carefully borne in mind that any injection or other treatment is only an adjunct, and that the general hygiene, open-air, climatic and tonic treatment, systematic rest, and good feeding should be always strictly enforced.

Davos-Platz.

Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

VACCINE TREATMENT OF ACUTE PNEUMOCOCCAL TONSILLITIS.

By S. P. SHIVDAS, L.M. & S.,

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A PATIENT, aged 37, was seen on March 18th, 1912, suffering from a severe inflammation of the right tonsil, the result of an injury caused by the breaking of a silver tongue-scraper in the mouth about eight days previously. The microbic infection was probably conveyed from this abrasion. The patient had some swelling and pain in the right side of his throat, with a rise of temperature to 100° F. On the next day it increased in severity with rigors, the temperature being 100·2° at mid-day and 101·6° in the evening. Pain was radiating in the right temple, eye, and ear; swallowing was difficult. On the third day the temperature rose to 102·2° in the morning and 102·6° in the evening, with great restlessness, pain, and inability to take even liquid nourishment. The swelling had considerably increased, with severe throbbing pain. The left side of the throat was unaffected. On the morning of the 21st, the fourth day, the patient got worse. The temperature was 103° and the pulse 140. Pain in the temple, ear, eye, and throat was intense, with great thirst and exhaustion. The slightest attempt to gulp down even liquids caused the most agonising suffering. In the evening the temperature rose to 103·8°. On the 22nd, the fifth day, his condition was extremely grave; the pulse was very small, with considerable exhaustion. The temperature in the morning was 103·8° and in the evening 104·2°. On account of great suffering the patient fainted twice on this day.

During these four days various remedies were tried, such as blisters, gargles, sprays, mixtures, hypodermic medication, and ice-bags, without any relief. Finally, vaccine treatment was decided upon. The surface of the affected tonsil and the surrounding parts having been cleared of the viscid secretion by a spray of a solution containing sodium and potassium citrates and chlorides, material was obtained for cultures by a platinum loop from the abraded surface of the tonsil and it was implanted on blood agar. Smears were also made for direct examination under the microscope. The smears showed epithelial cells in which were embedded a number of lanceolate, Gram-positive, capsulated diplococci with a few short bacilli and scattered leucocytes. Cultures after 24 hours showed a number of pure colonies of pneumococci and a very few of Hoffmann's bacilli.

Immediately after the examination of the smears a dose of 12 millions pneumococcus stock vaccine was administered at 10 A.M. on the 22nd, which was followed by a reaction for 10 hours with aggravation of the signs and symptoms. After this the pain in the eye, temple, and throat decreased. The temperature steadily lowered to 99·4° and the pulse to 100. On the morning of the 23rd the swelling had much decreased and the patient was easier. At this time a teaspoonful of Brand's essence of meat was taken with but little difficulty after four days of complete starvation. In the evening a return of symptoms was noted with rigors and a rise of temperature to 101° and pulse 120. The patient was somewhat restless.

On the morning of the 24th his temperature was 101·2°. His auto-pneumococcus vaccine being ready a dose of 15 millions was given at 9 A.M. A slight reaction occurred for four hours, after which there was a decided change for the better. The temperature gradually came down to 99° in the evening and the pulse was 85. There was very little pain in the throat and none in the temple, eye, or ear. A little liquid nourishment was taken without any pain. The swelling in the throat had greatly diminished,

and the patient was able to speak a few words audibly after four days. He felt very well on the 25th and had a good night's rest, but sweated profusely between 1 and 3 A.M. On the morning of the 26th he was almost all right and made a fair breakfast of porridge, bread and butter, without any difficulty in swallowing. The swelling had entirely disappeared, and there has been no return of symptoms since.

During this illness the patient had lost 10 lb. in weight. Except only two doses, one of stock and the other of auto-genous vaccine, no other measures were employed during the course of vaccine treatment.

Bombay.

AN UNUSUAL PNEUMOCOCCAL INFECTION.

By LACEY BATHURST, M.B., B.S. LOND., M.R.C.S. ENG.,
L.R.C.P. LOND.

THE following case presents features which make it worthy of being recorded.

On April 6th a woman, aged 47, fell from a low stool in her own home, striking her left side on the stool. She did not appear to be seriously hurt, and did not seek medical advice till some seven hours later, when she presented herself at my surgery. A careful examination revealed no signs of any serious injury. The urine was normal, there had been no expectoration, there were no visible signs of bruising, and there was no shock. I advised her to rest as much as possible for the next few days, and ordered a belladonna plaster as a placebo. I did not see her again until twelve days later, when she sent for me on account of severe skin irritation caused by the plaster. She complained of headache, and had vomited, but temperature and pulse were normal, and she was about again apparently well in three days' time.

On April 26th I was again called to see her. Whilst going about her household duties she had had a severe rigor. She had severe pain in the left chest, painful cough, and was bringing up considerable quantities of typical rusty sputum, accompanied by blood. The temperature was 103° F. and the pulse-rate 136. Crepitant sounds and harsh breathing were to be heard over the whole of the left axillary region and the whole of the lower half of the left side of the chest behind. Within the next 24 hours typical bronchial breathing developed over the whole of this area. After the rigor had occurred the first urine voided contained blood, and every subsequent specimen became darker and darker in colour. On examination it was found to contain a considerable amount of blood and a large amount of albumin and tube casts. The patient rapidly sank, and died on the fourth day of the pneumonia.

A specimen of the urine was submitted to a pathologist (Mr. W. Gough, of Leeds), who reported that in films numerous capsuled diplococci having all the characters of pneumococci were found. In culture the same organism was found, but was overgrown by coliform bacilli. This leaves very little doubt that there was a simultaneous infection of the lung and kidney by the pneumococcus, and so far as I can find by reference to the authorities the condition is one of extreme rarity.

The history of recent accident (three weeks previously) is interesting, and might raise in certain cases the medico-legal question as to whether it could be considered a predisposing cause or a contributory cause of death.

Leeds.

PRESENTATION TO A MEDICAL PRACTITIONER.—

Mr. Samuel Macvie, M.B., C.M. Edin., J.P., was on Oct. 11th presented with a solid silver loving cup and a purse containing 160 sovereigns by his friends and the inhabitants of Chirnside in honour of his appointment as a justice of the peace and as an appreciation of esteem and regard. The inscription on the cup was as follows: "1876-1912. Presented to Dr. Samuel Macvie, J.P., along with a purse of 160 sovereigns, as a public recognition of the faithful performance of his professional duties, and in warm appreciation of his service to the community for the last 36 years. Chirnside, October, 1912." In addition to the presentation a mask was performed in honour of Dr. Macvie, the three goddesses of Healing, Music, and Art claiming him as their subject and follower.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

MEDICAL SECTION.

Rupture of an Aneurysm of the Aorta into the Right Auricle.

A MEETING of this section was held on Oct. 22nd, Dr. FREDERICK TAYLOR, the President, being in the chair.

Sir JOHN BROADBENT described a case of Aneurysm of the Aorta which ruptured into the right auricle. The patient was a man, aged 40, who shortly after being crushed between the buffers of two railway trucks became very short of breath and developed œdema of the lower extremities and abdominal wall. The physical signs in the heart and pulse were those of aortic regurgitation, and traumatic rupture of the aortic valve was diagnosed. Repeated effusion into the right pleural cavity took place, requiring tapping every two or three days, no less than 42½ pints being withdrawn from the right pleural cavity in the space of a month. The man survived about four months from the date of the accident and onset of symptoms. At the necropsy there was a small aneurysm about half an inch in size immediately above the right posterior cusp of the aortic valve, which opened by a small slit into the right auricle. It appeared that during systole of the heart this communication between the aneurysm and right auricle would be occluded by the aortic valve as it was floated up, but would be fully open when the aortic valves were closed, so that blood would flow from the aorta into the right auricle during diastole. Sir John Broadbent referred to a collection of 43 cases made by Peacock of communications between the sac of an aortic aneurysm and adjoining great vessels or cavities of the heart, and also to a paper by Pepper and Griffiths on Varicose Aneurysms of the Aorta in which 25 cases of aneurysm rupturing into the superior vena cava were described. He contrasted the symptoms of rupture of aneurysm into the pulmonary artery with those of rupture into the superior cava, the former being mainly those of pulmonary engorgement, the latter those of obstruction of return of blood from the superior vena cava. He pointed out that in rupture of an aneurysm into the right auricle symptoms intermediate between the two might be expected, and in the few cases on record this appeared to be the case. In the instance he brought before the society the symptoms of obstruction to venous return were entirely absent, presumably because the aortic valve during systole of the ventricle also acted as a valve, occluding the communication between the aneurysm and right auricle.

Dr. F. PARKES WEBER said that, in spite of the history of traumatism in the case, there might have been syphilis, as there so frequently was in aneurysm, and, if so, that would account for the pleurisy and chronic effusion. Nowadays one would apply the Wassermann reaction to such a case, but, unfortunately, the fluid of pleuritic effusion gave a positive reaction when there was no evidence of syphilis, so that it was necessary to test the blood also.

The PRESIDENT referred to a paper on a kindred subject which he had published in the *Guy's Hospital Gazette* in 1884—namely, on aneurysm communicating with the pulmonary artery. Investigation of a number of cases showed that the cause of the murmur might be different in different cases. In his own cases of rupture into the pulmonary artery the murmur was not constant in time. Sometimes there was a systolic murmur, sometimes a double murmur, sometimes a quasi-double murmur. The occurrence of pleurisy, as in Sir John Broadbent's case, was exceptional. There were numerous cases of mitral disease in which the first symptoms were referable to congestion of the inferior vena cava, and not to the pulmonary circulation.

SECTION OF OBSTETRICS AND GYNÆCOLOGY.

A Case of Hæmatocolpos.—Gelatinous Glandular Cysts of the Ovary and the so-called Pseudomyxoma of the Peritoneum.

A MEETING of this section was held on Oct. 10th, Dr. AMAND ROUTH, the President, being in the chair.

Mr. R. DRUMMOND MAXWELL read a paper on a case of Hæmatocolpos with remarks on the Structure of the Vaginal Wall. The patient, aged 19, had been married a few

months, and came to the hospital complaining of dyspareunia. There was no abdominal swelling and the external genitalia were normal; the introitus vaginæ was closed by a thick, fleshy septum, and when pressure was applied to the hypogastrium this septum did not bulge at all. Rectal examination showed the presence of a large, tense, cystic, intrapelvic swelling, the lower pole of which appeared to be about 1½ inches above the septum; it was of about the size of the uterus at the twelfth week of gestation. The physical signs suggested a hæmatometra rather than a hæmatocolpos, and it was in consequence expected that some disorganisation of the tubes would have occurred. Laparotomy was, therefore, performed, but the uterus and appendages were found to be perfectly normal. The supravaginal cervix was slightly dilated and disappeared into the tense, cystic mass. The abdomen was at once closed, as it was recognised that the condition was retention in the upper two-thirds of the vagina, the lower third not being canalised. Guided by two fingers in the rectum, an incision was made with scissors closely following the floor of the urethra, into which a sound was inserted. After blunt dissection upwards for about 1½ inches the lower pole of the swelling was reached. Before opening this it was freed from the paravaginal cellular tissue to enable a tube of it to be drawn down and stitched to the introitus. A little more than a pint of unusually thick tarry fluid was evacuated, and the circular edge of the tube was drawn down so as to project beyond the vulva. A thin strip of tissue was removed from both the anterior and posterior vaginal walls for microscopical examination. The hymeneal tissue showed the typical appearances described by Blair Bell. The vaginal wall was covered by epithelium, consisting partly of stratified cells and partly of high columnar richly muciniferous cells. In some places the columnar cells were superimposed on several layers of stratified epithelium; in other places the columnar cells were being shed so as to allow the stratified epithelium to appear. This appeared to negative the view that the stratified epithelium spread upwards from below and replaced the columnar cells, but suggested that the Malpighian layer of the skin first produced columnar muciniferous cells, and later a stratified layer. Mr. Maxwell suggested that the initial function of the columnar layer was to canalise the vagina by pressure from its mucin secretion. Several pseudo-glandular crypts, lined by columnar cells, and a few definite racemose glandular spaces were also found.

The paper was discussed by Dr. H. RUSSELL ANDREWS, Dr. H. R. SPENCER, Dr. T. G. STEVENS, Dr. T. W. EDEN, Dr. W. S. A. GRIFFITH, and the PRESIDENT.

Mr. THOMAS WILSON read a paper on Gelatinous Glandular Cysts of the Ovary, and the So-called Pseudomyxoma of the Peritoneum. He said that certain glandular proliferating cysts of the ovary were made up of solid jelly-like material in a multitude of small loculi with delicate transparent walls, which were prone to rupture and allow a free escape of the gelatinous contents into the peritoneal cavity. Here the gelatinous substance adhered closely to the parietal and visceral peritoneum, and even found its way on to the upper surface of the liver, spleen, and stomach; the omentum usually formed a very thick, hard plate. Such cases were formerly known as colloid cancer of the peritoneum or ovary, and might be conveniently termed pseudomyxoma of the peritoneum; they probably formed from 2 to 4 per cent. of the cases of ovarian glandular cysts. Firm gelatinous cysts of the ovary that had not ruptured were also met with; but these were found usually in single and nulliparous women under 40, while true pseudomyxoma was found most frequently in married multiparæ between the ages of 40 and 60. The onset, symptoms, and physical signs of pseudomyxoma of the peritoneum did not differ notably from those of the ordinary glandular ovarian cyst, and in none of the six cases here related was there any symptom or sign of previous perforation or rupture of the cyst wall; neither was the peculiar nature of the ovarian affection suspected in any of them until the abdominal incision was made. The affection of the ovary was unilateral, the pedicle usually well formed, and the Fallopian tube and mesovarium generally unaffected. The gelatinous substance contained pseudo-mucin; the cysts were lined by a single layer of typical secreting epithelium. The parietal and visceral peritoneum in contact with the effused jelly might be unchanged, but usually showed signs of chronic irritation due to attempts to absorb