guard against leakage, it may be omitted and good after-results obtained. Of much more importance than the creation of a circular valve at the inner extremity of the new canal, in fact the essential feature of this operation, is the direction given to the new canal by the selection of an area of the stomach-wall for the performance of this plastic procedure somewhat to the right of the abdominal incision. The new canal, when formed, should have an oblique direction to the left. Any increase of intragastric pressure will then bring the walls of the fistula together and effectually prevent the escape of stomach contents.

I have performed gastrotomy five times as detailed above and always without inverting the proximal end of the new canal. In other words, in five patients I have simply sewed the new canal near its base to the margin of the opening in the rectus sheath and the mucous membrane of the external opening of the canal to the skin, depending entirely on the constricting influence of the rectus fibers and the oblique direction of the new canal for tight closure. In three of these patients the malignant disease was so far advanced that they did not survive the operation long enough (three or four weeks) to be up and around, and there was no opportunity, therefore, to test the tightness of the new canal in a satisfactory manner. These three patients occupied a recumbent position all of the time after operation. There was not a drop of leakage in any of them. Of the two other patients, one lived a sufficient length of time after the gastrotomy to be up and around as a normal individual, and he had no leakage. The fifth patient is still living. He has had leakage only on severe exertion. Such leakage, however, has been inconsiderable and the patient has been in the habit of controlling it by inserting a soft rubber stem pessary when going to work (he is a carpenter). For the past three months he has been unable to work and has omitted the use of the pessary altogether.

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SALVARSAN VERSUS PROFETA'S LAW *

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The theory of syphilitic immunity, as established by Ricord, has long been upset. If there is a syphilitic immunity in infected persons this is due to two circumstances combined: first, to a saturated condition of the fluids and solids of the organism with spirochetes and their toxins; second, to the capacity of the organism to produce antibodies to counteract the poisonous influence of the virus. With time the spirochetes become inactive and the disease, in a latent condition, loses its poisonous influence. The Wassermann test in these conditions turns negative, and yet the patient is not cured, and may show syphilitic signs of a late type. The attenuation of the virus is seen also by the observation of syphilitic families, when we see the first pregnancy end in miscarriage, the second in premature birth, the third child born alive, and only after a few days showing some syphilitic manifestations, and others born well, showing only late, faint signs of the disease.

The diminution in the poisonous intensity of the virus occurs slowly and at times in a saltatory way. In some

syphilitic families a healthy child is born, and the next child will show signs of hereditary syphilis.

I shall repeat my statement, made at other times, that the spirochetes in the organism of the father, after a certain time and after some treatment, are unequally distributed, hiding themselves in those organs and those tissues which are not so easily affected by the antisymphilitic remedies. Whether an infected or a healthy child is born to him may depend on the presence of the spirochetes in the semen.

It is exceedingly rare and difficult, however, to find that the mother who gives birth to a syphilitic child is not infected with syphilis. The Wassermann test of to-day has already destroyed Colles-Baumes' law. They claimed that mothers bearing syphilitic children from fathers affected with latent syphilis escape the disease, or at least pass through a modified form of it. Their children, affected with mucous patches on the tongue or the lips, suckle the breast of the mother without infecting her; but if they were to suckle the breast of any other healthy woman, she would be positively infected.

Montesano¹ writing on Colles' law reported a case of a woman, who returned, after four years' separation, to live with her husband who had been infected. She became pregnant and gave birth to a child apparently well. She never had any signs of syphilis until two years later. Then the child was taken with epileptiform spasms and the mother had ulcerative patches between the toes. Wassermann test of both the mother and the child proved to be positive. The woman had been declared immune according to Colles' law, and yet she had a latent syphilis. The immunity of the mother who has in her uterus a syphilitic fetus is only ephemeral. She has not escaped infection as Ricord claimed, but has latent syphilis.

Profeta's law² maintains just the reverse of what has been asserted to happen to the mother and to the child. It was maintained under his theory that this child coming from syphilitic parents has acquired a congenital immunity, which protects it, at least temporarily, from syphilitic infection. This occurrence was explained in two ways: either that the placenta would be able to oppose a strong barrier to the entrance of the spirochetes, protecting the fetus mechanically, or that the child, saturated with antigens arising from the system of the mother, would be protected and immunized from subsequent infection.

Profeta's law had a strong support in a series of observations from Profeta³ himself, and later from Caspray, Finger,⁴ Ogilvie,⁵ Bruggeman and Glück.⁶ But in recent years exceptions have multiplied to such an extent that I must agree with Matzenhauer⁷ that it has no more reason to be called a law.

To-day we can say that there is no congenital or hereditary syphilis without syphilis of the mother. Immunity, either active from the passage of toxalbuminous substances, or passive from antigens passing from the mother to the fetus or vice versa, can no longer be maintained.

1. Montesano, V.: Osservazioni sulla legge del Colles, Report Soc. Ital. di dermat. e sifil., 1913.

2. Profeta, G.: Sulla sifilide per allattamento, Sperimentale, 1865.

3. Profeta, G.: Variazioni su motivi di sifilide congenita per allattamento, Glor. Ital. d. mal. ven. Milano, 1900, p. 165.

4. Finger: Ueber die vererbte Syphilis, Finger Arch.

5. Ogilvie: Congenital Immunity to Syphilis and the So-Called "Law of Profeta," Brit. Jour. Dermat., 1899.

6. Glück: Ueber das sogenannte Profetasche Gesetz, Deutsch. med. Wchnschr., 1902, No. 9.

7. Matzenhauer, R.: Die Vererbung der Syphilis, Ergänzungsheft, Arch. f. Dermat. u. Syph., 1903.

* Read in the Section on Dermatology of the American Medical Association, at the Sixty-Fourth Annual Session, held at Minneapolis, June, 1913.

After these observations I shall refer to the clinical case, the subject of my late study and the motive for this paper.

Patient.—An Italian laborer came to consult me for a lenticular papular syphilid with all the accompanying symptoms. Injections of gray oil were given and the eruption was gradually disappearing and the man was feeling much better. He was not seen for some time until he came with his wife, who had recently come from Italy to join him. He had infected his wife, of course, and she also had papular syphilid. It was at the beginning of the new era of treatment, the salvarsan, which had to accomplish the *sterilisatio magna*, and both husband and wife were treated with two intramuscular injections in the lumbar regions with a full dose of 0.6 gm. After the injection both improved remarkably. The woman was in the beginning of pregnancy. Her husband had not shown any symptoms since the injections; Wassermann and Noguchi tests

the mucous patch at the right corner of the mouth of the mother, and the initial lesion on the left of the chin of the child.

COMMENT

The child was perfectly well and had never shown any sign of luetic taint. The father, with the mercurial treatment and after the salvarsan injection had shown no further symptoms, had negative Wassermann, and was able to generate a child free from lues. The mother, also, showed no signs of lues for some time and it seems that the active spirochetes were killed. I would say, with Pollitzer, that some of the inactive spirochetes still remained in her tissues, and were not allowed to pass through the placental filter. This case gives no support to the idea of Matzenbauer that the fetus receives infection from the mother only; it would rather maintain the opinion of Hainiss⁸ that the cause of hereditary lues is the infected sperm.

The father had shown no symptoms for a long time, the Wassermann test had been negative, and he did not communicate the disease to the offspring. The mother, at the time of conception, although still having spirochetes in her system, did not communicate lues to the offspring. Some months afterward she showed mucous patches of the mouth. The receptivity of the infection by the child shows that he had no immunity whatever and his own mother with her saliva containing spirochetes in a maternal kiss inoculated him. The result was an initial lesion, and secondary eruption. If the Profeta law had any bearing the mother could never have inoculated her child, because it would have been protected by immunity.

Immunity in syphilis does not exist, and when a child born from a syphilitic mother is not infected that shows that he has latent syphilis, which sooner or later will manifest itself. In all cases of doubtful condition of infection examined by Linser,⁹ Wassermann was found positive. I must state with Bergrath¹⁰ that children are born either infected or healthy. Immunity does not exist, and what had been considered as immunity was only a latent condition of the disease.

Immunity against a reinfection is produced only by the existing syphilis, while immunity after perfect recovery, according to the experiments in animals carried on by Neisser, has to be entirely excluded. When syphilis is cured any immunity disappears. Moreover, while the disease is attenuating gradually, according to Finger, slight reinfection may occur.

I can state, therefore, that the child was perfectly free from syphilis. It is necessary to admit that the father was cured of syphilis. The mother was not cured because she showed later syphilitic mucous patches, but at the time of the pregnancy the spirochetes were not able to reach the fetus, which developed healthy and free from syphilis. The mother, neglecting treatment, allowed the spirochetes to become active again, and she showed mucous patches, which infected her child.

Since the use of salvarsan we have witnessed admirable results. Indeed, before the use of salvarsan cases of syphilitic reinfections were reported as of rare occurrence and were also questioned. After salvarsan, cases of syphilitic reinfection are numerous and every day increasing. Ascertained cases of syphilitic reinfections

Lesion on left side of baby's chin, and mucous patch in right corner of mother's mouth.

were found negative. The woman could not be induced to have a Wassermann test made. She had one necrotic abscess in the place of one of the salvarsan injections, which healed up in a short time after due treatment. For some time I lost sight of this couple. The woman came again with a well-nourished, well-developed baby 8 months old, which when carefully examined showed no signs of lues. She related that the pregnancy at the time of the syphilitic manifestations ended in miscarriage. Since the salvarsan injections she had seen no signs of the infection, and she had given birth to the child she had in her arms. She came on account of a sore under lip, which was touched up with a solution of bichlorid 1:100 in alcohol and ether. The sores in her mouth were undoubtedly mucous patches of the mucosa. A few weeks later she came on account of the child, who had an initial lesion on his chin, as shown by the illustration, with enlargement of the sub-maxillary and cervical lymph-nodes. At the same time the face, chest, back, arms, thighs and legs were covered with a macular syphilid (roseola). I had the picture taken to show

8. Hainiss: Budapest Orv. Usag., 1912, No. 11; ref. Dermat. Wehnschr., 1912, No. 516, p. 1690.

9. Linser: Sitzung des med.-natur. Verein Tübingen, February, 1909, quoted by Bergrath (see Note 10).

10. Bergrath: Ueber Syphilis congenita in der II. Generation, Arch. f. Dermat. u. Syph., 1910, cv, 143.

have been recently reported by Covisa and Nonell,¹¹ Mrongowius,¹² L. Jullien,¹³ Belin, Milian and Amodrut,¹⁴ Fournier,¹⁵ Wüstenberg¹⁶ and many others. This shows that by means of salvarsan, either alone or in association with the other antisyphilitic remedies, we obtain complete recoveries in syphilis.

Harold J. Lewis¹⁷ reported a case of severe syphilis in a woman who was in her fourth month of pregnancy. After two intravenous injections of salvarsan, she recovered and at full term she gave birth to twins in good health.

CONCLUSIONS

As a conclusion we can state that in the presence of the Wassermann test and of the administration of salvarsan, Colles-Baumes' and Profeta's laws have no right to existence. Syphilitic immunity lasts as long as the disease lasts, consequently the child in this case was born perfectly free from syphilis, although born from a woman who later showed syphilitic symptoms.

The opinion of Pollitzer¹⁸ that salvarsan kills the active spirochetes and allows the inactive spirochetes to escape unaffected finds support in my case, in which the mother had conceived and carried to full term the child free from syphilis, when she still had spirochetes in her system.

In this family salvarsan had cured the father, had operated a great improvement in the condition of the mother, and had saved the child from maternal syphilitic infection.

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ABSTRACT OF DISCUSSION

DR. ALFRED SCHALEK, Omaha: I believe that in the light of our present knowledge of syphilis, some of the laws regarding the transmission of the disease might well be regarded as obsolete. Statistics show that 100 per cent. of women with syphilitic children give a positive Wassermann, but the children of a syphilitic mother do not always show such a reaction. There is no acquired immunity in these cases, and I trust that the writers of text-books on the subject of syphilis in the future will revise these old ideas, which have been accepted and unquestioned for so many years.

DR. M. L. HEIDINGSFELD, Cincinnati: The Wassermann test has largely cleared up the situation, and has demonstrated that the circulation between mother and child is so intimate that if one is infected the other almost necessarily shares the infection.

The very unique case reported by Dr. Ravogli, however, should be thoroughly investigated before we accept it at its face value, and there are certain features about it which should not be overlooked. In the photograph of the child there is a sore which might pass for an initial lesion. The eruption on the body is largely papular, and we know that in cases in which salvarsan has been used and a secondary eruption occurs, it is usually much earlier than in cases in which salvarsan has not been used. It is also possible that we have here a superadded infection, as described by Bingner. The possibility should not be lost sight of, therefore, that we are dealing here with a relapse rather than with a fresh infection. The indications point to a relapse or possibly some sporadic infection.

11. Covisa and Nonell *Actas Dermosifilograficas*, Madrid 1911, No. 1.

12. Mrongowius: *Russky Vraisch*, 1912, No. 26; ref. *Derm. Wehnschr.*, 1912, No. 51a, p. 1563.

13. Jullien L.: *Bull. méd.*, 1912, p. 715; *Derm. Wehnschr.*, 1912, No. 51a, p. 1564.

14. Belin, Milian and Amodrut: *Reinfectio Syphilitica nach Salvarsan*, *Bull. méd.*, 1912, p. 195; ref. *Derm. Wehnschr.*, 1912, p. 1167.

15. Fournier F.: *Rev. prat. d. org. gén.-urin.*, September, 1912.

16. Wüstenberg: *München. med. Wehnschr.*, 1912, No. 30.

17. Lewis, Harold, J.: *Salvarsan in Pregnancy*, *THE JOURNAL A. M. A.*, Aug. 24, 1912.

18. Pollitzer: *Salvarsan*, *New York Med. Jour.*, Feb. 4, 1911.

DR. A. RAVOGGI, Cincinnati: In answer to Dr. Heidingsfeld I would say that this child was perfectly well, without any enlarged lymph-nodes, and showed no suspicion of syphilis. No Wassermann test was made at that time, therefore, as there were no indications for it. After the appearance of the initial lesion on the chin, however, there was no doubt in my mind that it represented a syphilitic infection, and improvement occurred under small doses of calomel, which is my usual treatment of syphilis in children. I am convinced that it was not a case of re-infection and that the infection came from the mother.

MESENTERIC CYSTS

WITH REPORT OF A CASE OF SANGUINEOUS CYST OF THE MESENTERY OF THE SMALL INTESTINE

CHARLES H. FRAZIER, M.D.

PHILADELPHIA

Cystic tumors of the mesentery are probably more uncommon than similar lesions of any of the other structures of the abdominal cavity. The difficulties of differential diagnosis in these cases, however, and the grave results when intervention is delayed too long behoove us to give more thought and attention to what was once considered one of the rarities of surgical pathology. Indeed, up to 1850 mesenteric cysts were recognized only at necropsy, and between 1850 and 1880, though occasionally operations were performed for so-called mesenteric cysts, they usually followed inaccurate diagnoses and terminated fatally. Even in 1883, Collet writes, in a very exhaustive thesis on this subject, that laparotomy for mesenteric cysts had never been performed up to that time after an exact diagnosis, the conflict arising sometimes over cysts of the ovary, omentum or sigmoid colon, and sometimes over a small floating kidney, which was mistaken for a cystic tumor of the mesentery. We find the first description of one of these lesions given by Benevieni in 1507, while Ballonius, Hortius, Tulpius and other doctors of the seventeenth century mention similar affections, which they found at necropsy. These accounts, however, are very uncertain and confused. In 1886, Angagneur collected statistics which show that eighteen out of ninety cases (or 5 per cent.) of tumors of the mesentery were cystic. His work, together with the monographs of Braquehay in 1892, and later of Moynihan and Dowd, and the efforts of the French surgeons, Péan, Millard and Tillaux, gave a new impetus to surgical endeavor in this field.

My attention was first directed to this subject by a patient who was referred to my clinic at the University Hospital by Dr. J. B. Keylor of Cochranville, Pa.

Patient.—C. B., aged 44, was admitted Jan. 14, 1913. He was married and had one child living and well, and denied all venereal disease. Eleven years ago, he fell through an opening in the barn floor, and in so doing pulled a corn-sheller after him which landed across his abdomen. During the next seven years, he suffered from time to time from attacks of colicky pains, but no nausea or vomiting, and no diarrhea or constipation. In 1909, he noticed a small mass the size of a walnut about 5 cm. above the symphysis pubis which slowly increased in size for two years until it extended 2.5 cm. below the umbilicus and laterally across the abdomen. During the past year, it has grown more rapidly and has extended 5 cm. above the umbilicus.

Physical Examination.—Starting about 3 cm. above the pubis, there arose a dome-shaped mass which extended 5 to 6 cm. above the umbilicus. It was hard, although with a certain amount of elasticity, and only attached around the