REPORT OF CASE

History.—A well-developed, robust-looking Italian, male, aged 34, was brought into the hospital with a penetrating bullet wound of the abdomen. At autopsy all organs were found normal except the peritoneum, which showed extensive peritonitis. The intestines were matted together owing to the same condition. In the intestine 75 cm. from the pylorus two perforations were found, i. e., wound of entrance and wound of exit. About 15 cm. from the sigmoid flexure in the descending colon another perforation was seen. About 30 cm. from the pylorus a flat tumor mass was found in the intestinal wall, on its free border, opposite the mesentery. It was yellowish-gray, about the size of a quarter, markedly defined from the surrounding tissue, and slightly protruding into the lumen of the bowel. The tumor and part of the intestine for about 7 cm. on each side of it were removed and sent to the College of Physicians and Surgeons, Baltimore, for microscopic examination. Dr. William Royal Stokes reported the tumor to be an accessory pancreas, or, as some may call it, "aberrant or supernumerary pancreas." On section the organ had the same yellowish gray color as the pancreas. Sections of it showed that it was enclosed on one side by peritoneum and some muscular tissue, and on the other side by the submucous coat and the mucous membrane.

Dr. H. W. Stoner made the photomicrographs here shown (Figs. 1-4).

To the embryologist, physiologist, and pathologist this condition must surely be of some interest as to its correlation with the true pancreas in health and disease. Interesting queries can be evolved from such an anomaly, as, for instance, whether the presence of such a tumor could prevent diabetes in a patient in whom the islands of Langerhans of the true pancreas were affected. Or whether in a diseased condition of the pancreas, would the accessory pancreas undergo sympathetic degenerative changes or hypertrophy and take up the function of the true pancreas?

38 High Street.

A PLASTER SUPPORT FOR GASTROPTOSIS

S. D. DICE, M.D.
SARANAC LAKE, N. Y.

I have employed for some time with good results, a useful method of securing abdominal support, with zinc

Fig. 1.—Pattern for plaster support for gastroptosis.

oxid adhesive plaster on moleskin. It is adapted to cases of gastroptosis and enteroptosis requiring some mechanical support in the various wasting diseases, especially chronic tuberculosis, in which digestive disturbances are so common and so important to correct.

A patient in bed will often experience relief and benefit from the constant wearing of a light plaster support of the abdomen, although it is generally assumed, on theoretical grounds, that the sagging viscera require no support at such times. Elastic belts for abdominal support are often not comfortable or effective in the lean individual with a flat abdomen, even with an extra pad inserted under the belt, and holes cut in the elastic

Fig. 2.—Plaster support applied.

to ease up the pressure over the bony prominences at the sides. The plan herewith presented consists of a plaster pattern, with eyelets at the sides for lacing, as now generally used in surgical dressings, when it is desired to avoid a change of plaster at each dressing.

The shape and size of the plaster apron will vary, of course, with each individual. The general outline is shown in Figure 1.

The plaster should extend from the umbilicus to the symphysis pubis, and in order to include the side tongues in the same piece with the apron, the 7-inch wide plaster will be necessary. (Fig. 2.)

The strap for the back should be $3\frac{1}{2}$ inches wide, cut straight, or slightly curved toward the ends; the length must be about 3 inches shorter than the actual measurement, leaving the space of $1\frac{1}{2}$ inches on each side, for the uplift traction on apron ends and lacing. (Fig. 2.)

The edge of the plaster along which the holes are punched for eyelets should be faced underneath with an extra narrow plaster strip, so as to make a double thickness to give the eyelets a better staying grip. Less traction on the plaster will be required, when it is laced up, if the patient assumes the recumbent position, which will relax the abdominal muscles and allow the viscera to lie in a more natural position.

The advantages claimed for this pattern and lacing are evident:

1. Quick relief is afforded by unlacing, when the abdomen distends with gas.
2. The single thickness of plaster over the abdomen obviates the necessity for an overlapped edge which often causes a sore ridge on the skin, in the methods requiring a three- or four-piece pattern.
3. There is a small economy of plaster over other methods.

4. It permits easy removal for a tub bath, and a reapplication of the same plaster by the patient, provided (a) that the skin is cleansed of bits of adhesive residue, with turpentine, which should be used before wetting the skin, and removed at once with soap and hot water to avoid irritation; and (b) that the abdomen is shaved clean of new hair growth after every bath.

When the plaster is reapplied to the skin, if it does not adhere readily with the aid of a hot-water bag over the abdomen, then a strip of fresh plaster may be strapped across the lower abdomen temporarily (as shown in Fig. 2 on the left) allowing one-half to lap over lower edge of apron, the other half to extend lower on the skin. After fixation is assured, this temporary strip may be taken off.

The insertion of the eyelets at the sides will be found convenient when the abdomen has been strapped with plaster according to Dr. Rose's method or any other.

104 Park Avenue.

A TABLE FOR EYE, EAR, NOSE AND THROAT WORK

L. W. DEAN, M.D.
IOWA CITY, IA.

This table was designed with the view of securing one that would serve equally well for a cataract operation,

Fig. 1.—A table for eye, ear, nose and throat work, shown with the top of table horizontal.

Fig. 2.—View of table with head lowered.

Fig. 3.—View of table with head elevated.

brain surgery, mastoid operations, throat work, laryngotomy or bronchoscopy. The table has now been in use for one year and has filled the requirements for this work. The table can be raised to a height of 41 inches and lowered to 31 inches. This allows the operator to work standing or sitting. The table may be tilted to any desired position. This can be done very rapidly if difficulty with anesthesia or other conditions indicate the need for a change of position.

The head-piece of the table may be elevated to any desired position. This advantage, together with the tilting of the table, greatly diminishes the work in bronchoscopy and laryngectomy. In bronchoscopy it is not necessary to have an exceedingly well-trained assistant to hold the head.

The table is firm in every position and there is but slight opportunity for wear.

MITRAL STENOSIS OF TRAUMATIC ORIGIN*

DAVID RIESMAN, M.D.
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History.—N. H., an able-bodied married man of thirty-five, a musician by profession, was returning from a playing engagement one morning at 4 o'clock in the month of August, 1910. Suddenly, when about three squares from home he was set on by foot-pads. Terror-stricken, he ran as fast as his legs would carry him, grasping tightly in one hand his violin and in the other a heavy box containing his music. He arrived at his home utterly spent and exhausted, and with an intense feeling of choking and suffocation. For half an hour he had to stand up and struggle for breath. Gradually the sense of suffocation lessened, its place being taken by a distressing palpitation. There was no real pain. Later in the day the patient consulted a physician, who told him there was nothing serious the matter with him, and that he would soon be well again. By the following day, the palpitation had ceased. Two or three months later it returned, and has troubled the patient intermittently ever since. It caused him to consult me March 21, 1911.

Examination.—I found a presystolic thrill in the apex region, a loud churning presystolic mitral murmur, accentuation of the second pulmonary sound, and, on a later examination, a doubling of the second sound at the base of the heart.

The man's history is entirely negative; aside from an attack of lumbago some years ago, he remembers no illness whatsoever. His mother died at 55 years of age, of a cause unknown to him. His father is still living. Prior to the episode that I have related, he was in every sense, so far as he knew, sound and well.

How shall we interpret this case? I am well aware of the difficulty of proving a given case of heart disease to be the result of trauma. A cursory glance over the literature is not particularly informing, except that it leaves little room for doubt as to the fact that injury and strain can produce functional and muscular disease of the heart. With respect to endocardial, particularly valvular, lesions, the testimony is more questionable. In accidents such as crushes or severe contusions, hemorrhages and tears have been found in the valvular and mural endocardium. Bernstein,¹ who, in 1896, collected all the cases of heart disease of traumatic origin recorded—a total of one hundred and twenty-four—found only a few instances of involvement of the valves; none of which corresponds to the case here reported. There are in his list a few cases of mitral stenosis that followed and seemed to be due to violent blows, falls or contusions. A few additional examples are found in Richard Stern's valuable monograph, "Die traumatische Entstehung innerer Krankheiten." Külbs,²

* Read before the Section in Medicine of the College of Physicians of Philadelphia, May 22, 1911.

1. *Ztschr. f. klin. Med.*, 1896, xxix, 510.

2. *Verhandl. d. deutsch. path. Gesellsch.*, 1908, xli, 172.