(*ichthiosis hystrix*) were cases of this disease. When I returned from Paris the first patient I saw on entering the clinic was this patient, and she presented the same affection. By one who had seen the disease it was immediately recognized by this peculiar appearance of the face. The disease has not advanced very greatly since that time. The whole forehead is occupied by a mass of horny papular growths. Behind her ear the process is much more fully developed. On other parts in the pubic region this process is still more highly developed. There is a little on the wrists. It extends down on the chest in front and in the rear about the same distance. There is a little scattered eruption on the arms and legs. The very peculiar bodies which are found in every one of these papules, large round cells, are not, it has now come to be believed, animal parasites, but are peculiarly modified epithelial cells. It is not a coccydial disease, and even Darier has given up that opinion. Although the French name remains, *keratosis follicularis* is the proper name, because it is a descriptive title and not misleading. We have a case here which is of medium grade, and my first case was this young woman's father. That does not indicate that it is a contagious disease, because this girl was less than a year old when separated from her father and never saw him afterwards, nor does it show necessarily a hereditary tendency to the affection, because it is only in one or two other instances that it has affected more than one member of a family.

POINTS IN OPERATIVE TECHNIQUE.

DR. A. T. CABOT spoke of three cases showing points in operative technique and illustrated them by diagram. The first case was one of intra-ligamentous cyst. This cyst, growing in the broad ligament, pressed down behind the uterus so as to fill the whole pelvic cavity and then projected upward into the abdomen. On coming down upon it from above, the peritoneum was split and the cyst shelled out readily over its upper part from the enveloping broad ligament. When, however, the edge of the pelvis was reached, the cyst became very adherent and the walls were extremely thin, tearing readily. As the separation of this part of the cyst was evidently going to be very difficult and accompanied by hemorrhage difficult to stop, it was decided to leave it *in situ*. The edges of the cyst were then stitched to the torn edge of the peritoneum around the edge of the pelvis, so that the cul-de-sac in the pelvis behind the uterus was lined with cyst membrane in the place of peritoneum. The appearance was the same as that of normal peritoneum and, in fact, the cells lining such a cyst are similar to those of the peritoneum, so that there seemed to be no reason why it should not act serviceably in place of the peritoneum which it had displaced. The patient made an uninterrupted recovery without fever, and left the hospital well a fortnight later.

The next case was one in which, after removing a pyosalpinx on one side, the Fallopian tube and ovary on the other side were found fixed behind the uterus close to the cervix by light adhesions. After these adhesions were separated, it was found that the Fallopian tube was pervious and the fimbriated extremity apparently uninjured. It was, however, impossible to prevent the ovary and tube from falling back into the former uncomfortable position behind the uterus whenever they were let alone. To prevent this tendency

for them to fall back into the pelvis the broad ligament close to the Fallopian tube was attached to the peritoneum at the brim of the pelvis by a single catgut stitch. This was quite sufficient to hold them in this new position and it seemed probable that the light adhesions that would form would hold them there long enough to allow the other organs in the pelvic cavity to assume their normal relations and fill the place in which the ovary had lain so that it could not afterwards fall in there.

The last patient was a man with a long sinus running up beside the rectum and rather behind it. This had been operated upon as a fistula, and in so doing the anal sphincter had been completely divided so that the patient had absolute incontinence of feces and was incapacitated for work. It was decided to try and separate the sinus from the rectum in such a way that the rectal sphincter could be restored. For this purpose the incision usual in the Kraske operation for the removal of the rectum was made on the right side, as the sinus lay to that side of the rectum. After dividing the bone the lower part of the long sinus was made easily accessible. An opening was found about an inch and a half or two inches up into the rectum and the bridge of tissue that was left was divided, thus throwing all of the lower part of the sinus and the rectum together. Careful dissection was then made of all the tissue involved in the sinus lying on the rectal wall until all of the parts in immediate contact with the rectum and with its sphincter had been thoroughly refreshed. This defect in the posterior rectal wall was then closed by a series of layers of buried stitches, making a very satisfactory perineum, as it were, and the sinus was brought out at the upper extremity of the Kraske incision. Careful search with a probe failed to detect the cause of this sinus, although it seems probable that it depended upon a disease of the bone somewhere near the sacro-iliac joint.

The result of this operation was the complete restoration of the sphincter and entire recovery of the continence of the bowels. The sinus is very much shortened and a good drainage provided for it.

EXOPHTHALMIC GOITRE.

DR. JAMES J. PUTNAM demonstrated eight cases of exophthalmic goitre, to show the variability of this affection in type, and to illustrate certain points in treatment. A further report will be made upon these cases at another time.

The question is much discussed at the present day, whether the symptoms of this affection are due to a toxic substance secreted by the diseased thyroid gland, or present in the circulation because the thyroid gland is diseased, or whether they are due to a disorder of the nervous system; or, finally, whether we should divide the cases, as Buschan suggests, into those of true Graves's disease, which Buschan considers to be of nervous origin, and false or secondary Graves's disease, which he considers to be due indirectly to various causes acting through the nervous system. Enlargement of the thyroid would then count as one of these latter causes.

In the opinion of the speaker, the difficulties in the way of making a classification of this sort are at present unsurmountable. It is impossible to state what constitutes true Graves's disease in terms sufficiently definite to command acceptance. Different types of

the disease obviously exist, but they shade into each other, and are not separated by sharp lines.

As regards the toxic (thyroid) theory we are not able to prove or to disprove it absolutely, but the great probability is that it is not true in the sense that the thyroid disease is the only essential factor in producing this malady. It is probable that certain peculiarities or "predisposition" on the part of the nervous system must be present, or is present in the majority of cases.

This factor of predisposition is studied to advantage by a careful comparison of the conditions obtaining in Graves's disease with those obtaining in health, or in strong emotion, which is a state of quasi-health. If this be done various points of resemblance are found, such as justify the designation of Graves's disease *from this point of view* as a "neurosis of emotion."

There is no doubt that the administration of thyroid preparations excites a condition more or less closely resembling Graves's disease, and the possibility supports itself that even in health the thyroid secretion may play a part as a nerve stimulant.

On the other hand, cases of unquestionable benefit from the use of thyroid preparations in Graves's disease are occasionally seen. It is difficult to predict beforehand which cases will be the ones to respond in this way. Perhaps, as a rule, those presenting the most marked symptoms of general nervous irritability are the most susceptible, but this cannot be asserted as an invariable rule.

Dr. Putnam's cases were used so far as possible to illustrate these statements, especially those with regard to the effect of thyroid preparations. It was also shown that many patients had been benefited considerably, especially as regards their nervous symptoms, from other kinds of treatment in the out-patient department of the hospital. A part of this improvement seemed attributable to long-continued faradism; another part, of undeterminable amount, to the moral encouragement of the treatment used, irrespective of its direct effect.

THREE CASES OF CONGENITAL HEART DISEASE.

DR. CHARLES W. TOWNSEND: These three cases shown here all have the characteristic cyanosis of congenital disturbance of the heart, due either to a malformation or to fetal endocarditis. The cyanosis is variously explained as due to insufficient oxydation of the blood, to the admixture of venous and arterial blood, or to passive congestion of the cutaneous vessels. It is possible that all these factors may exist in one case.

CASE I. Nellie M., ten and one-half years old. Family history negative. At birth, her finger-nails and lips were noticed to be blue. At the time of weaning, when fourteen months old, she became more blue, and the cyanosis has increased with age. The patient has had whooping-cough, measles and scarlet fever; has not had rheumatism. She suffers from dyspnea and palpitation on slight exertion, and occasionally from pain about the heart.

The patient is fairly developed and well nourished. Her face is dusky, the lips and finger-nails being markedly blue; the fingers are clubbed. There is no edema. An examination of the heart shows the apex beat in the fifth intercostal space in the mammary line. Cardiac dulness extends a finger's breadth to the right of the sternum, and to the left mammary line. There is a loud systolic murmur heard over the whole cardiac

area, loudest in the third left interspace. A slight thrill is to be felt and the pulmonic second sound is accentuated. The exact diagnosis of the lesion in these congenital cases is, of course, always difficult, and it is not uncommon to find several lesions associated. The signs in this case would rather indicate an open ductus arteriosus. With a weakened pulmonic second sound and the other signs as before, pulmonic stenosis or tricuspid regurgitation would be thought of.

CASE II. Mary G., twenty-three years old, born in Ireland, a waitress, and the eldest of twelve children, all living and well. Has always been blue from birth. She has had measles, and at times asthma, but never rheumatism, scarlet fever nor chorea. Slightly short of breath, and troubled at times by palpitation. These symptoms have increased in the last year although she is able to do her work as a waitress. The first catamenial period occurred at the age of twenty; she has never been regular, having had only nine periods in all, the last seven months ago.

On physical examination the patient is seen to be poorly developed, short, and shows cyanosis of face, lips and finger-nails. The apex beat is in the fifth space inside the nipple. There is no enlargement, and there are no murmurs.

CASE III. Ida C., twenty-six years old, born in Naples. Is said to have a blue brother living in Italy; four other brothers are well. The patient has been blue from birth, but has always been well, and she affirms that she is able to run fast and upstairs without getting any more out of breath than others. The catamenia began at the age of fourteen or fifteen and have generally been regular. She is married, and has had two children, the first born two years ago, the second last September. Both were still-born, the first two weeks premature, the other three weeks premature.

She is a well-developed and well-nourished woman, markedly blue, especially about the lips and finger-nails. The mucous membrane of the vagina looked almost black. The heart is not enlarged and there is generally no murmur to be heard. On one occasion a soft systolic murmur over the pulmonic area was detected. The hemoglobin was found to be 70 per cent.

To test her comparative ability to go upstairs quickly, I sent her and one of my assistants down stairs in the out-patient department with instructions to run up again as quickly as they could. The assistant's pulse went up from 90 to 124 or 34 beats, while the patient's rose only 24 beats, from 100 to 124.

The absence of cardiac murmurs in these last two cases of congenital heart disease is, of course, unusual, although Holt states they are absent in one-fifth of all cases. In 19 cases, most of which have come under my observation at the Lying-in and Children's Hospitals, five, or 26 per cent., had no murmurs. One of these cases without murmur was extremely blue, and died in seven days. The autopsy by Dr. Whitney showed an opening between the two ventricles, a much enlarged aorta and small pulmonary artery. Another case, seen in private practice, where the autopsy showed a much hypertrophied heart and large ductus arteriosus, there was no murmur heard till towards the last, when a faint systolic murmur developed.

DR. CUTLER: Was an examination of the blood made?

DR. TOWNSEND: The hemoglobin in this case was 70 per cent. I think a blood-count was not made.