

acid three times daily. Slight edema of scrotum. Micturition entirely by perineal wound.

Nov. 3. Wound shows little tendency to heal, but looks bright and clean. Attempt to wash bladder via penis or perineal wound very painful. Micturition free through perineum.

Nov. 6. Complains of "stitch" in left side on deep inspiration. Examination shows only slight friction rub in left base in axillary line (cancerous pleurisy?). Pain entirely relieved by tight swathe.

Nov. 8. Pain in chest has disappeared. General condition about the same. Locally no induration about wound but finger introduced into it comes in contact posteriorly with a rough, indurated mass. Urination entirely by perineal route, and under perfect control. Sounds up to No. 24 French passed easily and without pain or bleeding through entire course of urethra to bladder. Bladder washed as before. Slight cystitis.

Nov. 12. Patient was discharged relieved.

Pathological report by Dr. William F. Whitney: "Fragments curetted from the urethra showing, on microscopic examination, solid masses of large, flat, epithelial cells, with occasional whorls infiltrating the deeper tissues.

"Epithelioma."

A letter from the town clerk of Marshfield, Mass., where the patient lived, states that he died on March 30, 1905 (eight months from time of entrance), of cancer.³

CASE II. Entered July 26, 1889, in the service of Dr. Arthur T. Cabot. Age fifty-eight years, single. Occupation, farmer; born in England; family history not recorded.

P. H. Gonorrhea fifteen years previously. Acute retention seven years later, relieved by catheterization by his physician. Since then has had more or less difficulty of micturition, with dribbling.

P. I. About one week before entrance noticed a tender bunch in the perineum.

Physical examination. Enters with an abscess in the perineum, size of a hen's egg, tender, red and painful. Patient thinks the abscess ruptured while on his way to the hospital. Pus and urine escape from the opening. No record of any rectal examination.

July 27. Operation by Dr. Cabot. Olive-tipped bougie shows tight stricture four inches from the meatus, just in front of the abscess. An incision through the abscess opens several pockets containing pus and cheesy material. A long urethral stricture was laid open, but the bladder could not be entered, owing to swelling of the tissues from edema and urinary extravasation.

Aug. 1. Good convalescence. Passing water freely through wound.

Aug. 6. Operation by Dr. Cabot. Director passed easily into bladder through wound, of which the swelling had now subsided. Some indurated, grayish granulations growing along urethra, and in perineal wound removed with scissors. Perineal stricture cut, and catheter tied in bladder.

Aug. 10. Bladder washed with boracic acid solution. Considerable urine still comes through perineal opening:

Aug. 14. Very little leakage.

Aug. 27. Catheter removed. Urine still comes freely through perineum, but also to some extent through the penis.

Aug. 28. Patient discharged against advice.

Pathological report by Dr. William F. Whitney, on specimen removed at operation:

³I was fortunate enough to have charge of this case as a house officer. After it was found that cancer was present, I made a thorough physical examination, with metastases in view, but none were to be found.

"Mass which had grown from the urethra into a wound made for perineal section.

"Composed of masses of epithelial cells, many imbricated, and some showing fatty degeneration, separated by firm bands of connective tissue.

"Epithelioma."

Diligent search of state and town records and correspondence with local authorities, has failed to elicit any further information about this man. I have learned only that he is dead, but the time and cause of death are not known.

If these two somewhat incomplete cases, and the foregoing remarks serve in any way to put the general surgeon on his guard, this paper will have served its end.

A CASE OF ACQUIRED DEXTROCARDIA ASSOCIATED WITH ADVANCED PHTHISIS.

BY J. HERBERT YOUNG, M.D., BOSTON.

CASE 412. M. C., female. Age, nine years. Admitted to the House of the Good Samaritan Dec. 4, 1906.

Mother stated that the patient had coughed practically since birth, with expectoration for the past two years. There had never been any hemoptysis. Patient's father died of pulmonary tuberculosis, Dec. 28, 1906, after an illness of two years.

Physical examination of the chest was as follows:

Heart.—The greatest cardiac impulse was felt in the fifth space in the left mammary line 7 cm. to the left of the median line, and by percussion the left border corresponded. The right border could not be determined. No visible pulsation was noted. Heart sounds regular, of good quality, no murmurs.

Lungs.—The right side moved less. There was dullness throughout the right front, and behind from the apex to mid-scapula, and at the extreme base. Bronchial breathing at the right apex behind and in the second space right to the anterior axillary line, broncho-vesicular breathing elsewhere throughout the right lung. Scattered dry râles were heard throughout the right front and fine moist râles throughout the right back. There was no dullness on the left, but a few medium moist râles were heard at the apex behind.

Tubercle bacilli were present in the sputum.

Feb. 25, 1907. *Heart.*—Visible pulsation in the second, third and fourth spaces at the right border of the sternum. The greatest cardiac impulse was felt in the fourth space, 2.5 cm. within the left mammary line, 4.5 cm. to the left of the median line, where the left border was found by percussion. The right border was 5.5 cm. to the right of the median and 1.5 cm. within the right mammary line. The upper border was at the third rib. The sounds were regular and there were no murmurs.

Lungs.—The examination of the lungs was the same, except there was bronchial breathing over the upper half of the right lung in front.

April 22, 1907. *Heart.*—Pulsation was seen in the first, second and third spaces in the right parasternal line. The cardiac impulse was best felt and the sounds heard loudest in the third space right, 1 cm. inside the mammary line, 6 cm. to the right of the median line. The borders could not be determined by percussion. There was pulmonary resonance over the normal area of cardiac dullness. The sounds were regular and there were no murmurs.

Lungs.—There was dullness throughout the right front and back with amphoric breathing and voice sounds above the right clavicle and in the outer half of the first, second and third spaces right; bronchial

to amphoric breathing at the right apex behind to the lower angle of the scapula, with increased voice sounds. A few dry râles were heard at the right base. Dulness at the left apex behind, with a few dry râles.

June 7, 1907. Heart. — Visible and palpable pulsation in the second and third spaces between the sternum and the right mammary line. The cardiac impulse was best felt in the third space in the right mammary line, 7 cm. to the right of the median line. The left border was beneath the sternum and could not be accurately determined. The upper border was at the second rib and the right border in the right mammary line. The sounds were regular and there were no murmurs.

Lungs. — Dulness throughout the right front, except slight resonance, not tympanitic, from the apex to the third rib external to the right mammary line, over which area there was amphoric breathing, voice sounds, and cracked pot percussion note. In the back there was dulness below the lower angle of the right scapula, fair resonance above, with bronchial to amphoric breathing. Fine moist râles were heard throughout the lower half of the right lung. There was no further involvement of the left lung.

This case is unique in that during the transposition of the heart from left to right it was continually under observation. The displacement was gradual and, as it became more marked, signs of cavity were elicited at the right apex. There were no subjective symptoms referable to the heart, and, except for rare intervals when the patient was confined to her bed for a day or two, with slight gastric disturbance, she was dressed and about the ward all the time without any discomfort. Nor was there any clinical evidence that the heart was not performing its function perfectly in its abnormal position. X-ray examinations were made, but owing to the involvement of the right lung, the right border could not be accurately determined, although the absence of the normal cardiac shadow to the left of the sternum is clearly shown in the accompanying print.

About twenty-five cases of acquired dextrocardia associated with chronic pulmonary tuberculosis, without the presence of fluid or air in the pleural cavities, have been reported, but in all the cases, with the exception of four, the displacement was complete when the case first came under observation. A. K. Stone¹ mentions two cases from the literature which were seen before and after the displacement, in one of them there was a cavity in the right lung. Dunham² reported two cases which were also seen both before and after the displacement, and in which the diagnosis was verified by x-ray. One of these cases later showed signs of cavity at the apex of the right lung. In all the cases the right lung was the site of chronic phthisis, with the left but little if any involved.

In the article already referred to, Stone mentions the presence of cavities as a cause of cardiac displacement, and cites cases, while in the other cases reported the displacement has been ascribed to the sclerosis of the right lung, together

with compensatory emphysema of the left, that is, the heart is pushed as well as pulled over, and although in some of these cases cavities were described, their importance as an etiological factor was not considered. In the present case the cavity in the right lung, the loss of substance thereby producing a void into which the heart was aspirated, was considered the cause of the displacement. The rôle played by cavities was further emphasized by cardiac displacements of a less degree in three other cases. In two cases with a cavity at the left apex, the heart was pulled upward and outward. The third case showed, for over a period of many months, involvement of the entire left lung, but without signs of cavity, with the heart in normal position. In making a routine examination pulsation was felt in the fifth space 6 cm. outside the mammary line, 14 cm. to the left of the median line, where also the left border was found by percussion. From previous experience a cavity was suspected and was found just within the lower angle of the left scapula.

Stone's article has an extensive bibliography on the subject of cardiac displacements. Since its publication, a few single cases have been reported, but with the exception of Dunham's two cases, and one case reported by Lowenburg,³ they have not been reported in sufficient detail to be of any value.

I am indebted to the visiting physicians of the House of the Good Samaritan for permission to report this case, and to Dr. A. W. George, the Röntgenologist, for x-ray examinations.

Reports of Societies.

NEW ENGLAND OTOLOGICAL AND LARYNGOLOGICAL SOCIETY.

MEETING HELD AT THE MASSACHUSETTS GENERAL HOSPITAL, MARCH 15, 1907.

The President, Dr. A. COOLIDGE, JR., in the chair. Dr. A. P. ROGERS read a paper on

THE CORRECTION OF MALOCCLUSION AND ITS RELATION TO RHINOLOGY.¹

DISCUSSION.

DR. THOMAS FILLEBROWN: I am happy to have the privilege of opening the discussion upon so interesting a paper, and I shall be glad to say a word to emphasize its good points if I can. What the essayist has said about the widening of the floor of the nasal cavity, I think to be true. One point I think needs a little more emphasizing.

The common idea in regard to regulating the teeth is that the crowns are simply turned outward, but that the ends of the roots are not moved. I think you will find that stated in a great deal of the dental literature as well as in the general medical literature. I think this is not true. The leverage as it is applied will not confine itself simply to the turning out of the teeth, but it will and it does, as has been proved by these cases that the essayist showed this evening, and by a great many others, actually widen the arch. The bones move apart and new bone is formed, not only in this

¹ BOSTON MED. AND SURG. JOUR., vol. cl, no. 2, pp. 29-37, Jan. 14, 1904.

² *Ibid.*: Vol. cliv, p. 155, Feb. 8, 1906.

³ Am. Med., 1904, vol. viii, p. 403.

¹ See page 784.