this temperature was maintained, and promptly ceased if it was much exceeded. It, therefore, seems possible that failure to attend to these requirements may have accounted for the apparent lack of motility reported in these and similar cases and that both varieties will be found uniformly motile. Accurate laboratory investigation of the finer anatomy and characteristics of both ova and miricidia will do much to clear the matter up, especially if an intermediate host or means of cultivation outside the body be found.

The history of a five-year interval between the patients' residence in a probable center of infection and the appearance of symptoms is at least unusual. No record of so long an incubation period has been found elsewhere and it seems fair to assume that the condition might have been noted much earlier had his powers of observation been keener. It is at any rate interesting as showing how slight an amount of discomfort the disease may cause.

The absence of eosinophilia deserves further comment. Daniels⁷ states that "Eosinophilia may occur." On the other hand, Douglas and Hardy, quoted by O'Neil,⁸ found it present in 49 out of 50 cases studied "ranging from 1.3% to 40% and averaging 16.48%." The number of cases in which it lay under 5%, which may be considered the upper normal limit, and the presence or absence of other parasitic infections in the same individuals are not stated. Such complicating infections are notoriously common, and since in the present case no evidence of other parasites could be detected, it seems possible that Bilharziosis, if uncomplicated, may be found to show no eosinophilic increase.

The practical lesson to be learned from this case is the great importance of a microscopical examination in all cases of recurring diarrhoea or bloody stools occurring in patients who have been in the East or in the tropics, since not uncommonly the diagnosis may be established in this way where the true condition would otherwise remain quite unsuspected.

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 - ⁶ Gunn: *Ibid.*, 1906, xlv, 1031.
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- NOTE. — Micro photographs taken by Mr. Brown, of the Pathological Laboratory of the Massachusetts General Hospital.

CLINICAL NOTE ON POTT'S DISEASE.

BY GEORGE COLTON MOORE, M.D., BOSTON.

THE value, in tuberculosis of the spine, of unchanging fixation and the durability and effectiveness of a well-cared-for plaster of Paris jacket are so well illustrated by the following case, which I have had the opportunity of treating, that it seems worth reporting.

D. M., four years old, came to the Boston Children's Hospital, Out-Patient Department, Jan. 1, 1908, with incipient tuberculosis of the spine in the mid-dorsal

region. The diagnosis was established by the physical examination and by the x-ray. The child was put in a plaster of Paris jacket while lying on her face on a canvas hammock. This jacket was worn until Nov. 17, 1908, when it was removed because she had outgrown it. A new one was put on by the hammock method in two sections (1, with the hammock as taut as possible the plaster is put on up to the height of the knuckle [which in this case was very slight]; 2, then the jacket is finished with the hammock loosened so that it will sag and the child's back be hyperextended).

The child reported for observation from time to time but, although she was growing out of the top of the jacket, there were no unfavorable objective or subjective symptoms and, since it was keeping her back in good position, it was not removed until Jan. 31, 1911. It was then so small that she could not have worn it much longer with comfort, though it was still firm and would probably have been an efficient support for some weeks longer.

The note made at the time is as follows:

"Very small kyphos in mid-dorsal region, a few reddened areas from pressure. Lumbar spine shows nearly normal hyperextension. Very little motion in dorsal segment except upper 2-3 and lower 2-3 vertebrae. No muscular spasm. No psoas contraction. No extra fullness of iliac fossae. Knee-jerks lively but child's extreme nervousness may account for this."

In this case the child had, in over three years, only two jackets and obtained a result unusually good, the favorable result being, it seems to me, largely due to the fact that fixation was begun early in the disease and effectively continued with the minimum of manipulation.

The case shows, further, that ordinary plaster of Paris may be made into a comfortable "cast" that will be efficient as long as any one could wish to use it.

For permission to report this case I am indebted to Dr. E. H. Bradford, Orthopedic Surgeon to the Children's Hospital.

Medical Progress.

PROGRESS IN SURGERY.

BY E. A. CODMAN, M.D., BOSTON.

DUODENAL ULCER.

THERE is no question that the writings of Moynihan and the Mayos have aroused an intense interest as to the diagnosis and the value of operative treatment in duodenal ulcer. Even the busy general practitioner has begun to realize that many of these cases are under his care and that he must do his best to inform himself as to whether it is his duty to advise surgical consultation in his cases of "chronic dyspepsia" and "acid stomach." Moynihan¹ says that severe, recurrent hyperchlorhydria is duodenal ulcer and should always be treated by operation. He insists that recurrence after medical "cure" is the rule, and after gastro-enterostomy the exception. The medical journals are teeming with superficial articles dealing with this subject, and though they are as a rule by title on