the death of the fœtus until the time of the removal, and the pain is to be referred to the peritonitis.

Two years later the patient had removed to the country, where she came under the care of Dr. E. S. Jack, of Melrose, who has kindly sent me the following notes:

"On March 24, 1893, the patient consulted me at my office, complaining of uncomfortable sensations over the lower abdomen. She was flowing.

"She feared that she had same trouble on the left side, which had been found on the right side two years before, as she felt very much as she did then.

"The examination was negative as far as determining the existence of extra-uterine pregnancy on the left side, although some tenderness was found.

"I next saw the patient on March 30, 1893. She was lying upon the sofa and complained of colicky pains, and a feeling of discomfort. There was considerable tenderness over the lower portion of the abdomen. The pulse was 80 and the temperature 99.4°.

"The patient was ordered to bed, and was given hot applications, hot douches and salines.

"Friday, the pulse was 76 and the temperature was 99°. More comfortable.

"Saturday, the pulse was 76 and the temperature was 99.6°. More comfortable, though flowing some.

"On Monday, April 3, 1893, there was more pain and tenderness, particularly on the left side. Vaginal examination showed considerable resistance on the left side.

"On Tuesday, the condition was the same. I demanded a consultation and advised operation.

"On Wednesday morning the patient felt decidedly better, but about 11 A. M. I was suddenly called. The patient had more colicky pain, and was faint, and suffered from blurring of vision. I advised immediate operation, to which the patient consented."

I saw Mrs. M. J. in consultation with Dr. Jack on April 5, 1893. There was a tumor in the posterior cul-de-sac toward the left side. The patient's condition was not bad, there was pain and some flowing.

I agreed with Dr. Jack in the diagnosis of probable extra-uterine pregnancy. As the immediate condition was not threatening, it was decided that we should delay operation until the first reappearance of severe pain or other urgent symptoms. On the following day there were signs of internal hæmorrhage.

It seemed unsafe to defer operation longer. An opening was made through the old line of incision. The abdominal cavity was reached with some difficulty, owing to the adhesions of the omentum. It was found to be full of dark blood and blood-clots. The dilated tube and the ovary on that side were excised. The blood and clots which lay among the intestines as high up as the diaphragm, were removed. The abdomen was closed without drainage. The patient made a good recovery, and now is quite well.

The patient's condition before the last operation did not seem especially bad. There had been some quite severe pain accompanied by giddiness. Neither the countenance nor the pulse gave a true indication of the large amount of the concealed hæmorrhage.

This case affords strong argument against delay. Waiting for extreme symptoms in extra-uterine pregnancy should be discouraged as it should be in case of appendicitis.

The question must arise whether the manipulation of the preceding day did not assist in producing the

hæmorrhage. Such a result is, of course, quite possible.

The liability to rupture of the mass by handling should always be borne in mind. An examination must try the strength of the tissue much more than any movements or acts of the patient.

Dr. Whitney makes the following report of the specimen removed at the second operation:

"The specimen was a pear-shaped dilatation of the Fallopian tube, which measured about eight centimetres in length, and about four centimetres at its greatest diameter at the fimbriated end, which was widely opened when received. The inner surface of this dilatation was quite smooth except in one or two places where there was a little roughness and a hæmorrhagic mass. The walls were thin and fibrous.

"With this was a rounded mass of blood-clot (which had come from the interior of the sac, probably), rough on its surface and containing in its centre a very thin, fibrous sac. There was also an embryo about four and one-half centimetres long (about the eighth week). The ovary was small, and contained a corpus luteum one and one-half centimetres in diameter.

"The diagnosis is a tubal pregnancy, with rupture through the fimbriated end of the tube at about the eighth week."

A CASE OF TUBERCULOUS PERICARDITIS WITH ENORMOUS EFFUSION; GENERAL TUBERCULOSIS; AUTOPSY.¹

BY EVERETT A. BATES, M.D., SPRINGFIELD, MASS.

W. J. J. P. was a marble-carver, fifty-eight years of age. His father had died at thirty years of "dropsy"; the mother at forty years of "consumption of the bowels," with cough as a persistent symptom in her illness; and a sister at twenty-eight years of the same trouble as the mother.

Mr. P.'s army experience resulted in a bullet-wound through right flank, followed by necrosis of the crest of ilium, with complete recovery in fourteen months.

Four years later than this, when thirty-three years of age, and coming on after exposure, he had an illness characterized by fever, loss of strength and flesh, cough and expectoration, lasting ten weeks, called "quick consumption," and terminating in a rapid convalescence and recovery.

There is a history of intermittent fever for four consecutive springs some twelve years since; but apart from the above, and a tendency to "lung colds" and temporary cough, the subject of this report had considered himself well and robust until three years ago the past spring, when he had a sickness, called by himself "grippe," associated with fever, debility, and cough without expectoration. He considered himself well in a month, after taking tonics, including cod-liver oil.

Again, eight months later, and a year before his last illness, similar attacks, all termed "grippe." But during these three years — noticeably the past year — there has been slight but gradual loss of flesh and physical vigor; and during the last five months there again developed cough, slight at first, but later hard and useless. He began to feel conscious of an afternoon temperature, and finally, from increasing weakness, gave up work February 8, 1893. During the

¹Read at the meeting of the Hampden District Medical Society, September 19, 1893.

next ten days, slight dyspnoea and palpitation on exertion developed, with vague præcardial uneasiness, leading him to consult Dr. C. P. Hooker, with whom I saw the case March 18th, and by whose courtesy I am enabled to make this report.

The patient was a large, well-developed man, at this time fairly nourished. Skin sallow and dry; lips and nails a little dusky; very slight œdema of legs and ankles and of trunk, especially noticeable in the præcardial area; slight puffiness of eyelids. The jugulars pulsated and the veins of forehead were distended. Right semi-ventral decubitus was invariably assumed. The temperature varied from 100.5° to 102° in the afternoon, with a morning remission to normal. Pulse was 120, irregular and of fair strength. Respiration 26.

Inspection of chest showed præcardial fulness, with obliteration of intercostal spaces in this area. There was absence of cardiac pulsation or apex-beat. The præcardial fulness had for its upper boundary a line extending from the lower margin of the fifth rib, eight and one-half centimetres to the right of median line, to the junction of the right third rib with sternum, and thence in a gradual curve across sternum to second left interspace, downward through left nipple to fifth rib at a point thirteen and one-half centimetres from median line. With the patient sitting, this curve flattened perceptibly.

The heart-sounds—not abnormal in character—could be heard only, and faintly, in the second interspaces and the fifth and sixth interspaces left axillary line.

Dulness in the back was found below the eighth interspace scapular line on right, and eighth rib correspondingly on left. A few medium, moist râles above; lungs negative elsewhere. The liver was palpable below the costal border, with its lower line of flatness extending directly across abdomen.

The abdomen was full, not distended, with moderate dulness in flanks.

The urine was high-colored, loaded with urates, specific gravity 1026, no albumen, and no casts detected. No sputum could be obtained. The etiology of this affection was considered as, probably, tuberculous.

During the remaining six weeks of life the patient was comfortable; there was gradual loss of strength and moderate increase of plural and abdominal effusions, without apparent increase in pericardial.

Aspiration of the pericardium was considered, but not done, owing to the remarkable absence of distressing symptoms in spite of the enormity of the effusion.

During the last week delirium and anginal attacks at night developed; and the patient died suddenly on the morning of May 1st, while attempting to get out of bed.

The autopsy was performed eight hours after death. Rigor mortis present. Sternum prominent, slight general œdema, and subcutaneous tissues of trunk very watery. Head not opened. A considerable amount of clear serum escaped on opening the abdominal cavity. On removing the sternum, the pericardium presented as a large, distended bag, tense and nowhere adherent. The lungs were collapsed, and both pleural cavities contained a considerable amount of clear serum.

The outer surface of the pericardium showed numerous whitish elevations, some confluent and others dis-

crete. On incising the sac this pericardial layer was found to be greatly thickened, in portions as much as six or seven millimetres; the sac contained two litres of turbid, bloody serum. The cardiac layer of pericardium was everywhere thickened, and resembled so-called honey-comb tripe, and on section presented numerous opaque and yellowish points, and some yellowish masses scattered here and there. The heart itself, apart from a moderate degree of hypertrophy, was normal; its cavities were empty.

The pleuræ were nowhere adherent; the pulmonary layer was everywhere studded with grayish, opaque points up to a pin-head in size; the costal and diaphragmatic layers were free of these. The lungs, at the apices of the upper and lower lobes, showed old fibrous scars, and in other portions—as a rule, just beneath the pleura—many scattered and conglomerate tubercles. The air-passages contained reddish, frothy fluid. The bronchial glands and those in the anterior mediastrium were enlarged, caseous, and several perceptibly softened. The kidneys and spleen contained a few scattered tubercles. The pericardial fluid was not examined.

A CASE OF ACUTE HÆMORRHAGIC PANCREATITIS.

BY W. E. PAUL, M.D., BOSTON.

THE following case is reported as having some bearing on the subject of appendicitis. At the same time it illustrates the difficulty not infrequently presenting itself in making an ante-mortem diagnosis in abdominal affections. Moreover, cases of acute hæmorrhage into the pancreas are sufficiently unusual to warrant the report of an undoubted case however incomplete the data.

E. C., a robust farmer, aged sixty-two, suffered thirty years ago from severe intestinal symptoms. For five days death was expected, when something seemed suddenly to turn over in his stomach, and an intense epigastric distress, with vomiting, was relieved. The vomitus was black, but did not suggest blood.

Nine years later he suffered from symptoms similar in character but of less severity. A sense of discomfort was described as centering in the lower chest front and epigastrium. Every few days during the more recent years the distress has recurred, and during the past year its intensity has increased. For the past six years the patient has been confined to the house six weeks at a time. In the last summer of his life the attacks recurred daily, and required the patient to lie down.

Tuesday, October 3d, the patient felt more miserable, and at 11 A. M., Wednesday, had a decided pain in his epigastrium and under the lower half of the sternum, extending to each side perhaps as far as the nipples. He was looking forward eagerly to his dinner, feeling that the meal of pork and onions would relieve the distress and pain. He eat heartily, but immediately after finishing his meal was forced to leave the table and vomit the meal. Considerable retching followed, and the pain increased.

After about four hours the patient was visited, and was found pale, with a cold perspiration on the temples and hands; and suffering severely from most acute pain referred to the epigastrium and substernal region. The pulse was 70, of good strength, and the temperature was normal. Sulphate of morphia