well, the flow being scanty and attended with some pain. While engaged in her household duties, she was seized with severe, sudden pain, which doubled her up and compelled her to spend the remainder of the day on a couch. She had a feeling of faintness whenever she raised her head from the pillow. She spent the forenoon of August 11th on her bed, but sat up during the afternoon. Sometime after two o'clock of the morning of August 12th she was seized with very severe agonizing pain in the abdomen, accompanied by the feeling of impending death. Two tablets of morphia (probably one-quarter grain) were given by her husband without any relief, and aid was sought.

When seen at 3.15 A. M. (it was a warm morning) the patient was lying under heavy bed-clothes (two blankets and a thick quilt), but cold. Her body was covered with clammy perspiration, and she complained of exquisite pain. Countenance anxious; face and lips blanched; pupils large; pulse weak, but 55 (a rate wholly inexplicable to me then and now, but verified by auscultation of the cardiac sounds); abdomen tender to slightest palpation, especially to the right and below the umbilicus; thirst prominent; profound collapse.

One-eighth of a grain of morphia subcutaneously at 3.30, and artificial heat. At 4 A. M. she seemed at the point of death. Stimulants were administered; but whether any absorption took place is doubtful, as she vomited at 4.45.

At 5 o'clock Dr. Swan saw the patient in consultation. The symptoms were not so alarming; the pulse-rate was slow, such as to seem to Dr. Swan not to indicate hemorrhage. At 5.45 the patient was easier. Rectal and vaginal examination negative. At 10 o'clock Dr. Swan saw her with me a second time, when the gravity of her condition was more pronounced. Pulse 120, temperature 100.4° in axilla. Abdomen tympanitic, moved with respiration, tender on pressure, with dulness in the right iliac region.

At 12.30 she was seen by Dr. A. T. Cabot, in consultation. Pulse 128, temperature 99° in axilla. Face anxious, respiration sighing, skin bathed with clammy perspiration.

After consultation, a diagnosis was made of probable rupture of an extra-uterine gestation, and an immediate operation advised.

Corrosive pack (1 to 4,000) to abdomen. At 3.30 P. M. preparations were completed for laparotomy. An enema of whiskey, one ounce, and tincture digitalis, one drachm, given, and patient etherized at 3 P. M., when Dr. A. T. Cabot operated, Dr. Balch and Dr. Swan assisting. Pulse 148. A median incision was made through the abdominal walls, the tissues of which contained but little blood. When the peritoneal cavity was opened, dark blood flowed out, containing clots, some of which were quite firm and comparatively old. The posterior cul-de-sac was full of large clots. The fetus was discharged with the liquid blood, but was found and verified.

Upon examination it was found that the hemorrhage came from the right tube at the fimbriated extremity, where placental tissue could be seen; the right ovary was cystic. The tube was clamped, ligated, and the right ovary removed. The peritoneal cavity was freed of blood and clots by sponging, and the edges of the incision united by deep and superficial sutures. At 4 P. M. the patient was in bed with its foot raised and artificial heat applied. Pulse 140.

The patient rallied quickly without any vomiting; but as she complained of considerable pain and was restless, a rectal tube was passed, allowing the escape of considerable flatus, the bladder was catheterized and urine (six ounces) drawn. A subcutaneous injection of one-eighth of a grain of morphia was given at 7 P. M.

Patient had an excellent night's sleep, and her recovery was rapid and uneventful. Urine passed naturally within twelve hours, and the bowels moved fifty hours after operation, from the use of salines. On the third day after the operation there was a bright vaginal discharge and a piece of deciduous membrane on the napkin, which I regret was not carefully examined. On the ninth day the sutures were removed and the wound dressed with crêpe lisse and collodion. On the twentieth day the patient sat up in bed for a short time. In four weeks after the operation menstruation was re-established.

A CASE OF WEB-FINGERS, ASSOCIATED WITH CURIOUS ANOMALIES OF THE PHALANGES, METACARPAL BONES AND FINGER-NAILS; WITH SKIAGRAM.

BY F. B. LUND, M.D.,

Surgeon to Out-Patients, Boston City Hospital.

M. F., a girl of eighteen years, was referred to me at the Out-patient Department of the Boston City Hospital, by Dr. J. Orne Green, for advice with regard to operation for the separation of web-fingers. Operation had been previously considered, and advised against; but it was thought that the x-rays might perhaps give some further information with regard to the advisability of operation than could be secured by the ordinary methods of examination. Although the skiagram, which was kindly taken by Dr. F. H. Williams simply confirmed the previous decision with regard to the advisability of operation, it at the same time revealed such a curious condition of the bones of the hand as to render the case one of considerable interest.

The fingers of the left hand, which was smaller than the right, were completely webbed, down to the tips of the third phalanges, and all the phalanges were of equal length, so that, as is evident from the skiagram here reproduced, the ends of the fingers formed a straight line.

Instead of a separate finger-nail for each phalanx, one continuous nail extended across the whole width of the flipper-like hand, the line of demarcation between the fingers being marked merely by a slight but distinct groove. The phalanges were so crowded together that the hand was narrow and tapering. Flexion and extension of the phalanges was normal, as were all movements of the thumb. The hand was therefore of a good deal of service to its owner, and might be very well compared to a hand on which a mitten was worn. It was about two-thirds the size of the right hand, which was normal in every respect.

The skiagram shows the following curious condition: The second phalanx of the forefinger is rudimentary and is dislocated backward. The terminal phalanx of the forefinger is bifid, and the inner portion is ankylosed to the terminal phalanx of the middle finger. The metacarpal and first phalanx of the

forefinger are much longer and stronger than those of the other fingers, and there is a wide space between the first and second metacarpo-phalangeal joints. The middle finger shows a rudimentary metacarpal bone, about half the length of the others, and the normal number and relation of the phalanges. In the ring finger the second phalanx is absent, and in the little finger it is rudimentary. The phalanges and metacarpal bones of the three inner fingers are crowded so closely together that the bones touch each other at the joints.

Although since the use of the x-rays in diagnosis large numbers of anomalies of the phalanges have been brought to light, the bones of the hand here de-

picted are as "irregularly irregular" as any that I have seen published.

The skiagram showed conclusively that all that could possibly be done in the way of operation, would be perhaps to free the fore from the middle finger, and it was thought that even if this were accomplished, it might be impossible at her age to secure independent action of the muscles of that finger. There is little doubt that a dissection of the hand and forearm would show muscular anomalies, for example, absent or rudimentary interossei, etc.

In this case there was no family history of similar deformity, such as was present in the case shown in the JOURNAL of February 20, 1896, and in two of the cases quoted by Dr. Thomas Dwight in the editorial article on "Anomalies of the Phalanges" in the same number.

Medical Progress.

REPORT ON ORTHOPEDIC SURGERY.

BY E. H. BRADFORD, M.D. AND E. G. BRACKETT, M.D., BOSTON.

CURVATURE OF THE AORTA IN POTT'S DISEASE.

BOUCHACOURT,¹ in a bulletin of the Anatomical Society of Paris, has described the deviation of the aorta in dorsal lumbar Pott's disease, in the patient of Kirmisson, fourteen years of age. The same deformity has been described by Professor Dwight in the *American Journal of the Medical Sciences*, January, 1897. It consists of a curvature of the aorta independent of the curve of the spine. The spinal column was much shortened. The aorta was of the normal length, and not finding room along the column, was forced to wind itself irregularly from side to side.

PRIMARY ACUTE OSTEOMYELITIS OF THE SPINE.

Hahn² has collected a number of cases of osteomyelitis of the spinal column. The diagnosis is not easily made, and the prognosis is doubtful. Treatment consists of an early and thorough opening of the abscess and the prevention of the deformity by the treatment usual to tubercular disease.

G. H. Makins and F. C. Abbot have contributed an excellent article on this subject to the *Annals of Surgery*, May, 1896, with an analysis of 21 cases. In 11 cases the spinal cord was involved.

Müller³ describes a case of osteomyelitis of the spinal column, to which he adds the history of seven other cases. His patient was twelve years old; was seized with fever, headache, pain in the back, and a motor and sensory paralysis, with paralysis of the bladder, which he considered to be a case of Landry's paralysis, but which soon developed an abscess in the thoracic region, which was opened and showed a sequestrum in the thoracic vertebra, as well as a collection of pus in the spinal canal. This was followed by edema of the lungs and death. An osteomyelitis of two lumbar, three dorsal and a cervical vertebra was discovered.

The diagnosis between this and a tubercular process is based, according to Müller, on a very acute curve and the early appearance of paralysis.

ANCHYLOSIS OF THE ATLAS.

Gelsam⁴ reports three cases of ankylosis of the atlas. He has only been able to collect three of these cases, although Lombroso and Paoli claim a greater frequency. They present no clear symptoms during life. In one case the ankylosis was reported as a result of rheumatic inflammation; in the other two it seemed to be a defect of development. Gelsam considered in one instance the result to be due to an inflammation following a blow. Hann reports a case of acute osteomyelitis of the vertebra similar to that of Müller.

COSTO-TRANSVERSECTOMIE.

Menard⁵ reports the results of operation on cases of paralysis from tubercular spinal abscess by an opening through the posterior part of the trunk. The opening was made by the resection of a transverse process of the infected vertebræ and the adjacent rib. The

¹ Zeitschrift f. orthopädische Chirurgie, 1896, p. 423.

² Beiträge klinischer Chirurgie, Bd. xiv and Heft 1.

³ Deutsche Zeitschrift f. Chirurgie, Bd. xli.

⁴ Zeitschrift f. orthopädische Chirurgie, 1896, p. 433.

⁵ Revue d'Orthopédie, 1896, No. 2.