rate was irregular at 115 to 120 and quite arrhythmic. A capillary pulsation was easily demonstrated in the index finger, and the poorly sustained radial pulse on elevation aided in confirming the diagnosis of aortic insufficiency with broken compensation.

As it is not the purpose of this article to dwell on the pathology, it may be dismissed with the statement that rest in bed, moderate doses of digitalis and aspiration of 1100 cc. of serous fluid from the right side of the thorax brought prompt moderation of the symptoms. The orthopnea disappeared, the character of the pulse improved and its rate was at 80 in a few days. Following the tapping the lower border of the liver returned nearly to its normal limits and the epigastric distress then ceased.

However, the removal of the fluid did not alter the area of cardiac dullness. Inquiry of the patient revealed the following interesting facts relating to this transposed organ:

The position of the heart on his right side was noted at his birth by the physician, and the mother's attention was called to it. The patient has a twin sister whom, as a child, he very closely resembled in features, but her heart is normally located. Each of their parents was a twin, but their hearts are said to have been on the proper side. My patient has a wife and a twin son and daughter. The children are about four years old and look just alike. While the girl's heart is placed as usual, the boy's heart is, like the father's, on the wrong side of the chest. Some years ago the wife miscarried a pair of twins at the seventh month. Unfortunately no anatomical examination of the fetuses was made as to the heart's position.

It is of interest that the patient's twin sister also has a pair of twins (boy and girl), four years old, residing in a distant city, who are said to look just alike; but, in their case, my patient "thinks" their hearts are on the left side.

The patient is slightly under medium height, well nourished and claims unusual strength and health until recently. As a child he was naturally left-handed—a functional peculiarity noted in other cases of transposed heart. At school he was encouraged to use the right hand more and so became ambidextrous.

The percussion tone at the apex of the right lung is higher than that of the left—a fact which might be accounted for (in case the lungs are transposed) by the pressure of the right hydrothorax. Still, the character of the sign is but little altered since aspirating.

In conclusion, attention may be called to the following:

Dextrocardia, a local transposition, is comparatively rare and should not be confused with the not uncommon cardiac displacement due to disease. Blodgett states that in the examination of 20,000 recruits for the German army only two cases of dextrocardia were encountered.

The condition is said to have been very exceptionally noted at birth, and generally was not suspected during life.

Ballentyne, in his recent excellent work on "Antinatal Pathology and Hygiene" (1906), states that there had appeared no evidence of the transmission of this anomaly by heredity. He cites E. Rogi's cases of brother and sister as being quite unique as an instance of family tendency.

While dextrocardia is said to have been noted twice the number of times in males that it has in females, which may be accounted for by military and insurance examinations, yet many cases may

indicate a tendency for transmission, under certain circumstances, in the male line.

Aristotle was the first to describe transposed organs. It is of further historic interest that the wife of Henry IV of France (mother of Louis XIII) had the heart to the right of the sternum.

Several theories as to the cause of this anomaly have been advanced. However, Ballentyne states that the inverted position of single organs is not to be regarded as directly related to the causes of situs transversus viscerum (due to malformation of the germs, Winslow), but is ascribed to local anomalies in development, which belong to a later stage in embryological formation.

AN ABDOMINAL LESION SIMULATING CANCER.

BY BENJAMIN R. CATES, KNOXVILLE, TENN.

In the latter part of March, 1907, I was called in consultation by Dr. J. H. Wilkerson to see Mr. George Dunlap, who was suffering from some obscure trouble in the left lower quadrant of his abdomen.

I obtained the following history:

Mr. Dunlap is a merchant, fifty years old, large-boned, and inclined to be slightly obese. He relates he has always been healthy; but within the last six or seven years has been growing constipated to such an extent that he has had to use purgatives constantly.

Mr. Dunlap further says that on the twelfth of March, 1907, he retired at night as usual, remarking to his wife he "felt better than he had for months and months."

About 1 A.M. on the following morning he was awakened by a sharp pain in the left lower quadrant of his abdomen. The pain became so severe he sent for Dr. Wilkerson, who relieved him by a hypodermic of morphine and a purgative.

However, Mr. Dunlap did not feel inclined to go about his business, and was kept under the constant attention of Dr. Wilkerson.

After a few days of observation, Dr. Wilkerson suggested I be called in to consider the advisability of an operation.

When I saw Mr. Dunlap he was lying in bed, not suffering much pain; he had no inclination to move about. His pulse and temperature were normal, though Dr. Wilkerson said when he first saw Mr. Dunlap he was having fever. His abdomen was not distended.

Superficial palpation showed a slight degree of resistance on the left side, which on deep pressure in the left lower quadrant caused him to flinch and cry from pain.

From a digital examination of the rectum I could discover nothing abnormal, except, four or more inches from the anus I fancied there was a slight bulging of the bowel on the anterior surface. Anyhow, pressure against it caused pain.

With this history and examination I was not satisfied in my mind as to the pathology of the case and made arrangements to see Mr. Dunlap again in a few days. This I did without forming any well defined opinion other than that it was a case for operation.

I, therefore, suggested an exploratory operation, which was accepted.

Accordingly he was removed to the hospital of the Tennessee Medical College, and was operated upon April 4, 1907.

Thinking perhaps I might have an incipient cancer

of the rectum to deal with I made a long incision parallel to and above Poupart's ligament. When I got into the belly I found the pelvic cavity filled with small bowels and so adherent to every thing that I abandoned the first incision for the time being, and opened the abdomen in the middle line, in order that I might have a better field for operation. The small bowels filled the pelvis and hid the sigmoid and rectum from view. In sponging the adhesions apart, I broke into a pocket of foul-smelling pus on the left side of the sigmoid and rectum. I estimated there must have been half a pint of this pus.

While the pus had a foul fecal odor, I did not find any fecal concretions, nor did I find any communication with the bowel.

I then placed the patient in the reversed Trendelenburg position, placed gauze around the bowels, so as not to infect the general peritoneal cavity, introduced cigarette drains from both wounds down to the pocket of pus and closed the wounds down to the drains.

The subsequent steps of the treatment followed was to keep the patient in Fowler's position and to give daily enemas of normal salt solution by Murphy's plan. The patient made a slow but sure recovery, without developing any permanent fecal fistula, though for about a week after the operation the discharges had a decided fecal odor.

The pathology of this case was unique to me, and I was at a loss to account for it, because I had never seen a similar condition in the operating room, nor could I find anything in the literature in regard to it. Hence I called it acute periproctitis, and acute perisigmoiditis.

The etiology of this case was interesting, and in seeking for a cause I accidentally learned from the patient that a few years ago a traveling quack came through the town delivering lectures on "health and how to preserve it." Among other things he taught that people, in order to aid digestion and cure constipation, should eat every day a teaspoonful of sand. So this good man was induced by some friends to eat sand for constipation. This, I thought, may have been the secret of the trouble. The sand might have lodged in some of the folds or pockets of mucous membrane of the sigmoid or rectum and caused ulceration, secondarily setting up suppuration around the gut.

Since writing the above report of my case I have read very interesting reports in *Surgery, Gynecology and Obstetrics* for July, 1907, by Drs. W. J. Mayo, of Rochester, Minn., and George Emerson Brewer, of New York, on "Diverticulitis of the large bowel," that throw a good deal of light on the pathology of my case.

THE CHOLERA SITUATION IN RUSSIA.—According to press dispatches from St. Petersburg, Oct. 31, the latest official cholera statistics for the week ending Oct. 22 show that the epidemic is now being checked with the approach of winter. There were 1,009 new cases reported and 416 deaths were recorded. More than half the number of cases, 569, were in Kiev and Volhynia provinces, where the winter is belated. There were only 103 cases in the four southern provinces and 75 in the five provinces of the Middle Volga region.—*New York Med. Jour.*

Medical Progress.

PROGRESS IN SURGERY.

BY J. G. MUMFORD, M.D., BOSTON.

RESULTS OF THE OPERATIVE TREATMENT OF BREAST CANCER.

(Concluded from No. 19, p. 640.)

HALSTED, more than other writers, distinguishes degrees of axillary involvement, giving four groups of cases depending upon the extent of involvement: (a) base of axilla only; (b) base and mid-axilla; (c) base, mid-axilla and apex; (d) veins intimately adherent. He shows how groups b, c, and d are much the most difficult and serious and lead with considerable certainty to an involvement of the supraclavicular region, and he finds this region above the clavicle the seat of disease in a surprisingly large number of cases. Of his 232 cases the neck operation was done in 119; while of the remaining 113 cases, in which the neck operation was not done, 44 were operated upon subsequently. Halsted finds microscopic involvements of the neck glands in great numbers of cases which show no palpable evidence of disease in that region. For this reason, he insists upon the neck dissection in all cases in which the axilla is involved beyond the base. He lays down the following rules: the surgeon should perform the neck operation, "barring, of course, special contra-indications: (1) in all cases with palpable, operable neck involvement; (2) when the apex of the surgical axilla is involved. When mid-axillary involvement is demonstrable at the operation, special implication is almost certain, and hence, (3) in these cases also the neck should be typically cleaned of its lymphatics, as high, at the very least, as the bifurcation of the carotid.

"We find ourselves for the past two years again performing the neck operation in most cases. We omit it in hopeless cases."

As evidence that involvements of the neck do not imply necessarily a hopeless condition, Halsted cites 40 traced cases, in which cancer was found and removed from both neck and axilla. Four of these cases survive the three-year limit, showing us positively good end-results in 10%.

On the other hand, Greenough, and most of the other speakers, conclude from their studies that cancerous glands above the clavicle practically contra-indicate an operation for radical cure. Of 38 cases reported by Greenough, with involvement and removal of the neck glands, none survive. Willy Meyer does not favor the neck operation and finds none of his neck cases alive after a five-year limit. Ochsner dissected the neck seven times in 78 cases. His seven neck cases are dead. The studies and conclusions of these three speakers, however, are by no means as exhaustive and satisfactory as Halsted's, nor is their experience with neck involvements as extensive.

L. S. Pilcher supports Halsted's views in an entirely interesting and convincing paper. The former surgeon has made a painstaking endeavor