crutches, walking with difficulty. He said that he had always been a nose breather by day, but a mouth breather by night. Since childhood, he had had no sore throat, but he often has "neuralgia" over his eyes.

Examination.—When the patient came to me, he was thin, with haggard facies, and was unable to stand or walk without crutches. The right hip was very painful on motion and tender. The right knee had a very large effusion, and was painful; the right ankle was tightly distended, painful and tender. The man could bear no weight on the right leg at all, or bend the joints or sit on right hip. He could sit on the left side only. The examination showed a red pharynx. There was also nasal obstruction from a deflected septum. The tonsils were negative in appearance. Posterior rhinoscopy showed an enlarged soft adenoid which bled very readily. The left adenoid was the larger. Small lymph nodes were palpable along both jugular veins. There was no subjective symptom of the throat, however, and no obvious indication that any infection was present.

Treatment and Result.—The first treatment began with postnasal applications of hydrogen peroxid through the nose, followed by a 10 per cent. solution of silver nitrate and a chinosol nasal douche. The following day, the patient reported that he had felt relief in a half hour after the treatment of the previous day. When he came to my office this day, he had a good color, and his expression was no longer pinched. He said that the pain had entirely gone during repose. He was able to walk without crutch or cane, and could sit down normally. Palpation detected scarcely any fluid in the knee. A saturated solution of ferric ammonium sulphate and menthol and eucalyptol was applied.

On the fifth day of treatment, the hip had entirely recovered, and the nasopharynx also was well. The patient himself was much better and all pain was gone, both at rest and during locomotion. On the twenty-third day, after eleven treatments, there was no sign left of the old "rheumatism."

Here is a case of acute polyarticular "rheumatic" sinovitis. Under the usual hospital treatment the case was prolonged and convalescence delayed. The source of the rheumatic infection had not been located. On inspection of the postnasal adenoid or Luschka's tonsil region, the cryptic infection was discovered.

CONCLUSION

When, in cases of acute articular inflammation, the primary infection is not obvious, a cryptic infection probably thrives in the nasopharynx. Luschka's tonsil is the most usual seat of cryptic infections that extend to the general system or form metastatic inflammations.

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REPORT OF CASE OF UNILOCULAR OVARIAN CYST

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The patient, Mrs. H., came from a wealthy family; a clear family history was difficult to obtain, but she had no knowledge of any other member of the family having had a similar tumor; she had smoked opium for several years, which fact she succeeded in concealing from us until after the operation, by secretly taking pills.

The tumor had been growing for four or five years; there had been no severe pain, but great discomfort. When brought to the hospital the patient was also suffering from a severe attack of diarrhea, which, however, we succeeded in getting under control before the operation.

On measurement we found the patient to be 4 feet 10 inches tall and 5 feet 8½ inches in circumference at the waist line.

With an assistant on each side, she could with great exertion walk a few steps; getting her to the operating room, which is situated on the second floor, and on the operating table was a problem. As one of the visiting physicians aptly remarked, it was a case of engineering as well as surgery. She was too broad to sit in a rolling chair or balance herself on a stretcher, so we had four coolies carry her on an improvised stretcher—a woven cane bed—and when she was finally transferred from that to the operating table, we had to put her at an angle of 45 degrees, reclining on her side, with two assistants under the tumor to support it.

An incision about 3 inches long was made through skin and peritoneum just below the umbilicus, the cyst tapped and over 100 pounds of dark brown fluid removed. The cyst with its contents weighed 139½ pounds. The incision was then extended above and below, when, on examination, the cyst wall was found to be bound by heavy adhesions to the abdominal wall, intestines and omentum, while the pelvic organs, including the bladder, formed a solid mass for the pedicle.

The bladder was carefully dissected away from the mass, although in several places the adhesions were so dense that a portion of the cyst wall had to be left, and in spite of the utmost precaution the bladder was entered. After the bladder wall was finally dissected free, the rent was sutured, the pedicle clamped and tied, and the cyst wall, including both the ovaries and uterus, removed. The stump was covered with peritoneum and dropped back into the pelvis. About a quart of normal salt solution was poured into the abdominal cavity, and the abdomen closed. In the meantime the patient was very much in shock. Gradually, as the abdominal contents were removed, she had been placed in the horizontal, and finally in the Trendelenburg position. Intramuscular and intravenous infusions of normal salt had been given, while strychnin, nitroglycerin and pituitary extract had also been administered.

Recovery was uninterrupted. In three days the patient was urinating, the bowels moved without even a laxative being given, and in five weeks she left the hospital cured of her opium habit, and with no bad after-effects from the operation.

Six months after the operation she continues in good health.

The physicians who so kindly assisted in the operation were Drs. McCartney and Freeman of our own (Methodist) mission, Dr. Sheridan of the Canadian Methodist Mission, and Dr. Post of the American gunboat *Palos*, who was then in port.

The Physician and Health Administration.—In a reprint in Public Health Reports of a paper read by J. W. Trask before the Tennessee State Medical Association he again emphasizes the responsibility and the opportunity of the physician with reference to effective health administration and disease prevention. He says the principal function of the federal health department is the control of epidemics and the prevention of the spread of disease from one state to another. In order to accomplish anything in this respect it is necessary to have prompt and accurate information of the occurrence of epidemic diseases from every section. For this information the service is dependent largely on local boards of health, and they in turn depend on the notification of such diseases by physicians who come in contact with the individual cases. He says that physicians are still remiss in reporting cases to their local health departments, and do not recognize as they should that they are essentially a part of the health department. He says, "The practicing physician who fails to report a case of a communicable disease thereby endangers the welfare of the community and exposes others to the danger of contracting the disease, and among those thus exposed may be others of his patients. He is neither a good physician nor a good citizen, and must be considered as opposed to the principle of the control of disease and the protection of the community for which the health department stands."