



PLATE XII.

CASE 17 (2), showing epiphysis in good position after reduction under ether, and immobilization on Ham splint: not tendency to recurrence. Good final result.

Excision of the joint is probably never necessary. It was performed in Case 3 in this series, but that was a case in which the deformity had been allowed to remain unreduced for a very long time, and at operation reduction seemed impossible. Excision will practically remove the lower epiphysis and will, as it did in this case, form a very serious impediment in growth so that very marked shortening will result.

Case 8, referred to above as having peroneal paralysis, is very interesting, as showing the amount of interference with the growth of the epiphysis, which resulted from the compound separation. The epiphysis was reduced, remained in place and united. The injury occurred in 1905, when the boy was eight years old; subsequently the toe-drop was treated by Dr. Lund, who freed the external popliteal nerve from the surrounding scar tissue. He returned for observation in 1911, having grown to his full height and showing about 2 inches of shortening. He walks on the ball of his foot, and has to have a high heel on the shoe on that side. The accompanying photograph (Plate III) illustrates the amount of shortening and the smaller size of the limb.

The writers wish to express their thanks to those of their colleagues who have allowed them the use of their cases.

CONCLUSIONS.

1. Owing to danger of subsequent interference with growth, absolute reduction and fixation at the earliest possible moment is of great importance.

2. Early and repeated x-rays are necessary to control the completeness and permanency of the reduction.

3. In simple cases, where immobilization in flexion fails to hold the fragment in correct position from the start, open reduction with the use of a small nail or bone-plate is indicated.

4. In compound separation the same means of positive fixation is to be recommended.

5. The foreign body should be removed soon after union has begun in order to avoid interference with growth. This should be done not later than the 3rd week.

REFERENCES.

- ¹ Monsehr: Abstract in *Cblt. f. Chirurgie*, 1898, vol. xxv, p. 175.
- ² Scudder: *Treatment of Fractures*, 7th Edition.
- ³ Stimpson: *Fractures and Dislocations*, 6th Edition, 1910.
- ⁴ Cotton: *Dislocations and Joint Fractures*, 1910.
- ⁵ Kirmisson: *Congres de Chirurgie*, 1904, vol. xvii, p. 580.
- ⁶ Desmarest: *Rev. de Chirurgie*, Oct. 10, 1912, p. 517.
- ⁷ Broca: *Congres de Chir.*, 1904, p. 626.
- ⁸ Reboul: *Congres de Chir.*, 1904, p. 617.
- ⁹ Hutchinson: *Lancet*, 1898, vol. ii, p. 1630.

Clinical Department.

EXCESSIVE POLYURIA OF ARTERIO-SCLEROSIS.

BY W. E. PAUL, M.D., BOSTON.

A LAWYER, within a year of his demise at 45 years of age, suffered from dyspnea and cough, lost notably in weight (over 40 pounds), and found he was drinking an increased amount of fluids and passing a good deal of urine. In the last eight months of his life the blood pressure varied from 190 mm. to 220 mm. of mercury. He had little edema; 5 months before death a decided neuro-retinitis developed with a considerable loss of vision.

The analysis of the urine made by Dr. David L. Williams 7 months before death gave the following record: quantity, 4,060 c.c.; specific gravity, 1.008; reaction, slightly alkaline; albumen, slight trace; sugar absent; urea, 0.50%; no diacetic acid. Microscopic examination showed 2 to 3 small granular casts per slide, few small clumps of pus, few uric acid crystals, few triple phosphate crystals, little mucus, few squamous cells, few neck of the bladder cells, large numbers of bacteria.

The general course was of emaciation and increasing weakness with mild delirium and some restlessness in the final stage.

Transitory hemiplegic attacks with aphasia and accompanying mental torpor (claudicatory) recurred many times.

With this background the record of the amount of the urine, incomplete as it is, justifies

itself on account of the large quantity excreted:—

Eight months before death, Feb. 5,	154 ounces
May 20,	832 ounces
May 27	640 ounces
June 1,	640 ounces
June 10	832 ounces
July 23,	640 ounces
Aug. 1,	512 ounces
Aug. 5,	768 ounces
Aug. 13,	640 ounces

Reports of Societies.

BRISTOL SOUTH DISTRICT MEDICAL SOCIETY

The meeting of the Bristol South District Medical Society was held at the New Bedford Public Library, Thursday, May 8, 1913.

DR. BOWERS, President of the State Medical Society, was present and spoke upon the Midwife Question, stating why the Committee of the State Medical Society felt obliged to differ with the representatives who appeared from New Bedford when this law was under consideration and who advocated midwife registration. Dr. Bowers also spoke of other legislation pending and desirable in which the District Societies uniting and, as the Massachusetts Medical Society, should exert commanding influence.

The subject of the meeting was

DISEASES OF THE STOMACH.

DR. J. J. HATHAWAY, of New Bedford, presented a paper upon

MEDICAL DIAGNOSIS AND TREATMENT,

describing early symptoms, various conditions which patients presented in hyperchlorhydria and achylia gastrica. In discussing the question of diagnosis, difficulty of recognizing more serious conditions, particularly malignant diseases, was emphasized. Conditions were described, and cases cited in which medical treatment (which the speaker presented in detail) had proved successful, also cases which the internist, after a fair observation and trial, must refer to the surgeon.

DR. CANNY, of New Bedford, presented slides from x-rays of stomachs in various positions and conditions.

DR. P. E. TRUESDALE, of Fall River read a paper upon

CANCER OF THE STOMACH.*

The speaker showed lantern slides of microscopic sections excised at operation, giving history and final outcome.

* See JOURNAL page 44.

The discussion was opened by DR. FRED B. LUND, of Boston.

DR. LUND: In malignant disease in any part of the body, and in particular in the internal organs, earliest possible diagnosis is absolutely essential to cure. We know that cancer while a local disease can be cured, but when once extension into the lymphatics has begun, and this may begin very early, we are often unsuccessful. Cancer of the skin, being where it can be seen, is early recognized and often cured. Cancer of the breast, where the mass may grow to some considerable size before it is noticed, is cured much less frequently. Cancer of the stomach is often found very late and cures are correspondingly rarer. However, cancer of the stomach is not intrinsically more malignant than cancer of the breast or of the lip, although it is possibly a little more so than cancer of the large bowel. Cancer often begins in the site of a chronic ulcer, and the symptoms caused by the ulcer may lead to exploration and cure. But there are certain cancers, especially those which originate on the fundus and toward the greater curvature, the symptoms of which are very insidious, and which I believe at least may arise without chronic ulcer. I have seen several cases of cancer of the stomach where physicians themselves were patients, in which the surgeon was consulted too late for anything more than a fruitless exploratory laparotomy. Cancer which is located at the pylorus by causing early obstruction is much more likely to be recognized early, and, therefore, is much more amenable to surgical cure.

Depending upon the x-ray for diagnosis of cancer of the stomach is extremely dangerous. We cannot accept the diagnosis of the Roentgenologist who may declare that a condition is cancer and inoperable; nor may we any more accept as final the verdict of the x-ray concerning suspected conditions. Even at operation, it is sometimes impossible to tell a chronic ulcer from a cancer; but fortunately in this case, the surgeon usually has no difficulty in deciding what to do. If the chronic ulcer is on the stomach and the patient is in good condition, excision should be done. If the lesion is on the duodenum, where cancer is very rare and chronic ulcer is the rule, it is usually better to do an enterostomy than run the small likelihood of the growth being a cancer. The x-ray has been of value in the early diagnosis of ulcer in the duodenum and has assisted many a doubting Thomas in a determination to have an exploration done where the symptoms ought to have made the course perfectly plain without the x-ray. We have no feasible methods of direct inspection of the interior of the stomach such as we have for the interior of the bladder in cystotomy and the shadow pictures of the x-ray give us so far the best substitute. It should always be used, but is dangerous if depended upon to the exclusion of other diagnostic methods and of common sense.

We must be more on the alert and more suspicious in doubtful cases, and more ready to do laparotomy. Late explorations where nothing is done discredit surgery; but still they have to be done because, as we all know, every surgeon is familiar with the fact that in cases where symptoms have only recently appeared or been complained of, an inoperable condition is often disclosed. Greater readiness to explore will render this sort of thing less frequent. Delay in these cases is more often the fault of the patient in consulting the physician late, than it is