ankles. He continued, however, to attend school and be active until about six months before coming under observation, when a more severe attack of rheumatic pain, with great weakness, caused him to go to bed. After two weeks' rest he improved but did not return to normal. About five months later he became very dyspeptic and edematous and remained in bed from that time. The dyspnea was so severe that he required to be propped up and his weakness was intense. His previous medical history was of considerable interest. He had had measles and whooping-cough in childhood. At 6 years of age a doubtful attack of meningitis was followed by chorea. At the age of 9 he suffered a severe attack of acute articular rheumatism which affected his ankles, knees and shoulders. His family history was of no importance and the social history was that of an active school boy.

Physical Examination.—The patient was an underdeveloped boy with a slight frame, poor musculature and little panniculus adiposus. He was markedly anemic. There was no general adenopathy and no osseous deformity. The skin was cool and moist, showing no eruption. There was marked edema of the ankles. The ocular movements were free in all directions; pupils reacted normally to light and in accommodation. The conjunctivae as well as all visible mucous membranes were very pale but showed no signs of jaundice. The tongue was coated, the throat normal, and the teeth in good condition. There was distinct pulsation of the veins and arteries in the neck, but the veins were not very prominent. A blowing, systolic murmur was audible over the carotids. The thorax was narrow and thin-walled, with prominent ribs and clavicles. The superficial veins were conspicuous. The precordia bulged somewhat and seemed to pulsate with each beat of the heart. Expansion was poor, being greater on the left than on the right. The lungs were resonant throughout and the breath-sounds were puerile, especially at the apices. A few rales were heard at the bases. The boundaries of the heart were the second rib above, the sixth interspace in the anterior axillary line to the left, while the right border extended 3.5 cm. to the right of the sternum. On auscultation double mitral and double aortic murmurs were heard, the muscular elements being very weak. There was no pericardial friction. The liver extended from the fourth rib to 2.5 cm. below the costal margin. The abdomen was distended, the walls weak and thin. Splenic dullness was normal and the organ was not palpable. The extremities, save for the edema, were normal. The radial pulses were synchronous and equal, but very weak and irregular, only every other heart-beat being transmitted at the wrist.

Laboratory Examinations.—Blood: Hemoglobin 58 per cent.; white blood-cells, 12,100. Urine: amber, light flocculent precipitate; Sp. gr. 1.025; acid; albumin, a faint trace; sugar, negative. Sediment showed hyaline and many dark granular casts, many cylindroids, much mucus.

The patient was under observation for six weeks and seemed to respond slowly to treatment, although he continued to run a hectic temperature and a rapid pulse. No blood-culture was taken. The daily notes on the case are of no special interest except the one already quoted. Death occurred suddenly and no autopsy was obtained.

1811 Spruce Street.

MENSTRUAL SUPPRESSION DUE TO HYPOTHYROIDISM

CATHARINE MACFARLANE, M.D.
GERMANTOWN, PA.

Mrs. F., aged 25, came to my clinic at the Woman's Hospital Jan. 28, 1911, complaining of amenorrhea of eight months' duration.

History.—Menstruation had been established at 13 and had always been regular, profuse and painless, the periods lasting four or five days. The patient married at 18 and three years later became pregnant, but miscarried at four

months, cause unknown; a second early miscarriage followed a fall. After the miscarriages she continued to menstruate regularly until 1910, when she missed her periods in March and April; a normal period occurred in May, 1910, after which there was no return. During these eight months of amenorrhea, she suffered from almost constant headache, backache and nausea, numbness of the hands and arms and vertigo; she complained of feeling stupid and sleepy; she put on flesh steadily, finally weighing 230 pounds, and her abdomen was noticeably increased in size.

Examination.—The patient was 5 feet 6 inches tall and appeared large and clumsy; her face was bloated, eyelids puffy, eyes heavy, lips thick and complexion pasty; her skin was dry and rough, the flesh swollen, firm and inelastic; her mental state was dull and listless. Pelvic examination revealed normal organs with no signs of pregnancy; the abdominal enlargement was evidently due to accumulated fat; systolic blood-pressure registered 120 and the red cells numbered over six million.

Treatment.—The whole aspect of the patient was so striking and so like myxedema that, in view of the negative blood and pelvic findings, the possibility of the amenorrhea being due to deficient thyroid secretion at once suggested itself and she was accordingly directed to take 5-grain tablets of the dried thyroid gland three times a day.

March 25, 1911, after eight weeks' treatment, the patient menstruated for the first time in ten months; the flow was dark in color and moderate in amount, lasting five days; the headache, backache and numbness were all relieved. From this time on the patient menstruated regularly every four weeks, with the exception of May, 1911, and her symptoms gradually disappeared. Nov. 22, 1911, she weighed 216 pounds, her features were clearly defined and her expression and conversation, when compared with last January, seemed animated.

5808 Greene Street.

A SPORADIC CASE OF INFECTIOUS HEMOGLOBINURIA *

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Definition.—An infectious disease of the new-born, occurring during the first two weeks of life, and of an epidemic nature.

Historical Data.—This disease seems to have been described first by Charrin, of Paris, in 1873, with a report of fourteen cases. In 1879 Winckel, of Dresden, reported twenty-three cases in the Foundling's Hospital, and described the disease in detail, from which time it has been known as "Winckel's disease."

Etiology.—In regard to the etiology, little of certainty is known, but the disease is generally conceded to be of an infectious origin, and occurs in epidemic form in institutions. The nature of the infection is unknown, but Garrod, of London, included it under diseases of the kidney, and states that it is probably due to bacterial toxins. It is not due to infection of the umbilical cord.

Pathology.—There is a yellow staining of the skin and internal organs. The spleen is large, hard and darkened, and filled with blood-pigment, which is diffused throughout the pulp and free in the blood-vessels. The kidneys are dark brown in color, the tubules being filled with granular pigment, which shows under the microscope to be crystals of hemoglobin, and small hemorrhages show in their substance. The liver and heart are sometimes found to be fatty. The umbilical vessels show no sepsis. The urine is brown, albuminous and contains methemoglobin and deposits a sediment com-

* Read before the Okmulgee County Medical Society, September, 1911.