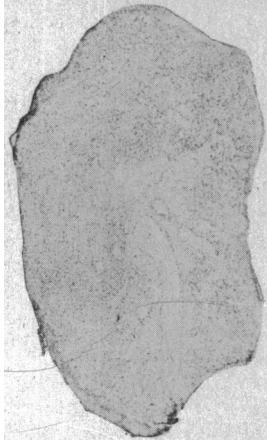


interwoven arrangement. The tumor is highly vascularized, and in the center are numerous cavernous spaces, lined with flat endothelial cells. Specimen 2 shows nearly the same morphology, except that the blood in the cavernous spaces may be much more readily demonstrated.

**Treatment:** The tumor should always be removed. Victor Lange recommends the sharp spoon, but this method is liable to spoil your specimen. The snare, hot or cold, will serve very well; if the wire be thin and flexible hardly any difficulty may be experienced in extirpating it *in toto* with one attempt. Then too,



the hemorrhage is liable to be profuse, and before trying extirpation we should be prepared for this. A small quantity of ferripylin in powder on a piece of cotton, held against the bleeding point, will cause the hemorrhage to cease instantaneously. The base should be well cauterized with chromic acid.

#### DISCUSSION.

**DR. FREUDENTHAL**—Dr. Pierce did not find any mention of similar cases in American literature. Dr. Roe and Dr. Cobb have published cases, and I also published two cases, two years ago. One of my cases was an angioma. Regarding treatment, I apply my nasal bag filled with ice, thus preventing severe hemorrhage. This I did with much success in one case, a few months ago.

**DR. COBB**—I think bleeding polyp of the septum is known under the head of angioma, and about eighteen cases are reported. At the Pan-American Congress I reported a case with the literature as far as I could learn it. In this case there was no recurrence, but I believe that angioma does sometimes degenerate into sarcoma.

**DR. ROE**—As a case of angioma of the nose which I reported three or four years ago has been mentioned in the discussion, I will simply say that the growth was exceedingly vascular and occupied the greater portion of the left nostril, extending about two-thirds toward the posterior portion. I first tried to remove the growth with a galvanic cautery snare, but the attempt was followed by such profuse hemorrhage as to necessitate the packing of the nose. I then tried the cold wire Jarvis snare and succeeded in removing the growth without hemorrhage. The patient was a man about 60 years old. After encircling the growth with the snare I instructed him how to turn the nut on the snare so as to cut through very slowly, and to stop the instant that any bleeding occurred, and when this ceased to turn the nut again. In this manner we consumed I think about two hours in the removal of the growth. After the removal I cauterized the base with chromic acid. After about six months there was a slight recurrence of the growth, which I removed in the same manner. I then lost sight of the patient, but about six months afterward learned that he died somewhat suddenly of anemia, characteristic of malignant growths. In this case the tumor started as a purely benign growth, as a microscopic examination of the portion first removed showed it to be a true angioma; while that which reappeared six months later showed sarcomatous elements, indicating that the growth had developed from a benign to a malignant one. We can not, however, positively say that the malignant elements may not have been in the deeper structures or in the base of the first growth, although at that time they were not apparent.

**DR. PIERCE**—My case was neither an angioma nor a sarcoma but a telangiectoma. I am opposed to the idea of a benign tumor degenerating into a malignant tumor.

## SOME NOTES CONCERNING THE INFLUENCE OF SEXUAL EXCITEMENT UPON INTRA-NASAL DISEASE.

Presented to the Section on Laryngology and Otology, at the Forty-eighth Annual Meeting of the American Medical Association, held at Philadelphia, Pa., June 1-4, 1897.

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When some certain offense against personal hygiene is generally recognized as one of several possible contributing causes of a disease, it would seem but reasonable that inquiry concerning it should become a matter of routine, and that in the event of its complicity, it should receive in the plan of treatment the degree of prominence it merits. It is a matter of common knowledge that sexual excitement, frequently repeated and prolonged, can occasion a great deal of vascular disturbance within the nose. With the production of such excitement through the olfactory sense, I am not now concerned. It is with the reverse of this phenomenon that this paper is to deal. A fugitive coryza quickly following upon the heels of a venereal debauch, is an instance of this, though it is a more than usually pronounced illustration of the effect of erotic excitement upon the nasal vasomotor mechanism. Lesser degrees of the same effect, however, are of much more frequent occurrence, I suspect, than many of us believe, and it is because of their frequency and the influence they exert in aggravating existing nasal disease and in hampering the action of local or general treatment directed to its cure, that that they become worthy of some special study.

Among the whole of our patients, it is in but a comparatively small number that we find sexual excitement an active cause of trouble. For the sake of convenience, they may be grouped within two fairly well defined classes. First we have a number of young people whose exposure to it is largely innocent—one might almost say legitimate. I mean those who are on the brink of wedlock, those who are availing themselves of the privileges which custom accords to the preliminary betrothal. Thackeray, in his "Shabby Genteel" story, refers to them as "those who are legally engaged in sighing, gazing into one another's eyes, hand-squeezing, kissing, and so forth (for with such outward signs I believe the passion of love is expressed)." This transition stage between celibacy and marriage is one of acknowledged risk. Long engagements have, for many excellent reasons, been denounced time and again, and the intimacy, the excess of tenderness which too commonly accompany them, are accountable for much suffering both immediate and remote. As long as "the flesh and the Devil" are mixed up with human love affairs, so long as the average man's love is so strongly sensual and so feebly spiritual, so long will protracted engagements be baneful.

It will be my endeavor to show by a single example how the nose and its diseases may be affected by the emotional turbulence of this pre-nuptial period. It is that of a young woman whom I first saw in October, 1893. She had had attacks of hay fever in each of the three preceding years and following the one of 1893 she had developed symptoms of asthma. The nasal examinations disclosed a pair of turgid inferior turbinates, while those immediately above them were found greatly hypertrophied and along the

lower margin of the left a fringe of budding polyps. These latter were thoroughly eradicated with the curette and the bodies themselves reduced by a few repetitions of chromic acid cauterization. The erectile tissue of the lower turbinates regained its full contractile power under simple astringent medication, the asthmatic paroxysms ceased, and the next two years passed with no recurrence of the hay fever. The early months of last year, 1896, were spent in Florida, and when my patient returned to Philadelphia she was wearing an engagement ring. The man in the case was barely twenty-five, a veritable Romeo in the ardor of his passion, and blessed with enough health and virility for two ordinary men. The engagement had been of but slightly more than two months duration when the young woman reappeared in my office with a complaint of renewed nasal discomfort. The middle turbinates were again markedly hyperemic and the lower greatly engorged and prominent. Two or three weeks of the local treatment that had previously been successful in reducing these latter, made very little impression upon them now, and a threatened return in the early summer of the hay fever symptoms induced me to send for the young man and persuade him to assist me in my effort to relieve the sufferer, by becoming considerably less demonstrative of his affection for her. Parenthetically, it may be hinted that sexual intercourse even though carried to considerable excess, is less provocative of damage to the nasal erectile structures, than frequent and prolonged sexual excitement which remains ungratified. For so young a man this one received my remonstrance very sensibly, exercised more self-restraint than I had expected, and with the result that within a couple of weeks the engorged turbinates had shrunken almost to normal, the hyperemia of the middle ones was scarcely noticeable, and there was an entire subsidence of nasal symptoms. The inference is unmistakable. Nothing would be gained by the addition of other examples more or less reiterative of this one, but I may be pardoned for alluding to the fact that is essential in securing the co-operation of one or both of the young people without hurting their feelings or giving any offense. A bachelor is by no means necessarily a misogynist, and I would not be suspected of wishing to dim the brightness of "love's young dream," but if one of the dreamers chances to have any catarrhal condition of the upper air tract, a few judicious words counseling patience before and moderation after marriage may, if heeded, be preventive of a decided aggravation of such condition. I pass to the consideration of a second, the members of which, however, are far from being as innocent as those of whom I have just spoken. It is composed of the man-about-town, single or married, youthful or mature, the sybarite, the voluptuary, the libertine. Whatever we may choose to call him, he is a very numerous personage and though he may escape those specific diseases which so frequently roughen the way of this variety of transgressor, yet, sooner or later, his nose may become the humble agent of retributive justice. The man who enters a physician's office with a venereal disease anticipates the kind of questions he will be asked and is generally willing to answer them unreservedly, but he who comes to the rhinologist with merely a complaint of nasal respiration, of more or less rhinorrhea, and of, perhaps, some dull frontal headache, is apt to be astonished and, not unlikely, resentful, if he be closely

questioned concerning his sexual morals. I do not know whether it is dread of the patient's displeasure or simply a want of appreciation of the frequency and potency of this genetic factor in the history of functional nasal disturbance, that leads to the omission of such inquiries, but will it be denied that they are the exception rather than the rule? The exercise of a little discrimination, of, perhaps, a little common sense, will protect a large proportion of our male patients from being subjected to an investigation of this nature, but in many others there will be fair reason to suspect moral laxity, and in these, there should be no hesitation in either confirming the suspicion or in taking the fault for granted and dealing with it frankly and vigorously.

Without having treated any great number of such cases, I have met with sufficient of them during the past few years to open my eyes to the fact that some early failures to effect in them decided and permanent improvement, were due to my failure to recognize and remove the principal cause of their annoying symptoms. A brief reference to the patient who first enlightened me on this point may be of interest.

He was a widower just turned 40, handsome, well-read, widely traveled; a man of most versatile cleverness, an excellent musician, something of an artist, and an occasional writer of very fair verse. All these merely personal details are distinctly relevant, because they are the very things which make a man *persona grata* to the other sex and which consequently expose him to greater temptations than his less attractive fellow. In such men, therefore, we may look much more confidently for easy virtue as an exciting cause of nasal trouble, than in those to whom nature has been less kind. This man recited a list of symptoms that was suggestive of enfeebled vasomotor control over the circulation of the pituitary membrane. There were brief intervals during which he was comparatively comfortable, but the greater part of the time he was seriously annoyed by nasal obstruction, by marked hypersecretion, by occasional paroxysms of sneezing, and by some dull frontal headache. An accompanying marginal blepharitis also testified to the intra-nasal irritation. His statement that he had already endured considerable treatment was amply confirmed by my rhinoscopic examination. His turbinates, both inferior and middle, presented an array of galvano-cautery cicatrices that reminded one of the scarred faces of the German duelists. This seemed to have been the favorite local treatment, but in addition, a fancied neurotic temperament had been assailed with many pills, a suspicion of gout had been threatened with drowning by gallons of lithia water, and, finally, some one had tapped both his antra through the inferior meati as a sort of forlorn hope. It was only a happy accident that saved me from the fate of my predecessors. A review of the treatment he had received yielded me little hope of finding anything of promise that had not already been tried. The end of a month of tentative local treatment, of regulation of diet, exercise, and some other matters of personal hygiene, found us but little beyond the point from which we had started. But just at this critical juncture when I could detect some slight signs of disappointment and failing confidence on the part of my patient, a bit of scandal came to my aid. It was the whisper of an intrigue in which my patient was playing the rôle of Juan. At our next interview this Lovelace admitted without any reluctance the habit-

ual looseness of his conduct with women. He made no attempt to conceal his amused incredulity when I charged this vice with being largely responsible for his nasal discomfort, but he agreed nevertheless to give virtue a month's trial. Not to rob this remedy of any possible credit, all other treatment was for the time suspended. Brief as it was, the period of probation proved more than sufficient to vindicate my faith in the prescription, and I was able to dismiss my patient with the assurance that his best safeguard against future return of this trouble, would be a rigid observance of the spirit as well as the letter of the Seventh Commandment. It is always my endeavor to be as sparing as possible in the use of drugs, but in cases such as this, where from long disuse, self-control has undergone a shameful enfeeblement, the bromids or any of the other anaphrodisiacs may be utilized to dull the vicious appetite, until sufficient will power is regained to completely conquer it.

## DISCUSSION.

Dr. MACKENZIE—The relationship between over-indulgence of the sexual powers and morbid conditions of the throat, eye and ear has been recognized from a very early period. The fact is about as old as literature itself, but the pathologic relation between the nose and the reproductive apparatus is a matter of recent recognition. The first attempt to reduce the subject to a scientific basis was made by me some fifteen or sixteen years ago, and I subsequently published the result of my observations in the *American Journal of Medical Sciences* for April, 1884. Subsequent observations made, among others, by Arviset, Ischwell and Joal in France and by Peyer, Endries and Fliess in Germany have only served to sustain the positions taken in my original essay. Fliess has written a very elaborate monograph on the subject. The phenomena observed furnishes food for reflection not only for the physiologist and pathologist, but also for the biologist. In contemplating them, we are brought face to face with a most interesting enigma—a problem of life whose biologic significance it must be the task of the future to divine. Dr. Grayson's cases furnish additional corroborative evidence of a most important physiologic relationship.

## DIFFICULT DEFECACTION IN INFANTS.

Presented in the Section on Diseases of Children, at the Forty-eighth Annual Meeting of the American Medical Association, held at Philadelphia, Pa., June 1-4, 1897.

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CLEVELAND, OHIO.

I should be unmindful of the history of human experience should I harbor the hope that the several affirmations set forth in this paper would be accepted without disagreement by a body of medical men. Remembering, however, that there is very little progress in knowledge except along lines where soundest casuists doubt, I propose for discussion the problem of difficult defecation in infants.

It is generally recognized that infants strain at stool.

The infant strains at stool because of the imperfect development of the anatomic features concerned in the mechanism of expulsion. These are as follows:

1. The infant's lower gut is muscularly deficient.
2. Its mobility within the abdomen is obstructive to defecation.
3. The rectal valves are obstructive.
4. The infant's anus not being sufficiently expansible is also obstructive.

The specimens of infant recta and sigmoid here

shown are the first taken in my research on this subject, and are fairly illustrative of the facts upon which the foregoing declarations are based. The large specimens examined are those of adults and are typical.

The dried specimens shown in plates 3, 5, 7, 9 and 20, were prepared by flushing the intestine and then fixing the subject in the genu-acromial posture; the anus was then fixed open and melted paraffin was injected under about twelve ounces pressure. When hardened that portion of the gut occupied by the cast was removed<sup>1</sup>. Specimens shown in plates 11 and 12 were prepared by placing the subject in the dorsal decubitus and by opening the descending colon; the intestine below was then washed out and the colon perforation fixed at the abdominal wound, which save for this point was sewed up, the anus was tied up and as much melted paraffin as would enter under two pounds' pressure was forced into the gut; subsequently the sigmoid and rectum were removed as in the other cases. After immersion in alcohol the specimens were varnished.

The following are the memoranda of the autopsies made in this study:

Case 1.—Female, still-born; height 16 inches (40.64 cm.); circumference at anterior superior spinous process  $7\frac{1}{2}$  inches (19.05 cm.); anterior superior spinous process diameter 3 inches (7.62 cm.); ensiform to pubes 4 inches (10.16 cm.); transverse diameter pelvic outlet  $\frac{3}{4}$  inch (1.90 cm.); peritoneum at last vertebra of coccyx. (Plate 3.)

Case 2.—Female, age 1 hour, height 17 inches (43.18 cm.); circumference at anterior superior spinous process  $7\frac{1}{2}$  inches (19.05 cm.); anterior superior spinous process diameter  $2\frac{1}{2}$  inches (6.35 cm.); ensiform to pubes 4 inches (10.16 cm.); transverse diameter pelvic outlet  $\frac{1}{2}$  inch (1.27 cm.); peritoneum at last vertebra of coccyx. (Plate 5.)

Case 3.—Male, age 1 month, height 23 inches (58.42 cm.); circumference at anterior superior spinous process 9 inches (22.86 cm.); anterior superior spinous process diameter  $3\frac{1}{2}$  inches (8.89 cm.); ensiform to pubes 4 inches (10.16 cm.); transverse diameter pelvic outlet  $\frac{5}{8}$  inch (1.59 cm.); peritoneum at last vertebra of coccyx.

Case 4.—Female, age 6 weeks, height 24 inches (60.96 cm.); circumference at anterior superior spinous process  $10\frac{1}{2}$  inches (26.67 cm.); anterior superior spinous process diameter 3 inches (7.62 cm.); ensiform to pubes  $5\frac{1}{2}$  inches (13.97 cm.); transverse diameter pelvic outlet  $\frac{5}{8}$  inch (1.59 cm.); peritoneum at last vertebra of coccyx. (Plate 9.)

Case 5.—Female, age 2 months, height 20 inches (50.80 cm.); circumference at anterior superior spinous process 8 inches (20.32 cm.); anterior superior spinous process diameter 3 inches (7.62 cm.); ensiform to pubes  $3\frac{1}{2}$  inches (8.89 cm.); transverse diameter pelvic outlet  $\frac{3}{4}$  inch (1.90 cm.); peritoneum at last vertebra of coccyx. (Plate 20.)

Case 6.—Male, age 6 months, height 24 inches (60.96 cm.); circumference at anterior superior spinous process 10 inches (25.40 cm.); anterior superior spinous process diameter 4 inches (10.16 cm.); ensiform to pubes 5 inches (12.70 cm.); transverse diameter pelvic outlet  $\frac{3}{4}$  inch (1.90 cm.); peritoneum at last sacral vertebra. (Plate 11.)

Case 7.—Male, age 6 months, height 24 inches (60.96 cm.); circumference at anterior superior spinous process 12 inches (30.48 cm.); anterior superior spinous process diameter 4 inches (10.16 cm.); ensiform to pubes 5 inches (12.70 cm.); transverse diameter pelvic outlet  $\frac{3}{4}$  inch (1.90 cm.); peritoneum at first bone of coccyx. (Plate 12.)

Case 8.—Male, age 17 months, height 25 inches (63.50 cm.); circumference at anterior superior spinous process 12 inches (30.48 cm.); anterior superior spinous process diameter 4 inches (10.16 cm.); ensiform to pubes 6 inches (15.24 cm.); transverse diameter pelvic outlet 1 inch (2.54 cm.); peritoneum at last sacral vertebra. (Plate 7.)

Examination of the pictures of the dried specimens reveals that the wall of the infant rectum and sigmoid flexure is thin compared to that of the adult. (See plates 3, 5, 7, 9 and 20.) It is impossible to distin-

<sup>1</sup> For more particular description of the method of preparation see paper by the writer in Mathew's Quarterly Journal of Rectal and Gastro-intestinal Diseases, July, 1896.