CASE 16. Mrs. E. L., age sixty-one. Family history good, husband died of cancer of intestines two years before; has had stomach trouble for three years with distress, burning and little pain after meals, often nausea. Two weeks ago pain has been much worse, when she vomited one-half cup of clear red blood. Physical examination: Weight 142, heart somewhat enlarged, second aortic accentuated and rough, pulse irregular, temporal arteries tortuous. Stomach contents acid, but no free HCl, no retention, occult blood present. Urine gave from 20-30 casts per slide, a trace of albumin, quantity around 1,000 ccm. Smooth diet with test treatment caused entire relief of trouble. Diagnosis: Chronic non-mucous gastritis with erosions or ulcer, secondary to arteriosclerosis and chronic nephritis. Patient gained steadily on treatment and had been practically entirely free from any gastric symptoms and has gained greatly in strength up to the present, three years after.

REMARKS ON CASES.

Cases 1, 2, 3, 4, 5, 7, 8, 12, 13, illustrate those of Class 1, where operation should be immediately ordered and where it was obvious that medical treatment could do no permanent good. Case 6 in its earliest stages, Cases 9, 10 and 11 in their earlier stages, Case 11 in its earlier stages, illustrate the type where operation should be thought of and in the present light of our knowledge advised to the patient.

Cases 14, 15, 16 illustrate cases where surgery is not in question.

Case 16 might have been thought operative by some surgeons, yet, in view of the serious arteriosclerotic changes and chronic Bright's, and also of the great immediate relief on the test treatment, and considering the age, it seemed prudent to advise against such measures. This was substantiated by the future history.

Clinical Department.

SUDDEN DEATH FOLLOWING A PROPHYLACTIC DOSE OF DIPHTHERIA ANTITOXIN. AUTOPSY REVEALS STATUS LYMPHATICUS.

BY SYLVESTER F. MC KEEN, M.D., ALLSTON, MASS.

THE extreme rarity of the above occurrence induces the writer to report the following case:

In the patient's family, a servant, with a history of sore throat for several days, was found to have diphtheria and was removed to the hospital. The other members of the household had been pretty thoroughly exposed to infection, and it was, therefore, deemed advisable to give them all prophylactic doses of antitoxin. Consequently 500 units were administered to a second servant, also to the mother and sister of the patient. The latter, a girl of seventeen, was at high school, and it was arranged that she should call at the writer's office on her way home, which she did. Casual examination showed her to be well-developed and nourished, but of a pasty complexion. As in the case of the others, 500 units of state antitoxin, with the usual aseptic precautions, were injected deep into the deltoid muscle. Following this procedure, the nose and throat were explored to find a possible

cause for a sort of chronic coryza. The nasal passages were found to be unobstructed, and the mucous membrane practically normal. There were some adenoids and very slightly enlarged tonsils. After this examination the patient sneezed a number of times, but otherwise felt all right and seemed not at all nervous or disturbed. She left the office with her sister, to whom she complained immediately on reaching the sidewalk of a "stinging all over." They at once turned back to consult the writer. The patient grew rapidly weaker, collapsed on the steps, was at once carried in and laid on the floor. Already she was completely unconscious, cyanotic and pulseless; breathing was difficult, and froth and serous fluid ran from the nose and mouth. There were no convulsive movements. The body was limp; the face looked swollen; the corneal reflex was absent. In spite of artificial respiration, rhythmic traction of the tongue, and hypodermics of strychnia, death rapidly ensued. Less than fifteen minutes had elapsed from the time the antitoxin was injected until the patient was dead.

The autopsy (performed by medical examiner Dr. W. H. Watters) showed a persistent thymus gland, weighing approximately 25 gm., and its left lobe extending to about the level of the third cartilage; numerous enlarged lymph nodes in the mesentery, swollen Peyer's patches, an enlarged spleen and small adenoids. The heart was normal. The lungs were negative and showed very little edema. The kidneys and other organs appeared normal. The anatomical diagnosis was, therefore, *status lymphaticus*.

On inquiring further into the history of the case, the following facts were elicited: The father died of valvular heart disease. The mother is living and robust, but suffers from hay fever and chronic rhinitis (no untoward results followed her dose of antitoxin). The only sister is healthy. The patient had had measles and scarlet fever. For several years (although not lately) she had suffered off and on from attacks of asthma ("thymic asthma"?). For this condition she was treated by a physician, who found at that time a very slight but persistent trace of albumen and a leucocytosis. He advised removal of adenoids and tonsils, but operation was refused (perhaps fortunately!). It was said that laughing often brought on a wheezing attack. For some time past she was troubled by a slight chronic watery rhinitis (vasomotor?). She was always pale, although the Tallquist test a few months ago showed 100% hemoglobin.

Reports of Societies.

BOSTON MEDICAL LIBRARY IN CONJUNCTION WITH THE SUFFOLK DISTRICT MEDICAL SOCIETY.

MEETING OF JAN. 18, 1911.

DR. WM. J. MAYO, of Rochester, Minn., read a paper on

SOME OBSERVATIONS ON THE DISORDERS OF THE STOMACH AND DUODENUM, WITH ESPECIAL REFERENCE TO ULCERS.¹

DISCUSSION.

DR. F. C. SHATTUCK: In the first place, I wish to express the obligation every physician must feel to modern surgery, which, among many lessons, has taught him much with regard to the pathology, symptomatology and treatment of peptic ulcers. Among

¹ See JOURNAL, p. 477.