rarely met with. The tumors may attain enormous size and give rise to frightful deformity. It may occur at any period of life, arising from the periosteum or the bone proper, usually from the posterior nasal or the cavities accessory thereto, but with a special predilection for the roof of the posterior nares. Its growth is far more rapid than that of the mucous variety; the filling of the nasal and post-nasal spaces does not stop its growth, and the continued and ever-increasing pressure forces the bones of the nose apart (as is apparent to any observer by the appearance of frog-face), causes absorption and caries of the bony walls and ulceration of soft tissues, giving rise to an acrid discharge and also to frequent hemorrhages. Repeated severe hemorrhages may sap the patient's vitality. The constant direct absorption and swallowing of purulent discharges may gradually end life by septicemia. Sarcomatous degeneration is liable to take place, ending in a horrible death.

The appearance of the fibrous variety is so different from the soft that a mistaken diagnosis is impossible. It lacks translucency, has the color of surrounding tissues, perhaps a little deeper red, is firm and resistant to the touch.

EXPLANATION OF CUT.

a. Anterior surface presenting at left nostril; t, portion showing convolutions of inferior and middle turbinates; s, sulcus dividing polypus into nasal and naso-pharyngeal lobes; n p, naso-pharyngeal lobe; p, pedicle; length along left side of mass from a to n p, $2\frac{3}{4}$ inches, height at t $1\frac{1}{4}$ inches. The cut is nearly natural size.

With these preliminary remarks I wish to record the following:

A young German-American farmer presented himself complaining of total nasal obstruction. He had the general appearance of good health, but "frog-face" was at once apparent. Complained of some headache, of lack of ambition and of eyes watering constantly, mostly on left side. He frequently felt nausea, worse when reclining. The trouble came on insidiously and he thinks it may have been a year in its development. On inspection a solid mass completely occluding the anterior nares, presented itself at the left nostril. The septum was deflected decidedly to the right side; the soft palate was bulging downward. Digital exploration of the naso-pharynx revealed the entire space anteriorly occupied by a solid mass, its attachment uncertain.

The mass was removed with a polypus forceps through the anterior nares, the deflection of the nasal bony walls caused by the pressure of the mass

and the very slender pedicle (see cut) having made removal by this method and through this way comparatively easy. Macroscopically it is a soft, fleshy mass $2\frac{3}{4}$ inches long by $1\frac{1}{4}$ high in the middle portion (t) showing here beautifully the impression of the turbinated bodies on the tumor; width across the base, which corresponds to the floor of the nasal fossa, $\frac{5}{8}$ inch. Just back of the attachment of the pedicle is a deep sulcus (s) caused by its impingement on the nasal septum posteriorly, and which divides the polypus into two lobes, the nasal and naso-pharyngeal. The naso-pharyngeal lobe (n p) is $1\frac{1}{8}$ inch wide and $\frac{7}{8}$ inch high turned toward the right side, and by its shape, size and position occluded the right nasal fossa behind. The pedicle is very slender, $\frac{3}{8}$ inch long, very much constricted at the polypous end, showing conclusively that the polypus originated in one of the accessory sinuses, probably the sphenoidal. From the sulcus forward the growth is an almost perfect cast of the left nasal cavity.

This case is believed to be sufficiently unique to deserve a place in the literature of nasal polypi.

THE PHYSIOLOGIC ACTION OF THE THYROID GLAND.

BY HUBERT RICHARDSON, M.D.

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The very different results obtained by the administration of the thyroid gland, or its extracts, and the reports of its success in so many forms of disease, require some further explanation, and I here give the results of a few observations made during the past six months on its possible physiologic action among the insane.

In the paper read by Dr. C. G. Hill on the subject of thyroid feeding, an analysis of the urine made by Dr. Whitney is given, which shows that though the excretion of chlorids, phosphates, sulphates and to a lesser extent urea are slightly increased, the total solids are decreased, pointing to the non-elimination or non-formation of the more toxic products of metabolism, with the possible exception of the ethereal sulphates. Dr. Haig showed by experimentation on himself that thyroid feeding produced a retention or possibly a reduced production of uric acid. Dr. Perry, in his paper on the blood in thyroid feeding, has pointed out that the blood coagulates more quickly, that very slight leucocytosis, or none at all, takes place, but that there is an increase in the number of lymphocytes. A general desquamation seems to take place in the mucous membranes, as well as in the skin, pointing to an increased activity of cell production. Horbaczewski has shown that uric acid is formed from the destruction of polynuclear cells and that those drugs which produce a leucocytosis also cause increased elimination of uric acid, with a few exceptions, as antipyrin, which he suggests produce the leucocytes by the arrest of destruction consequently diminishing the excretion of uric acid.

In my own analyses I have found that the first result of thyroid feeding was to reduce the elimination of uric acid, though after a week or ten days it became normal, or slightly excessive, as the patient improved, presumably by increasing the production of the lymphocytes and also those of the mucous membranes and decreasing at first the destruction of the polynuclear cells. I have observed that when the

thyroid is given to patients whose urine showed excess of toxins, viz., uric acid, ethereal sulphates and pigment, it either produced little or no effect, or caused fever and debility without improvement. The best results have been obtained with patients who had been for some time in the institution and whose elimination had been attended to. I would infer from the above that the physiologic action of thyroid is, 1, increased production of lymphocytes and increased cell production generally, especially in the mucous membranes; 2, an arrest of the destruction of the polynuclear cells.

The above hypothesis would help to account for its success in some reported cases of albuminaria.

THE PALLIATIVE TREATMENT OF CANCER OF THE CERVIX UTERI AND BLADDER IN WOMEN.

Read at the Thirteenth Annual Meeting of the New York State Medical Association, Oct. 14, 1896.

BY NATHAN G. BOZEMAN, M.D.

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I shall confine my remarks to the treatment of carcinoma of the cervix uteri and the bladder in the stage of the disease when any operative measure may be of doubtful expedience, or in cases where operations have been undertaken and the disease still progresses, the condition of the patients being most distressing from hemorrhage, sepsis, incontinence of urine and all the evils resulting therefrom. My interest has been aroused in this class of patients, and no doubt you feel the same, because of their hopeless condition and the difficulty of caring for them in our public hospitals. Certainly, treatment will be directed to alleviating their suffering and rendering their surroundings as wholesome as possible.

Women afflicted with inoperable epithelioma of the cervix uteri, when they are not undergoing any treatment, complain most frequently of hemorrhage and a foul-smelling, bloody discharge from the vagina. The vaginal examination reveals a hard unyielding band of sclerous tissue in front of the cervix extending nearly around the vagina and constricting it; beyond this is the diseased cervix, which is either destroyed, leaving a deep cavity with necrotic walls, or there may be a cauliflower growth on the cervix. Usually digital examination causes excessive hemorrhage, which is controlled by placing the patient in the supported knee-elbow position, exposing the cervix by introducing a perineal elevator guided by the finger and gently brushing over the bleeding surface with a solution of persulphate of iron, or if necessary, touching it with the Paquelin cautery, then packing or columning the vagina with dry cotton. Great caution must always be observed not to injure the ulcerated surface with the end of the speculum. This accident I have found causes more bleeding than the digital examination. To guard against this I also use the knee-elbow position.

In some cases the first indication is to overcome the partial stricture of the vagina which I have referred to, in order to gain free access to the disease and to allow the uninterrupted escape of the discharges. This is accomplished by means of hard rubber intravaginal dilators of suitable sizes to admit of easy introduction. They are worn for several hours a day and are removed for douching. This gradual

dilatation is continued until the contraction has yielded. The treatment sometimes is painful and has to be alternated with columning the vagina. The column of antiseptic gauze and dry cotton I employ in all cases after first dusting on aristol or some other antiseptic powder, for a twofold reason: pressure and absorption of the secretions. When it is properly introduced it may be worn forty-eight hours, then removed for thorough vaginal douching during the next twenty-four hours. It produces pressure on the diseased surface and against the constricting band in the vaginal wall. The secretions are retained in it for a considerable time and it prevents bleeding; consequently the surface of the ulcer is maintained in a fairly clean state. I treat my patients about three times a week and I find that they are kept quite free of pain and are not annoyed by the discharges. The disease has a natural tendency to extend, but in none of my cases has a perforation occurred into the rectum.

Bozeman's Air and Water Irrigator.

I have had several where the bladder became involved and here is when I believe most of the pain from the disease begins. The first manifestation of the extension to the bladder is a severe form of cystitis with excessive vesical tenesmus and frequent urination, but when the perforation of the vesico-vaginal septum takes place and the urine finds a free outlet, all these painful symptoms subside; a vesico-vaginal fistula is then established and the bladder has physiologic rest.

Some of us are familiar with the pitiable and loathsome condition of urinary fistula cases in former times, when the sloughing of the vaginal and bladder walls was due to prolonged pressure of the head in the parturient state, and we all know of the successes of my father in his untiring efforts to close these openings and restore such patients to health, so that now by following his teachings we are enabled to close all forms of vesico-vaginal fistulae. Those caused by carcinomatous ulceration, however, should