tablished, so that instead of a normal or subnormal temperature, there was an elevation of temperature of 4.5 degrees.

Another most interesting point in the case is the character of the hematoma, i. e., its assuming such a relation as to interfere with the blood supply of the uterus, causing disintegration of its muscular tissue and at the same time simulating so perfectly in its position and consistency a fibroid uterus.

It is interesting to speculate on what the outcome of such a case might be without surgical interference.

In many parts of the body less favorable to absorption, hematomas are completely decimated. An early rupture into the broad ligament is one of the most favorable conditions for recovery without interference, especially if the rupture is accompanied by the death of the embryo. But when a hematoma is formed in this manner it must be remembered that the sac enclosing it communicates with the Fallopian tube, within which may be harbored pathogenic bacteria, and this tube in turn may, and usually does, communicate with the uterus and through the uterus with the external world.

It may be said, therefore, that the hematoma, which is an excellent culture medium, is subjected in a greater or less degree to infection by micro-organisms finding their way through the uterus and Fallopian tube or from the intestines, and the patient may locally or constitutionally be infected through an abscess thus formed.

In this particular case the operation demonstrated an unusual condition of things. The nutrition of the uterus had been so seriously interfered with that the muscular tissue had undergone grave degenerative changes. Whether this breaking down of the uterine tissue would have ultimately resulted in forming a communication between the folds of the broad ligament and the uterine cavity and thus permitted the expulsion of the disintegrated hematoma and the products of a tubal pregnancy is a matter of conjecture.

Observers have reported that even the bones of the fetus have been expelled through the uterus, rectum perineum, gluteal muscles and abdominal wall. A case of the fetal sac adhering to and ulcerating through the uterus and discharging bones into the vagina is that of Bertino's referred to by Dr. Heineck.² The rest of the bones were removed by laparotomy eighteen months after the death of the fetus.

The efforts of Nature to remove the products of an ectopic gestation have been so faulty, and the dangers to the mother are so great, that we are justified in operating even if we know that some of the most favorable cases recover without interference. In fact, surgical interference is demanded in the light of to-day.

CASE 2.—Mrs. F. H. On Feb. 12, 1904, I operated in a case of ectopic gestation, the principal features of interest being that the patient had been ill for a week from extensive hemorrhage into the abdominal cavity and the gestation sac was found engrafted into the infundibulum and fimbriated extremities. The patient recovered.

ETIOLOGY.

The observations of Dr. J. Clarence Webster on the etiology of ectopic gestation are of interest. He claims that the idea of early writers of a mechanical interference to the advancement of the ovum toward the

uterus being the cause, has no foundation of fact. He says:³

In 1895 the author pointed out that these views were largely speculative. He showed that, while frequently these mechanical factors might be associated with ectopic pregnancy, there was no proof that they were the ultimate factors in its causation. He demonstrated the existence of the decidual reaction in the tubal mucosa in all cases of tubal pregnancy, and advanced the view that the fertilized ovum could develop only on tissue capable of undergoing a genetic reaction. Normally in the human female this reaction, occurring as the result of fertilization, takes place in the mucosa of the uterus. Its occasional occurrence in other parts derived from the Müllerian tract, i. e., Fallopian tubes, is to be regarded as a reversion in these tissues to an earlier mammalian type either in structure or in reaction tendency. The fertilized ovum coming in contact with any portion of the Müllerian tract capable of establishing with it the relationship necessary to its development may become attached and grow just as readily as if it were lodged in the uterine cavity. . . . It is, however, an unjustifiable assumption to hold that the ovum, if simply obstructed in its downward movement, may develop in a tubal mucosa that is perfectly normal or altered by inflammation. . . . The author strongly holds that there is no proof whatever that ectopic pregnancy begins its development on any other than Müllerian tissue. . . . In the rare condition of ovarian pregnancy it is not at all unlikely that the presence of Müllerian remains in the ovary may determine the site of pregnancy in this organ.

Certainly such views are in accord with the generally established principles of evolution.

If the determining factor in ectopic pregnancies were only a mechanical one the condition would be seen much more frequently than it now is. Furthermore, the mechanical factors that would interfere with the progress of the ovum downward would also be likely to interfere with the advancement of the sperm cell along the tube and be the determining factor in the production of sterility.

Undoubtedly, ectopic gestation occurs much more frequently than is generally supposed. Many obscure cases of illness in women in times past would to-day be attributed to this cause.

Like every other malady in the catalogue of diseases, it becomes more common as we become more proficient in the art of recognizing it. In every woman capable of impregnation a sudden attack of pain in the lower abdomen, faintness, acute anemia and nausea without elevation of temperature, should raise the question of the possibility of this condition in the mind of the physician.

A METHOD OF PRESERVING AND FILING MEDICAL RECORDS

BY MEANS OF SPECIAL ENVELOPES OR POCKETS.*

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No one will deny the advantage, I might even say the necessity, of keeping a careful record of medical cases. Such records are now kept with more or less care in most hospitals and dispensaries, as well as by many physicians in private practice. It is probable, however, that most practitioners are lax in this respect, especially in cases seen away from their offices, largely, no doubt, for the lack of a convenient system. In this paper I will confine myself principally to the methods of preserving

2. Heineck (Aimé Paul): *The Terminations and Treatment of Extrauterine Pregnancy, with a Report of Thirty-Two Cases Treated at the Cook County Hospital, Surg., Gyn. and Obst., March, 1906.*

3. Webster (J. Clarence): *Text-book of Diseases of Women*, p. 643.

*Read at the Northwestern Medical Society of Philadelphia, March 4, 1907.

clinical records, referring only briefly to the filing of reprints, clippings, etc. Medical accounts should, in my opinion, be kept entirely apart from bedside notes and, therefore, will not be referred to in this connection.

The book system of keeping records has a few, and only a few, undeniable advantages: It is safe, i. e., individual histories can not be lost, and it is convenient for recording eye, ear, nose and throat and other special cases in which printed forms, extending over one or two pages at the most, are commonly used. On the other hand, the book is inconvenient for medical and surgical cases, because several pages with confusing cross references are commonly required, and no arrangement other than the numerical is as a rule practicable. All notes taken at the patient's house, as well as laboratory reports, charts, etc., must either be copied or pasted in. Many other objections might easily be enumerated.

Card systems more nearly approach the ideal and permit convenient arrangement and indefinite extension of the histories. Prescriptions, reports, letters, etc., must still be copied, while charts, sphygmograms and

tals and consultants, is unnecessarily large and expensive (\$70 a thousand) for general use. For my own use I had small ($4\frac{1}{4}$ in. by $6\frac{1}{8}$ in.) manila envelopes made, without flaps or expansions. These are inexpensive (\$7 a thousand) and can be filed away, alphabetically or otherwise, in a standard cabinet or a desk drawer. They will file with or carry the card of the corresponding size (10 cm. by 15 cm.), which I previously used for all cases and still employ for transient office patients. This is one of the few instances in which the coexistence of two systems of measurement may be utilized to advantage, the "metric" card being one-sixteenth of an inch smaller or larger than the standard sizes ($4\frac{1}{4} \times 6\frac{1}{8}$ or 4×6). The face of the envelope is ruled and printed, as indicated in the illustration, for convenience in filing either according to number, name or diagnosis. The ruled spaces are for subsequent diagnosis, with dates, or for recording the prominent features of the case.

As a rule I do not carry these envelopes with me to the patient's house, but write my examination or other information on prescription blanks or tablets of convenient size so that there is never any excuse for failure to record important data. When I reach home my notes, as well as copies of prescriptions, etc., are placed in the appropriate pockets. In this way clinical notes may be kept in an accessible form with the minimum amount of clerical work.

Such envelopes may also be used for systematically preserving minor medical notes and clippings, but for reprints, articles cut from journals and articles in course of preparation nothing is more convenient than ordinary 10 in. by 12 in. letter folders. These may be arranged in a regular cabinet or a set of "transfer boxes" may be used. The latter are labeled and stored like books. A satisfactory classification is the one used by the Index Medicus. An alphabetic arrangement is also said to be convenient. The main headings are written on guide cards or on the transfer boxes, the subheads on the individual folders, which may be multiplied according to need. Abstracts usually are pasted on large sheets to prevent loss, those of similar import being grouped together. By a system of this sort much valuable material may be made immediately accessible without recourse to a library.

No.	Name	Diag.
Date	Address	
Native	Condition	Age
F. H.	Occupation	
No.	Name	Gen. Diag.
101	Mrs. J. W. Patient	
Date	Data for Index	
1906		
2-7	Acute tonsillitis	
6-5	Furunculosis	
12-13	Acute Cystitis	
1907		
2-23	Acute pharyngitis and bronchitis	

other original records can not easily be preserved with the history. It is possible to carry the smaller cards to the patient's house, but they are always more or less in the way and are likely to be forgotten.

The system which I have devised at the suggestion of Dr. Musser is a modification of the ordinary letter folder or vertical file. The envelope I had made for him is of a standard size (10 in. by 12 in.) so that it can be used in stock cabinets with standard index guides. It is made of "paperoid," a tough and durable material, and is furnished with expansile sides so that it will hold a large number of pages without becoming misshapen. It has no flap; the back is high, to display the patient's name, etc.; the front folds down half way to afford easy access to the contents. In this pocket are placed the history cards or sheets, full size temperature charts and laboratory reports, etc. Printed forms for convenience in recording physical signs or laboratory findings can be used with this system at but slight expense.

This pocket, though an ideal filing device for hospi-

THE "OPEN METHOD" TREATMENT OF CANCER.

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CHARLOTTE, N. C.

In improvising this method an effort has been made to utilize three fundamental principles which are recognized as the best that modern medicine affords for the treatment of this class of cases.

First, enucleation of the ulcer or, if it be a case of tumor and involved lymphatic glands, the complete removal of both glands and tumor; second, drainage accomplished by leaving the wound wide open and allowing it to heal by granulation instead of closing the skin over and obtaining union by first intention; third, treatment of the open wound with the Roentgen ray.

The details of this method are carried out as follows: The patient is prepared for operation in the usual manner, with one exception. Instead of scrubbing the site of the operation a soap poultice or plain antiseptic dressing is applied and left until the patient is anesthetized.