passed some bloody urine; for three days pain persisted and on Jan. 29 began in the left kidney, becoming extremely severe and requiring morphine. He remained in bed, with irregular fever, much pus in the urine, and a varying amount of pain, until seen in consultation on Feb. 3.

Physical Examination.—A tall, slim man, pallid, features drawn, tongue thickly coated. Pulse regular, fair strength, 100, temperature 100.2. Heart, lungs and extremities negative. Abdomen: slight, general distention and muscular spasm; tenderness and spasm most marked in left loin, where a sense of deep resistance and almost of fluctuation was felt. No edema. Urine: pale, alkaline, 1010, very much thick ropy ill-smelling pus. Albumin $\frac{1}{2}\%$ +. Sediment, pus, bladder cells and granular detritus; no tubercle bacilli found. Inoculation of guinea pigs negative. He had been having Pot. acetat, sodium bicarb. urotropin in small doses, together with bladder irrigations. The diet was exclusively liquid, and he drank large quantities of water.

He did not improve and was seen again in consultation with Drs. F. S. Watson and McIntyre. Operation recommended on left kidney for drainage; performed on Feb. 28, Dr. Watson assisting. The lumbar incision revealed a very large kidney, thin walled and containing an enormous amount of pus. No calculi were discovered nor could the ureteral opening be found. The wound was drained through the flank by a large rubber tube.

Immediately after this operation, the right kidney reacted and the temperature rose. There was tenderness and muscular spasm in the right hypochondrium and an increase of pus in the urine. These signs gradually disappeared, and during the late spring and early summer, the patient was able to be out of doors and take short drives. Drainage of the kidney was continued, the rubber tube emptying by catheter into a hard rubber flask supported by a belt worn around the patient's waist. This method was suggested by Dr. F. S. Watson and had been used on a patient of his, who has worn it without discomfort for four years, following his regular routine of active work.

Early in July, 1903, Mr. C. complained for the first time of some localized pain and tenderness two or three inches to the left and just below the umbilicus. No tumor was discovered; the pain caused an increased desire to flex the left leg, a position often voluntarily assumed by the patient at various times during several years past. This local tenderness slowly disappeared, but returned again, and after Thanksgiving, became so severe as to compel consideration of a third operation. He was moved to the Boston City Hospital on Dec. 7, and an x-ray plate was taken. This showed a shadow fully as large as an olive, at the site of the pain and tenderness, where a tumor could now be felt. It was decided that operation in his enfeebled condition would be accompanied by so much danger that it would be justifiable only when his pain and distress became unendurable, particularly as a complete cure seemed out of the question. He returned to his home on Dec. 11; the pain increased, as did the tumor and tenderness. Dr. Paul Thorndike saw him in consultation Dec. 21 and operation for the relief of suffering was advised, and performed Dec. 24, Dr. Thorndike assisting. By this time deep fluctuation had developed near the left anterior superior iliac spine; the incision was made over this point parallel to the upper part of Poupart's ligament, the object being a retroperitoneal removal of the calculus, and drainage of the accompanying pus. Tissues were matted together by the long standing inflammation, and landmarks were obliterated. It was difficult to avoid opening the

peritoneum. The pus was easily evacuated, but the calculus, situated at the pelvic brim, and close to the left common iliac and vein, was reached only after persistent efforts and where it seemed as if the operation would have to be ended. The large stone appeared to have partially sloughed through the posterior ureteral wall and was in part imbedded in the psoas muscle. It was finally removed and the wound drained both with gauze and a rubber tube. It was not possible either to reach the kidney through the ureteral opening, nor the site of the calculus through the old nephrotomy wound. The patient stood the operation fairly well. He lived two weeks, without peritoneal complication, and with a diminution of the pain and muscular spasm which the calculus had caused. He died of persistent vomiting, being entirely conscious to the end. No autopsy was allowed, so that the existence of calculi in the pelvis of the right kidney remains unproven. A sound passed into the bladder did not detect a vesical calculus.

The large ureteral calculus probably developed rapidly from a small one originally formed in the pelvis of the kidney. Large as it was, it may not have completely stopped the passage of urine to the bladder, else we should have expected an atrophy of the kidney. This may have been averted by the drainage through the loin. The lack of an autopsy is much to be regretted as it leaves unsettled many important questions. There is little doubt that a series of small calculi passed at various times from this man's kidneys to his bladder; one of these lodged at the brim of the pelvis, enlarged rapidly and caused pain and spasm of the psoas muscle. The condition of the right kidney contra-indicated any operation except one of necessity. The case illustrates the necessity of early interference, and the comparative hopelessness of late operations. It is one of a comparatively small class in which a calculus in the ureter could be located by palpation.

COMA FOLLOWING LABOR.*

BY C. V. FRIEDMAN, M.D., BOSTON.

THE case, here described, was seen in the outpatient clinic of the Boston Lying-In Hospital. For amplifications of my notes and the hospital records, I am indebted to Dr. R. L. DeNormandie who, as house physician, had charge of the patient.

Mrs. E. H., age twenty-four; ii para. First delivery in October, 1901; low forceps; normal convalescence. I saw the patient on Nov. 20, 1903. The cervix was not taken up, there were irregular uterine contractions, temperature and pulse were normal, but patient looked anemic and flabby. Pelvis generally contracted, intercrural 25 cm.; interspinal 22 cm.; external conjugate 17 cm. Head high O. D. P. The contractions continued without progressive dilatation and she was given 30 gr. of chloral in two doses on Nov. 20 and again on Nov. 21; this secured some sleep each night.

Active labor began at 2 P.M. Nov. 22 and the patient delivered herself at 2.15 A.M. Nov. 23. Two hours later the externe left her in good condition. Temperature 100.8, pulse 90. Patient had a normal tempera-

* Read at the meeting of the Obstetrical Society of Boston, April 26, 1904.

ture and pulse in the morning and evening, took nourishment well, voided urine easily and was comfortable. At about 2 A.M. Nov. 24 she had a chill followed by a period of excitability (possibly a convulsion). She then became semi-comatose, and the condition noted when I saw her later in the day was as follows:

Patient unconscious but can be aroused with difficulty, to muscular action and inarticulate utterance. Occasional spasmodic movements of eyebrows. The hands are clasped over the occiput. When moved, patient resists, using both arms and both legs equally. The face is blanched, face and body wet with profuse perspiration. No edema. Respirations regular, stertorous, 28; pulse regular, normal in volume and tension, 80; temperature 102.8° F. Eyes closed, pupils equal, moderately constricted, react to light. No strabismus. Moderate lachrymation. Marked photophobia. Heart, lungs and abdomen negative. Uterus apparently well contracted, fundus just below umbilicus, no tenderness. Lochia normal. Knee jerks slightly increased but equal; no ankle clonus; no Babinski.

By catheter, two and a half pints of clear urine, acid, high, 1020, no sugar, no albumin, urea 1.39%.

By Saline catharsis, ice bag to head, forced liquids. There was slow but steady improvement. At midnight patient recognized her husband and, after vigorous arousing and interrogation, complained of pain in the occipital region. Forty hours after the attack began patient was lucid when aroused but soon relapsed into a semi-comatose condition. At the end of sixty hours she approached a normal mental condition but still complained of headache and of general soreness of the limbs.

Temperature and pulse reached normal on the third day and remained normal. The urine continued normal in amount and character except for the "slightest possible trace" of albumin which appeared first about fifty hours after the attack. At about the same time marked labial herpes appeared. Careful daily examinations revealed no further physical signs. The patient was discharged well at the end of a fortnight.

When I saw the patient during the coma I was not able to make a satisfactory diagnosis. As there was no previous history of epilepsy or hysteria I considered in order of probability, chloral poisoning, cerebral injury, eclamptic coma, diabetic coma and a severe, atypical intercurrent, febrile affection.

In spite of the possibility of delayed absorption and elimination due to the puerperal state, chloral narcosis was ruled out as the patient had in all but 60 gr. of chloral in divided doses at long intervals; the symptoms did not supervene until fifty-eight hours after the last dose; nausea and vomiting were absent. The reflexes were present and the pulse was slow and full. There were no signs of meningitis or cerebral injury except the coma. The absence of sugar threw out diabetes.

Having seen at the time several cases of influenza, all severe and variously atypical, it occurred to me as a possible diagnosis, but although I could not exclude it I did not feel inclined to accept it.

Having seen several cases of eclampsia in which the urine was normal in amount and character, cases where there was but a single convulsion followed sometimes by death, more frequently by recovery; cases where there were

no symptoms for one or two days after delivery, I felt inclined to consider this a case of pure eclampsia. That is, a case of eclampsia not exhibiting any of the various symptoms which are classed generally as eclamptic although they ought to be considered, perhaps, as the symptoms of distinctly secondary affections which are sequels of the eclamptic toxemia.

Reports of Societies.

THE AMERICAN THERAPEUTIC SOCIETY.

FIFTH ANNUAL MEETING, HELD AT THE ACADEMY OF MEDICINE, NEW YORK, JUNE 2, 3 AND 4, 1904.

FIRST DAY, JUNE 2.

The address of welcome was made by Dr. R. W. Wilcox, chairman of the Committee of Arrangements, and responded to by Dr. D. O. Leech of Washington, D. C. Thirteen new members were elected, and Drs. Georges Nayem of Paris and Heinrich Schoeler of Berlin were elected honorary members. An obituary was read of the late Dr. Robert N. Graham of Washington by Dr. Robert Reyburn, and appropriate resolutions were adopted by the Society. The president's address was delivered by Dr. Howard N. Barker of Washington, D. C. In it he dwelt upon the growing evils of patent and proprietary medicines and the various forms of quackery so prevalent, and upon the urgent duty of the medical profession to unite in systematic efforts for their curtailment. He also devoted considerable attention to recent advances in organotherapy and in the diagnosis, prophylaxis and treatment of tuberculosis.

SYMPOSIUM: RECENT ADVANCES IN ANESTHESIA.

The introductory to this was read by Dr. R. W. WILCOX of New York. A paper on

RECENT EXPERIMENTAL WORK

contributed by Dr. TOROLD SOLLMANN of Cleveland, was read by Dr. P. BRYNBERG PORTER.

GENERAL ANESTHESIA

was assigned to M. F. THOMPSON of Washington. Ether, he said, still holds highest rank as a general anesthetic. For short operations in children, chloroform is in favor. For prolonged operations in children, it is safer to substitute ether for chloroform as soon as loss of sensation occurs. For minor operations, nitrous oxide gas as administered to-day is an ideal anesthetic. The compactness of the gas as now furnished makes its use much more convenient than formerly. The gas-ether sequence is an excellent method in experienced hands, and appears likely to grow in favor. In 1902 McCardie reported on the satisfactory use of ethyl chloride in over 600 cases. He asserts that this agent possesses all the requisites of a perfect anesthetic, and that it is the safest of all anesthetics except nitrous oxide gas. Seitz records 16,000 cases with only one death, and that in a very unfavorable subject; and Soulier, 8,000 cases, with no death. Von Necken uses ethyl chloride whenever it does not seem safe to employ ether or chloroform, as in high degrees of circulatory interruption, fatty degeneration of the heart, disease of the respiratory organs, nervous shock, and enfeeblement from great loss of blood.