Realizing that the case was a serious one, a consultant was sent for, but before his arrival she had a second convulsion, and then a third during his examination. At this time the abdomen was very tender and quite tympanitic. The temperature was 101.2 with a pulse of small volume at 112. It was decided that rapid dilatation and immediate delivery was imperative. Under complete anesthesia, my hand was introduced into the vagina and the cervix dilated, but much to my surprise I found my finger in the cavity of an empty uterus scarcely above normal size. It was now evident that we had to deal with an extra-uterine fetus. Owing to the uremic convulsions and commencing peritonitis it was decided to operate at once and she was removed to Providence Hospital, where we operated two hours later. I made a median incision and came down upon a large placental mass just above the bladder. The sac was not adherent to the abdominal wall, but had ruptured and the fluid part of the contents had escaped into the abdominal cavity setting up a mild general peritonitis. After a careful search the opening in the sac was found on the left side of the placenta. On introducing the fingers into this the feet were at once reached, and by enlarging the opening the child was extracted through it. The position of the child was on the patient's right, with its right side toward the right, the legs extended across the abdomen and head turned extremely to the left and pushed up under the right lobe of the liver. It had been dead several days as the cord was somewhat shriveled and the skin was macerated. It was a well-formed female child weighing six and three-quarters pounds. There were no adhesions of the sac to the abdominal wall and but few to the intestines, which with two or three exceptions were easily peeled off without the use of ligatures. The placenta was quite firmly attached to the top and posterior surface of the uterus, and to the right broad ligament. But few vessels had to be tied. The principal nutrient vessel of the placenta, which was almost the size of a lead pencil, came from the under surface of the mesentery of the ileum. But a small quantity of blood was lost during the operation. The peritoneal surfaces presented evidences of commencing inflammation.

The abdominal cavity was thoroughly washed with hot boiled water until it came away perfectly clear. A large glass tube was inserted down into the cul-de-sac in the center of a gauze drain. The abdominal wound was closed by kangaroo tendon sutures for the peritoneum and fascia, with silkworm gut for the deep sutures through entire thickness of the parietes.

The patient was stimulated by rectal enemas of hot beef tea and whisky, with digitalin and strichnia, and by morning she had rallied from the shock nicely. The glass tube was removed on the second day and the gauze drain the fourth day, after which the wound united by first intention and the recovery was uninterrupted. The day following the operation the urine contained 75 per cent of albumin by volume, but this gradually diminished until there is now but a slight trace present. There were no more uremic convulsions after the operation.

For the Prevention of Blindness in Pennsylvania.—In order to prevent blindness, a law was passed by the Legislature of Pennsylvania in 1895, which imposes a duty upon all midwives, nurses or other persons having the care of infants, and also upon the health officer, and fixing a penalty for neglect thereof.

ELEVEN YEARS OBSERVATION IN THE USE OF CREASOTE, IN THE TREATMENT OF TUBERCLE OF THE LUNGS.

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For eleven years I have had a greater or less number of patients constantly under observation with the creasote treatment, and feeling the importance of the subject and the general interest taken in this disease, I have been led to report my experience. A large majority of patients have been seamen of the merchant marine. The conditions noted cover all stages of the disease.

The places of observation were South Carolina, Texas, different stations on the Great Lakes, a few cases at Evansville and St. Louis and the remainder at Port Townsend, Washington.

A majority of the cases were not diagnosticated by bacteriologic examination as physical methods easily revealed the condition. All cases of "chronic pneumonic phthisis," "chronic pneumonia," etc., are excluded.

Pure beechwood creasote was given throughout. Dosage ranging from one to seventy minims, has been tried. Some cases have been treated to a termination with a few minims given constantly and without variation. Others were given gradually increasing doses until the limit of toleration was reached, when the drug was recommenced at the small dose to be again carried to the limit of toleration. Still other cases were given gradually increasing doses to the limit of toleration then decreased to the point of toleration and kept there to the end of the treatment. Some of the cases had other treatment in conjunction, though the large majority were treated exclusively with creasote.

The serious objection to creasote is the unpleasant, sickening and burning sensation which it causes in the stomach. I have used the pure creasote made into emulsions, mixtures, pills, etc., none of which were at all satisfactory. The best method that I have found is to nearly fill a gelatin capsule with pulverized acacia, drop in a few minims of the creasote and take at once. If the dose is to be large this is a very bothersome way to give the drug. I have prescribed carbonate of creasote to a few private patients but the period of observation has been short and unsatisfactory; however, I think this a desirable way to give the drug. I have also given the drug by inunction but not with satisfaction. Patients show greater and quicker improvement from the treatment in a warm dry climate and the dosage is smaller.

If there be tuberculous infection of the kidneys, the general condition will be aggravated by giving the drug in any dose. My patients with high fever did not do well, probably on account of irritable stomach. Valvular heart disease does not interfere with the results of the treatment. Tubercular infection of the intestines and mesenteric glands is benefited by the treatment, though the point of toleration is lower. I have had no experience with tubercular meningitis. Tuberculosis of the bones and joints received no benefit. I have had no experience with the drug in the treatment of children. The age of the adult does not seem to make any difference. The treatment may bring on complications such as

severe headache, injection of conjunctiva, lachrymation, the sensation of constriction of the chest which soon passes off, bloody urine, indicanuria, transitory glycosuria, increase of the daily amount of urine, nervousness and disturbed slumber, a rash, and last and most serious and which is nearly always the final and fatal complication, pneumonia. It is especially dangerous to give the drug when there are kidney complications. When there is high temperature it does no good. With the complication of pneumonia it is absolutely dangerous. Pulmonary hemorrhage is rapidly improved. Prolonged administration causes severe and harmful anemia. If the test for blood or indican in the urine shows either to be present the drug should be discontinued at once. The treatment is of little avail when there is sapremia due to absorption from large cavities that have become infected with pyogenic bacteria. Small dosage with creasote is not beneficial; the only positive results obtained have been from a very liberal administration. Hopefulness led me to think many of my cases cured, but in nearly all, the disease has recurred. It has been impossible to follow all of these cases though a few report to me at stated intervals. I doubt that a single case has thus been cured. In comparison with other drug treatment creasote has given me the only satisfaction, however scant, obtained.

Large dosage with creasote given constantly at the point of toleration is dangerous for the following reasons: After continued administration for a great length of time, the patient becomes very anemic, from which trouble he rarely recovers; secondary infection of healthy lung tissue takes place from detached necrotic tissue producing a rapidly fatal pneumonia. Many of my cases on the large dosage have improved very rapidly and were thought to be nearly well. They have been exhibited to medical friends with much enthusiasm with the hopefulness that the cure would be permanent. Many of these patients would rapidly succumb to pneumonia probably a short time afterward. For a long time I thought the pneumonia to be only an accidental complication but I now feel convinced that the treatment is the cause, due to secondary infection with necrotic tissue as mentioned above. Finally I must state that I believe that no well marked case of tubercle of the lungs recovers with the creasote or any other drug treatment without the very best and most favorable climatic conditions coexisting with the treatment.

ON THE DIAGNOSIS OF GASTRIC ULCER.

Read before the Chicago Medical Society, Oct. 7, 1895.

BY L. HARRISON METTLER, A.M., M.D.

CHICAGO.

A disease that causes no less than 5 per cent. of all deaths and that can only be "approximately" diagnosed in the absence of hematemesis is still deserving of the closest study. The following case is presented as a text for a discussion upon the hitherto known signs of gastric ulcer.

N. H., aged 27, first came under my observation Nov. 29, 1893, through the kindness of Drs. Lyman and Ward, after a profuse hematemesis. Neither the family history of the young woman nor that of her early life presented anything of special note. Having somewhat of a neurotic type of constitution, she nevertheless has always borne the appearance of fairly good health, being well nourished and well developed. She has always been of a studious turn of mind and devoted much time

to music and literature. She is fond of outdoor sports and is an expert bicyclist. Except for a slight degree of paleness, one would never look upon her as in any way an invalid. There were no pulmonary or cardiac symptoms. Menstruation began at 15 and has always been regular, painless and scanty. Amenorrhea occurs at times. There is a tendency to constipation. About eight years ago she began to be troubled with dyspepsia. At that time Dr. Birdsall, of New York, treated her for anemia, which treatment she continued irregularly for five years. For her dyspepsia she consulted Dr. Vaughan, of Ann Arbor, quite a while ago, and he assured her then that she did not have gastric ulcer. Several physicians have diagnosed her case at various times as nervous dyspepsia and she has been almost continuously under treatment for this condition. Her appetite had always been good but she learned the necessity of being careful in the selection of her food. Near the cardiac end of the stomach she has had at times a slight gnawing or boring pain which shot through to the back and was felt near the angle of the left scapula. Sometimes after partaking of solid food the pain would become very acute and definitely localized so that she could easily cover it with a half-dollar coin. There was almost always more or less pain in the left hypochondrium, and its site never shifted anteriorly or posteriorly. Sometimes, she says, it feels as though a grape seed or other small, pointed object had gotten fast in the left side of the stomach. In the intervals between the taking of food, she feels as though the stomach were contracting or that its lining were forcibly drawing together. She suffers from occasional headaches, due probably to the anemia, but otherwise she is perfectly free from neuralgic pains. Three or four severe "fainting spells," about a year apart, have caused her considerable alarm. In them she became decidedly cyanosed and remained semi-conscious for a brief time. They always left her very weak. In one of these "spells" she fell completely dazed from off her bicycle. I can obtain no more definite history in regard to these attacks of syncope, as they occurred mostly when she was alone and closely engaged in some occupation. Their after-effects were vouched for by friends and relatives. It never occurred to her to notice the character of the stools immediately after them, as she supposed they were due probably to "biliousness" or "nervous weakness." There is a possibility that they may have been the result of small internal hemorrhages, which gave no other indication than that of mild shock. She does remember, however, that right after these spells the stools were somewhat looser than usual. She has frequent attacks of nausea, and though the appetite is good, food frequently produces a feeling of repugnance. There has never been any vomiting.

On Nov. 27, 1893, a severe hematemesis occurred, the first she had ever had. Members of the family declared it amounted to nearly two quarts of blood, probably an exaggerated estimate made in the excitement of the moment. The blood was described as very dark in color and full of small clots. This so prostrated the patient that she fell to the floor and was put to bed in a dazed condition, nauseated and completely exhausted. Menstruation began upon the following day and still more weakened her physically. The pain in the hypochondrium suddenly became much worse and was experienced most keenly on the left side and under the angle of the left shoulder blade. There was an intolerable headache. The temperature was not elevated and the pulse became subnormal. Just before the hematemesis the bowels had moved very freely, almost to the extent of diarrhea. They were noticeably dark in color. She had just been taking for her dyspepsia ten drops of dilute hydrochloric acid. Dr. Ward saw the case immediately after the hemorrhage and administered ergot, cracked ice, cold drinks and one-sixtieth of a grain of strychnia every four hours. Such was the history of the case related to me when I first saw it two days later, Nov. 29, 1893, at the urgent request of Dr. Ward, who was preparing to leave for California. I found the girl in bed, pale, with an anxious expression and complaining of the sharp burning pain in the stomach. Lying upon either side made the pain more acute. Not knowing what diagnosis had been given, I at once told the parents that, in my opinion, it was a case of gastric ulcer. Absolute quiet in bed was enjoined and all visitors positively forbidden. A drachm of milk and lime water or matzoon was allowed every hour. There was no vomiting when I saw her, so that I had no opportunity of examining the contents of the stomach and the passing of a tube to secure a sample of the gastric juice was entirely out of the question. A week later patient was still very dizzy and nauseated when she injudiciously attempted to sit up in bed. The bowels had moved twice, once normally and once after an enema. Both times they were quite normal in color. The headache continued to be dull and constant. The localized pain in the left hypochondrium did not abate but radiated