of the external rectus is not always of value as a localizing sign in tumor of the brain, as this nerve, on account of its long intracranial course, may be injured by pressure exerted at a distance. The tendency to silliness on the part of the patient in speaking, and to the attempt to speak like a child, is a little in accordance with the tendency to make jokes observed in case of tumor of the frontal lobe. Dr. Spiller said that Dr. Langdon's report does not state whether there was, in the case to which he referred, bilateral temporal hemianopsia. This condition may be looked for when the tumor is at the chiasm. Tumors at the base of the brain often are exceedingly difficult to diagnose, because of the general symptoms of pressure. Disturbance of smell is in some cases not important as a localizing symptom. Six or seven years ago Dr. Spiller had a case in which there was a tumor over the pons extending downward on the spinal cord, and causing very early loss of smell. Some years ago he had a case in which much thickening of the skull occurred over the tumor, and was caused by infiltration of the bone of the tumor.

Dr. B. ONUF, Sonyea, N. Y., asked what should be done in cases of incipient tumors with marked optic neuritis, in which an accurate local diagnosis can not be made. He thinks it has been reported that a relief of pressure is sufficient to bring about a restitution of vision, and he would like to know whether that experience has been repeated. It is of very practical value to know whether an operation should be advised or whether the patient should be advised to wait until an accurate diagnosis can be made. If restitution should take place the patient with optic neuritis would again be restored to vision, and the question arises, how long is it safe to wait; how long can the optic neuritis last and yet recovery take place?

Dr. CHARLES K. MILLS, Philadelphia, in replying to a statement, said that he would advise operation at once in a case of the kind mentioned, with this qualification, that sometimes it is advisable to wait for a short time for the development of focal symptoms which are suggestive; even in the absence of such symptoms, however, he believes that operation should be done to relieve optic neuritis or headache, or both. In a number of cases he has seen optic neuritis relieved by operation. He believes that in some syphilitic cases the operation should be done where the diagnosis of syphilitic affection has been made. It is a curious fact that in some cases the anti-syphilitic remedies relieve the symptoms more thoroughly after the opening of the skull, and they should, of course, be continued. He believes that the mistakes which have been made with regard to opening the head have been in the direction of ultra-conservatism.

Dr. DAVID I. WOLFSTEIN, Cincinnati, said that it does not seem from the description Dr. Keen gave of his case that it could be confounded with a tendency to joke. A question of interest in connection with the case, inasmuch as the tumor involved the right side, is whether there was anything there present which could be construed as intracerebral ataxia. In the case which Dr. Wolfstein reported, inasmuch as the asylum physician reported the presence of progressive dementia, he thought that he could explain the absence of all general symptoms by the presence of this dementia, but inasmuch as Dr. Langdon does not think dementia was present, it can not be explained on that ground. The tumors at the base of the brain are not necessarily accompanied by intense headache, and the optic neuritis was probably due to pressure on the optic nerve.

Capillary Nevi in the Aged.—A. Bauer, of Paris, holds that the relations between capillary nevi in the aged and lesions or functional disorders of the liver can be absolutely affirmed. The liability to disturbances of the liver during a long life, the frequency of its lesions in elderly people, and the constancy of the occurrence of cholemia, as tested by blood examinations in the cases he examined, lead him to this conclusion, as he announces in a communication to the *Archives Gén. de Méd.*, xciv, No. 34, 1904.

TWIST OF THE PEDICLE OF OVARIAN CYST COMPLICATING PREGNANCY.

A CLINICAL LECTURE.*

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FORT WAYNE, IND.

Gentlemen:—As our patient is anesthetized, we will proceed at once with the operation for the removal of the abdominal tumor, which you see we have here, and will read the history of the case later. Note that the peritoneum is slate-colored, as it always is with blood under it, and that on opening it a quantity of bloody serum runs out. Now that I retract the edges of the incision, note the color of the tumor, which presents slate in some places and deep cherry in others. I have now tapped the cyst and, as you see, the contents are bloody. I gradually deliver the cyst as it is emptied, and you note the numerous but easily separated adhesions. Through these adhesions these cysts are sometimes nourished after the pedicle has been completely divided by twisting. Now I deliver the tumor and show you here the twist in the pedicle which accounts for the blood in the tumor, as well as for that in the peritoneal cavity. The tumor springs from the right side and the pedicle presents, as you see, two complete sinistorspiral twists in accordance with Freund's law, which is based on the theory of Goodsir and Fisher, that all organisms grow in a spiral direction, left-sided ones twisting to the right and vice versa. The ligature is placed on the constricted portion of the pedicle and the sac removed. Now that it is out of the way, I show you, in the left of the pelvis, a good-sized, semi-fluctuating, flesh-colored tumor, which is the uterus pregnant about three months. We will now close the incision in the usual way with layer catgut sutures for the deeper structures and adhesive plaster for the skin. We will direct that this woman be given a hypodermic of morphia should there be any symptoms indicating miscarriage. However, I do not expect her to miscarry, as it is not the rule for these patients to do so. This is the fourth case of the kind in my practice and not one of them has aborted.

HISTORY OF CASE.

Let me now read you the history of this case as it was transcribed by me on her arrival at the hospital, about two hours ago.

Patient.—Mrs. M., aged 24, married four years, mother of two children, the youngest 18 months old.

History.—She made good recoveries from all her labors but thinks her abdomen has been large since her last confinement. When her last baby was three months old she commenced menstruating and did so regularly until July last, since which time, three months, she has not menstruated. She has always enjoyed good health. Several cousins and one aunt died from tuberculosis. Six days ago she was taken with pain in the right side of the abdomen, low down. The pain at first was not very severe, but became so in an hour, and a physician was sent for, who prescribed an opiate. Vomiting occurred soon after the onset of the pain and, like the latter, has continued, but has been controlled in a measure by the opiates. The pain seemed to spread and the whole abdomen soon became tender to the touch. Her bowels had been regular up to the onset of the trouble, since which time they did not move, notwithstanding rather vigorous efforts to make them do so, until yesterday.

*Delivered at Hope Hospital.

Her physician, Dr. Thomas of Decatur, suspected either appendicitis or an ovarian tumor with torsion of the pedicle.

Present Condition.—Well nourished, good color, pulse 120 a minute and of fair volume. Temperature, 100.2 F. Abdomen as large as that of a woman at or near term, and regular in contour.

Physical Examination.—This was quite unsatisfactory on account of extreme abdominal tenderness, which is general. However, a fluctuating tumor can be made out and the uterus seems large and has a soft cervix. There is no localized abdominal rigidity.

Diagnosis.—Pregnancy, complicated with ovarian cyst with torsion of the pedicle and consequent peritonitis. Immediate operation advised and accepted.

You are fortunate, gentlemen, in having the opportunity to see this case, because of the fact that they are not of very frequent occurrence and for the additional reason that they are, in a measure, emergency cases and therefore not often presented for clinical demonstration. The case, too, is quite typical of its kind and this adds to its practical value. This patient thought that she was unusually large but was not aware that she was the possessor of a tumor until she was told by the physician. Quite commonly these patients regard themselves as entirely normal until the torsion of the pedicle occurs, when an examination leads to the discovery of the tumor. As a result of the torsion, these tumors often enlarge rapidly. This is due to the hemorrhage into them and is explained by the fact that the twist relatively completely stops the return of the blood through the outer side of the pedicle, which, as you see, is quite thin, while the inner side, carrying the principal arterial supply, is quite thick and less easily strangulated. The amount of the hemorrhage, both within the tumor and into the peritoneal cavity, varies and may be so great as to prove alarming or even fatal, though this is rare.

I wish to call your attention particularly to the symptoms of bowel obstruction which were present in this case. This is a quite common cause of complaint in these cases. I can now recall two or three cases of torsion of the pedicle of ovarian cysts which were referred to me with the diagnosis of bowel obstruction and in which no mechanical obstruction was found. The bowel may, of course, be involved in the twist or it may be obstructed as a result of adhesions which form as a result of it, but my experience has been, as in this case, that the obstruction is adynamic in character and is a result of the peritonitis or of inhibition of the peristaltic movement consequent on the accident. Both of these factors were probably active in this case.

The treatment of this accident is, of course, operative, and, in my judgment, the sooner the operation is done the better. There are those who advise awaiting reaction when shock is marked, but I do not agree with them, for if the shock is due to hemorrhage it is likely to recur with the establishment of reaction. On the other hand, if the shock is the result of pain and nervous perturbation the anesthetic relieves both of these conditions and the removal of the tumor takes away the cause of them; hence, in my opinion, the best plan is immediate operation.¹

1. At present writing, three weeks after the operation, the patient is up and ready to leave the hospital for her home. Her recovery was uninterrupted by a single untoward symptom.

The shortest and surest way to prove a work possible is strenuously to set about it; and no wonder if that proves it possible that for the most part makes it so.—South.

THE BLOOD IN LOBAR PNEUMONIA, WITH REMARKS CONCERNING TREATMENT.*

EDWARD C. ROSENOW, M.D.
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BACTERIOLOGY OF THE BLOOD.

Of the total number of 175 cases of lobar pneumonia in which I have made blood cultures, 145 cases were reported in another article,¹ and 30 have been made since. In this series of 175 cases the pneumococcus was isolated in all but 15—that is, in over 91 per cent. Usually, only one culture (3 to 4 flasks) was required to demonstrate the presence of pneumococci in the blood, though occasionally a second culture was necessary to obtain the organism. In 11 of the 15 negative cases, only one culture was made, there being no opportunity for a subsequent examination. In the remaining 4 cases it was impossible, by repeated cultures, to demonstrate the pneumococcus in the blood. In one of these 4 a careful search in smears prepared directly from the blood showed undoubted pneumococci.

The leucocytosis in these 4 cases was high, and I was inclined to believe that the negative findings were the result, possibly, of an active phagocytosis; but the fact that in other cases with equally high leucocyte counts there were positive results, made this explanation seem improbable. A closer study showed that the cultures with negative results were made within twenty-four hours of crisis, while the cultures which resulted positively were made two or more days before crisis. Hence there seems to be a diminution in the number or viability or both of the pneumococci in the blood at the time of crisis. To this we will return later. Positive results were obtained as early as twelve hours after the initial chill, and as long as forty-eight hours after crisis. Cultures after crisis, however, usually proved sterile.

The mortality in the series studied was almost 40 per cent. The percentage of positive results, excepting the last twenty-four hours of life in the fatal cases, is equally high in the fatal and in the non-fatal cases. This seems to justify the conclusion held by Fränkel, Prochaska, Kinsey and others, that with proper technic blood cultures are of little or no prognostic value, because positive in both the fatal and non-fatal cases. A negative result indicates nothing, except probably that something is wrong in the technic. This is very well illustrated by the investigation of F. C. Kinsey,² who studied the blood in 50 cases of pneumonia in the same epidemic. In his first 25 cases positive results were obtained in only 3. After modifying his technic, however, the results in his next 25 cases are practically the same as in this series. Fränkel has had a similar experience.

That the pneumococcus is not only present, but present in large numbers in the blood, as Preble recently showed in a number of cases, is indicated by the fact that by direct examination of smears in this series the pneumococcus was found in 47 out of some 80 cases examined. In no instance could I demonstrate pneumococci in leucocytes.

In the light of these findings we would certainly be

* Summary of an investigation carried out in the Pathological Laboratory and in the Presbyterian Hospital, under the Alumni Fellowship Fund of Rush Medical College. This paper was read before the Chicago Medical Society, 1904.

1. *Journal of Infectious Diseases*, March, 1904. Here also is given a review of the literature.

2. *THE JOURNAL A. M. A.*, March 19, 1904.