, beginning at two a week and increasing to four. After the fifteenth exposure a very few hairs fell out; treatments were continued; after the seventeenth a large number fell out, and on the left side of the chin there was a reddening of the skin involving an area equal in size to a five-cent piece. Treatments were discontinued. Four days after, the patient was again seen. Almost all of the redness had disappeared and all of the hairs except five on one side and three on the other had fallen out.

At the end of a week the patient again returned. All of the redness was gone and the chin was entirely free from hairs.

As to the permanency of the removal of hairs by x-ray, the following may be quoted. Histologically the tissues showed: (1) Enormous thickening of the epidermis in all its layers; (2) atrophy of the hair follicles, which in places had entirely disappeared.

They conclude: The thickening of the epidermis in all of its layers, the increase of keratohyaline, and the quite extraordinary atrophy of the follicles may be viewed as a reaction against an irritant of unusual strength. This irritant appears to increase the vitality of the least differentiated skin elements, while the differentiated elements, hair, nails and glands, undergo retrogressive changes and atrophy. Of the hair follicles only traces remain, one, or at most three, in a microscopic field, and these are no longer follicles, but only conical prolongations of epidermis which dip down seemingly only half so deep as normal follicles. Of hair papilla, or regeneration bulb, every trace is lacking. Bearing these observations in mind, the statement that permanent removal of hair may be caused by exposure to x-rays loses some of its startling character.

The changes in the corium are those of an ordinary inflammatory process without peculiar features—to quote Kibbe: "Capillary dilatation, with collection of round cells scattered through its (the corium's) structure, particularly around the hair follicles." There is, therefore, little suggestive of the explanation of the effects of x-rays upon diseased conditions of the connective tissue structures of the skin, in the histology of x-ray dermatitis, as far as it has been studied. An analysis of the clinical phenomena does, however, throw some light on the subject. In the first place, as regards the hair follicles, Kibbe has made the interesting observation, which I am able to confirm as regards x-ray erythemas, that in the development of an x-ray dermatitis the erythema is seen, under a hand lens, to develop first as a "punctate redness due to hyperemia around the hair follicles." In other words, the

¹ Monats. f. Prak. Dermat., 1897, xxv, 9.