to the gangrenous area of the lower lobe. Just beneath the parietal pleura near the junction of the lower ribs with the spinal column there is a half-dollar-sized flattened elevation with circular outline covered with fibrinous exudate and on section composed of a red-black material resembling clotted blood. There was no perforation of diaphragm. The fibrinous exudate of pleura in places on the lung shows numerous minute vessels extending into it from the pleura.

Right Lung. In superior lobe a chestnut-sized area just beneath the pleura in which the lung tissue is broken down into a brownish-gray diffuent stinking material rather sharply marked out from surrounding lung tissue. In inferior lobe on pleura are two circular areas covered with a dirty, yellowish-gray exudate, rather sharply defined and varying in size from a half-dollar to a dollar. These circular areas seem to correspond to similar circular yellow elevations beneath parietal pleura, which on section are made up of a dirty gray diffuent purulent-looking necrotic material. They are situated in the posterior portion of the thoracic wall. A rib passing beneath one of them was excised and gave no evidence of suppuration in the intercostal or osseous tissue beneath. The areas in the pleura correspond to extensive areas of lung tissue transformed into a brownish-gray stinking diffuent gangrenous material. The areas are sharply marked off from surrounding lung tissue. The inferior lobe is markedly collapsed; its pleura and the pleura of the posterior and inferior portions of the upper lobe covered with a fibrinous exudate which in places is yellow, thick and infiltrated with fluid. The tissue of the superior and middle lobes is extremely pale, not consolidated and contains a small amount of fluid. In lower lobe there is apparently some consolidation in the neighborhood of one of these gangrenous areas, the tissue being resistant, grayish and homogeneous. The pulmonary arteries leading to the inferior lobes of both lungs were dissected, but no good evidence of embolism could be made out. Bronchi injected, and contain a considerable amount of a dirty grayish opaque fluid.

Stomach. The long row of sutures corresponds to the infolding of the stomach wall, the short row to a wound in the stomach wall with inversion of the edges and coaptation of the sound edges. At the pylorus there is a distinct loss of substance in the mucous membrane in the form of an oval ulcer, five centimetres long by two centimetres wide and perhaps four or five millimetres deep. Its margins smooth, to a considerable extent undermined and the mucosa projecting over. The floor fairly smooth with three to four small polypoid projections. The edge of the ulcer reaches to within one or two millimetres of the pylorus. The tissue in the neighborhood of the ulcer not especially indurated nor is the stomach wall especially thickened about it. The pylorus admits the index finger. The stomach, as it appears with the pleat in its wall, is of moderately large dimensions. The stomach contents show no evidence of hemorrhage. The mucosa not remarkable. Other organs not remarkable.

Anatomical Diagnosis. *Ulcus ventriculi*, with dilatation of stomach; gastrorrhaphy; gastrotomy; circumscribed fibrinous peritonitis; gangrene of lungs; fibrinous pleuritis.

Bacteriological report. Cultures in blood serum; spleen, liver, kidneys, and left side of the diaphragm

sterile; heart: one medium-sized, round, whitish, shining colony made up of *staphylococcus pyogenes albus*. Right pleura: Four colonies of *staphylococcus pyogenes albus*, and one of *staphylococcus pyogenes aureus*. Gangrene of lung: A fairly large number of colonies of *staphylococcus pyogenes aureus*; also numerous small, round, moist, colonies made up of streptococci.

DR. SHATTUCK: It seems peculiarly hard that this patient above all others should have succumbed to deglutition pneumonia because his stomach was washed out the morning before operation.

DR. WRIGHT: The autopsy showed that the cause of death was gangrene of the lungs. The stomach itself presented the greatest interest. I have here the specimen, hardened in formaline. This is the anterior aspect of the stomach wall. Here is the esophagus; here is the pyloric end. Along here you see a row of sutures, and at this point another row of sutures near the pylorus. When we open the stomach we find that the long row of sutures corresponds to an invagination of the stomach wall along this line, and at the pyloric end of the stomach we see a round ulcer about the size of a quarter-dollar, with smooth margins, a rather indurated base, and no extensive thickening of the stomach wall; in other words, a simple ulcer of the stomach situated exactly on the margin of the pylorus. At the autopsy I could find no evidence of stricture of the organ, but it seemed to me very probable that this ulcer might have interfered very materially with the working of the pylorus. The bacteriological examination of the various organs showed infection which proceeded from the lungs.

TWO CASES OF AORTIC REGURGITATION AND TABES DORSALIS.

DR. H. F. VICKERY: I desire to show two patients who came to me in the Out-Patient Department. The first one who appeared was the father of the second one. Two years ago, at the age of thirty-six, he complained of some stomach trouble. Incidentally, in examining him, it was noticed that there were enlarged glands in the neck and at the elbows, and that the pulse was of high tension, with the aortic second sound sharp and accentuated, without any cardiac murmur. He now presents the well-marked symptoms of an aortic regurgitation and of tabes dorsalis. With regard to the origin of the trouble, we have no history of any primary lesion. He acknowledges venereal exposure.

The little girl, who is now approaching fourteen years, is perhaps rather small for her age. She was the result of the first pregnancy; and since then two children have been still-born very near term. She was brought for a choreiform condition; she was nervous and fussy, and would drop things. She has improved a good deal. Other things to be noticed about her are as follows: around the angles of the mouth there is a scar-like condition; as her profile is seen, the bridge of the nose shows an abnormal depression, the frontal bone is large and the frontal eminences are well-marked; the upper central incisors are distinctly peg-shaped; there is evidence of a former keratitis.

All these things exist without a history of primary or secondary lesions in the family. As is often the case, the importance of the late manifestations are

entirely disproportionate to what seems to be the importance of original lesion.

DR. F. C. SHATTUCK reported briefly cases of

ACUTE CEREBRO-SPINAL MENINGITIS,

and showed one or two patients from the wards.

DR. WRIGHT: Cerebro-spinal meningitis is a disease characterized by a purulent infiltration of the meninges of the brain and cord. The pneumococcus and various other organisms have been found associated with this condition. It has long been believed that the pneumococcus was the most common cause of all forms of cerebro-spinal meningitis and of purulent lepto-meningitis. In 1887 Weichselbaum, and later others, called attention to a certain organism in certain epidemic cases. These observations were confirmed in 1895 by Jaeger, who maintained that this organism is the cause of the epidemic form of the disease. This idea I do not think is altogether borne out by the facts, but it seems very probable that a large proportion of cases of the epidemic form of this disease are due to the infection by this organism of Weichselbaum.

The present epidemic is apparently due to infection with Weichselbaum's coccus. The organism has no special difference from other cocci in its morphology. It is found inside the pus cells of the exudate and the appearances on direct microscopical examination of the exudate reminds one of the gonorrheal pus as seen under the microscope. In cultural peculiarities this organism differentiates itself from the gonococcus by the fact that it grows on ordinary culture media. It is entirely different from the ordinary pyogenic cocci. In some cases it grows readily, in other cases it is difficult to cultivate. In our autopsies here the exudate was very slight in amount and the microscopical examination showed extremely small numbers of this diplococcus in the pus cells. In one case the microscopical examination of the brain showed infiltration of the cortex with leucocytes in addition to extensive infiltration of the meshes of the pia. The cultures from both cases gave unsatisfactory results. Anatomically these two cases were remarkable by reason of the small amount of exudation on the surface of the meninges, by the coincidence of pericarditis in one and of areas of softening in the frontal lobes in the other. There was an endocarditis in the other case.

The experience of other pathologists in Boston who have made cultures from these cases is very much like ours here. They have found the organism extremely difficult to cultivate from the autopsy. From spinal punctures, however, for some reason or other the attempts have been more successful and I saw not long ago a spinal puncture in which there was an enormous amount of leucocytes present and many of them filled with this organism. From the fluid thus obtained Dr. Wentworth obtained numerous colonies of the characteristic organism. It is rather difficult to explain this negative result of autopsy culture. It may be explained by the fact that the organism has a certain slight vitality in the tissues, causes the trouble and dies out much in the same way that the gonococcus infects the Fallopian tubes, causes suppuration and dies out and the tubes are found sterile.

DR. TOWNSEND: In one case that occurred in my private practice the inversion of the thermic curve was very well marked for several days, the temperature being normal at night and 103° to 105° in the morning. In another case I saw in consultation the tem-

perature remained normal nearly all the time. The patient was a small child, had frequent convulsions and retraction of the neck, but at no time apparently was the temperature elevated.

INTERMITTENT HYDRONEPHROSIS.

DR. MAURICE H. RICHARDSON showed a patient upon whom he had operated for intermittent hydronephrosis. The cause of the dilatation of the renal pelvis was an obliquely inserted ureter. The principle followed was that of the Heinecke-Mikulicz operation for stricture of the pylorus. Fenger had adapted this principle to strictures of the ureter and to him Dr. Richardson was indebted for the suggestion of this method for the relief of an obliquely inserted ureter.

The patient, a nurse of twenty-eight, had had intermittent pain in the region of the gall-bladder. Exploration showed a tumor of the kidney, evidently a hydronephrosis. Further observation proved this to be intermittent. It was determined to explore, and if possible to remedy the obstruction. The kidney was exposed, and the ureter found so attached that dilatation of the renal pelvis compressed the ureter. The insertion of the ureter was altered and its calibre enlarged by first making a longitudinal cut through both pelvis and ureter, and by then closing the cut transversely.

The patient made a complete recovery, and was exhibited in perfect health.

Recent Literature.

Hysteria and Certain Allied Conditions. By GEORGE J. PRESTON, M.D. Small 8vo; pp. 298, with three plates and thirteen illustrations. Philadelphia: P. Blakiston, Son & Co. 1897.

It is somewhat singular that, with the exception of chapters in the recent systems of medicine, which sometimes have almost attained the dignity of monographs, we should have in English no work upon hysteria which embodies the modern investigations upon this disease. Dr. Preston's work, giving, as it does, a clear and concise summary of the recent French treatises, is therefore a welcome and useful publication. Dr. Preston has not only made a careful study of such recent treatises as those of Pitres, Gilles de la Tourette and Richer, but he has also made a survey of the earlier literature, so that he gives an interesting sketch of the earlier theories as to the nature of the affection. In two hundred and twenty pages he gives a history of the disease and the essential facts in regard to symptomatology and diagnosis. To do this in so limited a space is something of an achievement, and he has contented himself in the main with giving a synopsis of the recent French work with only an occasional addition from his own personal experience. In this we note two rather serious omissions. In the chapter on etiology he scarcely speaks of the importance of trauma in producing hysteria, although occasional reference to it is made elsewhere in the book. He says nothing, furthermore, as to the theories of Janet as to the psychical nature of the various symptoms of the disease, theories, which, although somewhat abstruse, are nevertheless of importance in explaining the anomalous character of certain symptoms and in prov-