

as these drugs are very frequently administered as stimulants, the objection should be borne in mind. We presume that the objection which Dr. Hemenway has to nitroglycerin is that it is not a direct cardiac stimulant; at any rate this is not its chief action, but acts by dilating the capillaries and relieving the strain on an over-worked heart. It also lowers the blood pressure considerably, and, as a lowered blood pressure is characteristic of acetanilid poisoning, it is, therefore, contraindicated. Alcohol is contraindicated, though to a less extent, for the same reason, and also on the general principle that it is unwise in case of poisoning to administer any substance which has marked solvent power over the toxic substance. The use of oxygen, and especially the blood-letting and injection of normal salt solution, are the most reliable means for combating acute acetanilid poisoning which are known as present.

A MONOCEPHALUS, TETRABRACHIUS, TETRAPUS.

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The birth of this monster occurred in my practice, July 23, 1905.

The mother, a native of Ohio, white, and about 40 years of age, has a large family. The labor was normal, although it was thought to be seven weeks premature. The fetus lived ten minutes. It weighed eight pounds. It was a double female with single head and thorax, four arms and four legs. The two abdomens were separate. The head was normal, with a small spina bifida at the neck.

ANTIDOTE FOR SUPRARENAL PREPARATIONS.

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Relative to the case reported by F. C. Bennett in THE JOURNAL A. M. A., November 17, I recently had an experience with adrin. The patient was given tablets containing among other medicaments adrin gr. 1/500, with directions to let one dissolve slowly in the mouth every three or four hours. The patient used one every hour for six doses, and then telephoned that he was suffering greatly with his heart and that pulse was "very rapid and weak, with smothering." I at once ordered recumbent position and strong black coffee, with almost immediate relief. I have used adrenalin and adrin a great deal with cocaine, and have witnessed these phenomena before, but heretofore have attributed it to cocaine, but there was no cocaine in these tablets.

THE OPSONIC INDEX IN TYPHOID FEVER.

A PRELIMINARY REPORT.*

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From a study of 33 cases of typhoid fever in which one or more estimations of the opsonic index were made, certain broad conclusions relative to the index in this disease may be deduced.

It has been demonstrated that there occurs during a typhoid infection a marked rise in the opsonic index: that the index varies from day to day; that there is early in the disease a high index; as the temperature

decreases this appears to fall and to rise again as convalescence approaches, but more cases must be studied before any final conclusions may be drawn.

That the high index is due to the presence of opsonin and not to the incorporation by the leucocytes of clumps of bacilli resulting from agglutination is demonstrated by a comparison of the number of phagocytes in the normal as compared with that of the patient's specimen. In many cases the index so obtained is very nearly the same as that obtained by the usual method of determination, i. e., by counting the number of bacilli incorporated. Furthermore, there may be marked agglutination and no increase in opsonin and vice versa.

The typhopsonin is thermostable, resisting a temperature of 60 C. for 30 minutes, being, however, destroyed almost entirely at a temperature of 75.

In order to counteract the lytic effect of the serum it is necessary in preparing the specimens always to first heat the serum to 56 C. for 30 minutes. The lytic effect is now destroyed but the opsonic activity of the serum remains apparently unchanged.

It seems likely that the opsonic index in typhoid fever will prove valuable from the standpoint of diagnosis, inasmuch as the index is high during the earliest part of the disease.

A POINT IN THE MANAGEMENT OF UVEAL SARCOMAS.

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Usually sarcomas arising in the uveal tract are slow in perforating the sclera and experience has taught us that, in their clinical course, they usually give rise to symptoms—interference with vision or glaucoma and the pain which goes with it—which attract attention to the condition before perforation of the sclera and extension to the orbital tissues take place. Accordingly the ophthalmic surgeon, as a rule, when he sees no gross perforation of the sclera, contents himself in dealing with uveal sarcomas by enucleating the affected eyeball. And this is good practice; for enucleation of the globe usually suffices, and the more radical procedure of exenterating the orbital contents, which theoretically, of course, would be more proper, is a far more serious operation and leaves the patient more deformed.

Sometimes, however, these growths go through the sclera comparatively early and sometimes macroscopically such extensions can not be made out. An experience with such a case has been instructive to me, suggesting a point in the management of cases of intraocular sarcomas which I think worthy of attention.

History.—The patient was a woman of about 60. The diagnosis of choroidal sarcoma was fairly certain. Clinically there was no sign indicating extension of the growth through the sclera. The eyeball was enucleated and macroscopically the globe showed no indication of extension of the growth externally. Just after the operation the eyeball was cut into two parts and the clinical diagnosis was verified. The tissue was preserved in formalin. After about one and one-half years the patient noticed a swelling in the orbit. Exenteration of the orbit was done and a pigmented tumor as large as a normal eyeball was removed.

Interested in this history I made sections of the eye, which had come into my possession through the courtesy of the operator, in order to see if I could find the place or places where the tumor cells had perforated the sclera. It took very little trouble to demonstrate an

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