miles during a period of cold weather, and the amœbæ were invariably motionless, even on the hot stage. In only one instance were pseudopods present, but they remained quiescent during a period of several minutes.

The diagnosis of a paracolitis in this case of dysentery was suggested by the acute, febrile attack connected with the limitation of the sudden and sensitive induration to the course of the ascending colon, the absence of a sharply-defined edge, and the failure to appreciate the fluctuation or elasticity which usually accompany an encysted fluid near the abdominal wall. An anatomical basis for this diagnosis is furnished by the evidence given by Dr. Councilman⁹ of amœbæ coli in the fat tissue of the meso-colon.

At present, ten days after the onset of the acute attack of fever and abdominal pain, the induration is very much softened and the temperature is normal.

Water which the patient was accustomed to drink was examined microscopically and found to contain small amœbæ in active motion, also a larger, quiescent variety. The latter corresponded in size with those found in the dysenteric stools. Their contents were alike coarsely granular, but were of a markedly green color.

Whatever may be said of the etiological significance of amœbæ coli in dysentery, marked diagnostic value must be attached to their presence. Although the case above reported is one which would be classified under the term dysentery, there were neither painful stools nor painful bowels during the greater part of the time. An ulcerative cecitis or colitis of malignant or tubercular nature was suggested by both positive and negative evidence. The discovery of the amœbæ coli, in the light of our present knowledge, was almost conclusive evidence in opposition. Kartulis¹⁰ has sought for them, in vain, in hundreds of intestinal cases other than dysentery and has found them in every case of undoubted dysentery and in all hepatic abscesses in dysentery. Osler¹¹ found them in pus from an hepatic abscess removed during life from a case of dysentery, and he has recently¹² found them in the sputum of a case of suspected pleurisy where there was no diarrhœa, only a little bloody mucus in consistent stools. In this last case the positive diagnosis rested upon the presence of the amœbæ in the sputum.

The accumulating evidence of the constant occurrence of the amœbæ coli in the stools, the intestinal wall and in hepatic abscesses in certain cases of dysentery, renders it highly probable that these amœbæ are of decided importance in the causation of dysentery, especially of the ulcerative variety.

Lösch¹² experimented with the amœbic stools and found that they violently irritated the mucous membrane which became ulcerated and amœbæ were found in the base of the ulcers. Kartulis¹⁴ claims that he has successfully cultivated the amœbæ and by injection-experiments on cats, has proven that the cause of dysentery is to be found exclusively in these amœbæ. These observations require confirmation, but it may be expected in the early future that the etiological importance of amœbæ coli in certain forms of dysentery may be as definitely settled as the diagnostic value of their presence must be admitted.

Clinical Department.

INCISION OF A FALSE ILIAC ANEURISM.¹

BY E. H. BRADFORD, M.D.

A STOUT man, with a history of previous good health, was brought to the hospital with the statement that two weeks before he had strained himself, and experienced considerable pain in the right groin. This pain had increased, and two days before entrance into the hospital he was obliged to lie in bed. He was examined by his physician, and referred to the hospital with the diagnosis of appendicitis. This appeared to be probable from the locality of the pain, and of the resistance felt in the groin. The thigh was flexed, and the patient unable to move, but the patient was not feverish, through restless, anxious and distressed, requiring opiates. The right thigh was somewhat swollen and congested. On palpation a large, indurated mass was felt in the groin, but no fluctuation was discovered, and no pulsation; though palpation was not thoroughly carried out, because of the patient's sensitiveness, which was marked. Under an anæsthetic the condition was very much the same. A large mass of induration was felt in the iliac region, and this was cut down upon in a line an inch above Poupart's ligament. The muscles were found congested, and when the peritoneum was reached, it seemed darker than normal. The incision into the peritoneum allowed a certain amount of clotted blood to escape; and as the wound was enlarged a large clot was pressed out, followed by fresh blood. The nature of the injury was then apparent. The wound was enlarged, the clots were turned out, and a jet of fresh blood about the size of the radial could be discovered issuing from the depth of the wound. Sponges were introduced into the wound to stop the bleeding; abdominal compression was applied, which controlled the bleeding; large abdominal retractors were placed in the wound; and by the use of these the bleeding-point was found at a great depth. This was finally secured by long-pressure forceps, and the bleeding stopped. Attempts, however, were made to tie the bleeding-point, but this was found impossible as the ligature invariably slipped.

Attempts were then made to dissect up the artery, and tie above and below, but this was found impossible. The cause of this was not determined until after death. The bleeding was stopped by means of pressure forceps, the forceps left in the wound and salt transfusion employed. The patient was removed from the table, but died four hours later. On examination the following condition was found: A true aneurism was discovered, arising a short distance below the bifurcation of the aorta (three-fourths of an inch), extending down to a short distance above the femoral, the internal iliac issuing from the aneurismal sac. This had ruptured, forming a large false aneurism, with the existence of clot, which had presented in the inguinal region, giving the appearance of inflammatory product. The bleeding-point was from the rupture of the sac; this was comparatively small and at the upper part of the sac. It was, of course, impossible to tie the artery; for the artery was not a simple vessel, but the sac of an aneurism, extending nearly to the aorta — beyond surgical reach.

The case is of interest, and needs to be recorded

¹ Read before the Boston Society for Medical Improvement, October 12, 1891.

⁹ Johns Hopkins Hospital Bulletin, 1891, II, 84.

¹⁰ *Obst. f. Bakt. u. Parasitenkunde*, 1891, ix, 365.

¹¹ Johns Hopkins Hospital Bulletin, 1890, I, 97.

¹² *Vierteljahr's Arch.*, 1875, Ixv, 190.

¹⁴ *Obst. f. Bakt. u. Parasitenkunde*, 1880, ix, 365.

not only because all serious errors in surgery, as well as successes, should be reported, but also because the case demonstrated the feasibility and ease with which the upper part of the common iliac could be reached by surgical intervention. It also illustrated with what ease the hæmorrhage was controlled by manual compression of the aorta, through the abdominal wall.

BULLET WOUND OF THE SKULL.¹

BY E. H. BRADFORD, M.D.

AN unusual course of a bullet is illustrated by the following case:

The patient was a man twenty-two years of age, who entered the hospital January 17, 1890, with a small pistol-shot wound in the right fronto-parietal region. There was a slight amount of swelling of three quarters of an inch in front of the punctured wound. The pistol had been discharged with suicidal intent, and the hair was singed. On probing the wound, the opening into the skull could not be found, and the bone only was touched. The patient was conscious, and all motions were good; but the right pupil appeared to dilate more rapidly than the left. The pulse was ninety, and there was no shock. The patient had some headache, but otherwise was in good condition. Two days after entrance the patient was etherized, and a curved incision was made over the wound and the flap reflected. A small fragment of a bullet was found under the skin, corresponding to the swelling that was felt; and a fragment of the outer table, of the size of a five-cent piece was removed, with the bullet-hole in the centre. Under this was found, lying in the fragment of the inner table, a misshaped bullet, which was lying with the butt-end close to the dura. The bullet had struck the skull, had fractured the outer table, had fractured the inner table, and penetrated the inner table. It had turned a half-revolution, so that its butt-end lay on the dura. The bullet was removed, and a complete perforation of the bone down to the dura discovered, but without wound of the dura. The patient made a rapid recovery.

The case illustrates the lack of reliability of the probe as a means of exploration, without preliminary trephining, as the position was not discovered until after dissection of the flap of the skin covering the wound. It also shows the remarkable fact that a pistol of good size, placed against the parietal region, may penetrate the skull without penetrating the dura, and leaving the bullet in contact with the dura with — what is still more remarkable — a complete revolution of the bullet in nearly its own axis from the point of impact to the point of rest.

A CASE OF SEVERE VOMITING OF PREGNANCY.

BY EDWARD O. OTIS, M.D., BOSTON.

On September 27th of the present year I was summoned out of town to see Mrs. S., in consultation. I found her in bed constantly vomiting and retching, with accompanying nausea and pyalism. Her suffering and distress were painful to witness, and I was vividly reminded of a terrific day of sea-sickness

I had recently experienced on the German Ocean. This was her second experience with severe vomiting of pregnancy, and before giving the details of this case I will narrate the previous one as she told it to me.

About three years ago she was married for the first time, being about eighteen or twenty years of age. Not long after her marriage, while in Southern California she received a severe nervous shock, having at that time passed a catamenial period by three weeks. Immediately upon this she journeyed to San Francisco, her home, and in a couple of days after her arrival began to feel indisposed. After three or four days' confinement in bed, nausea and vomiting began, and continued, with ever-increasing violence for a week. At the end of that time a consultation was held and an examination made. The urine was found to be highly charged with albumen, and the uterus retroflexed; in the words of the patient, "It had fallen back upon the kidneys." The temperature was said to have ranged from 101° to 104° F. From this time forward she was nourished by nutrient enemata of milk and brandy. The vomiting and nausea continued, violent and distressing; and three weeks after it first began a sponge tent was introduced into the os with the intention of producing abortion. This was repeated on the following day, and several hours afterwards, on assuming the upright position, the abortion occurred. The nausea ceased at once, and she was able to take nourishment by the mouth. The albumen in the urine rapidly decreased. The convalescence was slow, and it was not until about five months after the beginning of the catastrophe that she was well enough to be placed upon a steamer and sent down the Pacific coast on a cruise. She weighed at the time but seventy pounds. She gained rapidly, and a few days out was able to walk, and in a month's time, at the expiration of the voyage, she was nearly well.

Her husband died soon afterwards, and she remained a widow until the winter of 1890-91, when she married again, not deterred by this painful experience of the former matrimonial venture. All went well until the seventh of last September, when the catamenia, which was then due, remained absent. She was in the country at the time, and in the best of health. A little later she went to New York, and after considerable exertion and fatigue she first began to have nausea. This was on the seventeenth of the month. She returned to her home at once, the nausea increasing and the vomiting beginning. She kept about, however, until the twenty-second of September, when she took to her bed, the nausea, vomiting and retching being then almost continuous and very distressing. Her physician tried many remedies, cocaine, menthol, pepsine, bismuth, oxalate of cerium, chloroform, water, etc., but of no avail. When I saw her for the first time, on the twenty-seventh of the month, she presented a pitiful picture, vomiting or retching continually, and constantly harassed with pyalism and thirst. On vaginal examination I found the os far back in the left posterior corner of the vagina, and the uterus, so far as I could make out, laterally anteflexed. The os was small and firm. There was no rise of temperature at this or any time during her illness; on the contrary, it was a good deal of the time slightly below normal. The daily amount of urine was much reduced, ranging from $\mathfrak{z}\text{v}+$ to $\mathfrak{z}\text{xxviii}+$. There was no albumen. The pulse was fair and between 80 and 90. She was having enemata of peptonized milk and brandy every four

¹ Read before the Boston Society for Medical Improvement, October 12, 1891.