

only *drug* used was iron. For the rest I insisted upon forced feeding, graduated exercises done in class work, and moderate bicycling, which she had formerly enjoyed.

For a long time it was terribly discouraging for both of us. She returned at intervals, and always with the story that she was worse. In addition, she complained that her stomach had gone back on her and that she had a constant "bad feeling" extending from the left hypochondrium to the umbilicus. To account for this she expressed the fear that there were probably finger-nails in her stomach—she was an inveterate nail-biter—which she had swallowed; she had heard of a girl dying from such a cause.

I insisted that the prescribed treatment should be rigidly adhered to in every particular, and within three months she gained sixteen pounds. I then began to use suggestion without hypnosis, going, however, through the manoeuvres which are ordinarily employed to produce the first stage of the latter. This was done, at first, as often as three times a week. My only success was in substituting a different—though no more desirable—mental condition. Everything began to seem strange to her. As she herself said: "It seems queer to think of living; of having definite work to accomplish; to hear people planning to do things at some future time." The most commonplace acts of life assumed a character hitherto undreamed of by her, and she grew so discouraged at her condition and her impotency to rid herself of her horrid incubus that she threatened on two occasions to drown herself.

I continued my pseudohypnotic séances and set her definite tasks—such as memorizing passages from prose and poetic works, which was not congenial and consequently required considerable mental concentration—to do in the interim between visits. I also used the static breeze to the head, but merely to aid the suggestive measures. I never allowed her to abandon her work for even a day at a time and was finally rewarded—after many relapses—with what may practically be termed a complete cure. She now does not care to have the old fears or the queer thoughts mentioned at all. If they are spoken of, she changes color and turns the conversation into other channels.

## COLOSTOMY FOR OBSTRUCTION DUE TO MALIGNANT DISEASE.

BY J. B. BLAKE, M.D., BOSTON.

THE abdominal viscera from a case of extensive malignant disease were recently shown at the Surgical Section. The case seemed of sufficient interest to warrant a description. The patient was an Italian woman, age fifty. She had irregular and profuse menstruation until four months before entrance. Since then flowing had ceased, but the abdomen had increased steadily in size. In bed five weeks before coming to hospital. During this period her bowels moved only six times. She entered March 26, 1900. She was poorly nourished and cachectic. No nodules in breast, but some in left supraclavicular region. Abdomen considerably distended and tympanitic, except in right iliac region. Intestinal peristalsis visible. Uterus fixed in pelvis, and an ulcerated crater replaced the os. Rectal examination showed anteriorly a hard,

nodular, immovable tumor mass. Enemata gave but little results. No radical operation was advisable.

*Operation.*—A left inguinal colostomy was advised and accepted. After opening the abdomen in the usual position it was impossible to find either the sigmoid flexure or the lower descending colon. After some trouble the splenic flexure was found and brought into the wound, and opened seven hours later. A small amount of feces escaped, and the patient was relieved for a few hours only. She died four days later.

*Autopsy.*—Nothing of importance in head. Peritoneal cavity: Small intestines and stomach greatly distended; adjacent coils bound together by an almost black, sticky, mucoid-like material. Portion of intestine forming the borders of the surfaces in juxtaposition injected. No free fluid in peritoneum. Surface of intestine pale except the lines of injection along the contiguous surfaces. In splenic flexure is an opening 5 centimetres in size, edges swollen, reddened; surrounding mucosa dark. There is an adjacent pedunculated mass of fat, deep red, moist. Descending colon passes directly backward from splenic flexure for a distance of 12 centimetres. In the remainder of its course it is firmly bound down to the posterior wall of the abdomen. The pelvis is filled with a dense, firm mass; the anterior portion of the superior surface being formed by the wall of the bladder, which is covered with hard, irregular, grayish-white, opaque nodules 1 centimetre and more in size. A coil of small intestine is firmly bound down to this pelvic mass, and the sigmoid flexure is lost in it. Anatomical landmarks are completely obliterated in the pelvis. In the right posterior portion is a small, thin-walled cyst resembling in appearance a simple ovarian cyst, but no other evidence of the tubes or ovaries or of the outlines of the uterus can be discerned. The lumen of the loop of small intestine appears constricted, although its distal as well as its proximal end of the U-shaped figure is dilated. The cecum is bound down to the pelvic mass and the lumen of the ileum near the ileocecal valve appears occluded. The intestine here is bound down posteriorly and is apparently converted into a large cord. Beyond this point the intestine is collapsed. No trace of appendix is found. It is evidently buried in the mass of fibrous tissue about the cecum. Here and there over the serosa of the intestine and mesentery are firm, granular appearing, whitish nodules, .5 centimetre to 1 centimetre in size. Only three or four of these bodies were found. Similar nodular masses bound the sigmoid flexure to the pelvic wall. Gall-bladder distended; united to hepatic flexure by fibrous bands. Diaphragm fifth interspace left side; fourth space right side. In the upper part of the anterior mediastinum the tissue is indurated and a small dense area found, which on section shows a fibrous structure beset with white opaque spots, giving it a rough, granular appearance.

*Anatomical diagnosis.*—Cancer of bladder and vagina with direct extension into pelvic organs. Metastases in retroperitoneal, bronchial and mediastinal lymph nodes. Stricture of ureters; hydronephrosis of right kidney; obstruction of intestine at ileocecal valve; edema of lungs; chronic fibrous peritonitis; chronic fibrous pleurisy.

The case offers two points of interest: (1) The remarkable extent of the growth and the rapidity of its development; (2) an unusual complication in the

comparatively simple operation of inguinal colostomy. The distended small intestine bulged into the wound and was returned to the abdominal cavity with difficulty. The apparent absence of descending colon was very puzzling for some time and the presence of the omentum at the splenic flexure made it more difficult to bring the intestine properly into the wound. The operation gave no permanent relief, because the small intestine was occluded at the ileocecal valve. In palliative operations, therefore, for the relief of more or less complete intestinal obstruction due to intra-abdominal malignant growths, it is well to bear in mind that the right as well as the left inguinal region may be the seat of the stricture; and it is possible that in these cases a median incision and an exploratory operation, as a preliminary, would be advisable. If the condition of the case demanded, an artificial anus might be made at this opening. There was no indication of the hydronephrosis before death.

## Reports of Societies.

### AMERICAN DERMATOLOGICAL ASSOCIATION.

TWENTY-FOURTH ANNUAL MEETING, HELD IN WASHINGTON, D. C., MAY, 1, 2 AND 3, 1900.

FIRST DAY.—MORNING SESSION.

THE President, DR. HENRY W. STELWAGON, of Philadelphia, read the

#### ANNUAL ADDRESS.

Our ultimate aim, he said, is the diminution of suffering and the cure of disease. It is well to remember that this end is not attained by the clinician alone, nor by the therapist alone, nor by the pathologist, nor by the bacteriologist, but by these investigators going hand in hand, each having an important and necessary share in the final result. Bacteriology especially must be persistently cultivated. At the same time, the hereditary receptivity, the family vulnerability, the environment, and the state of the general health, are factors of moment in many cases, and their removal or modification by hygienic and constitutional treatment will often render the microbic invasion less calamitous, and be of aid in removing the disease.

The reader referred to the teaching of dermatology in the medical colleges, and the increased importance attached thereto and the great advances therein. He spoke of leprosy as a disease which must as yet be considered from the standpoint of prevention, and the necessity that the matter should be handled by the national authorities.

#### BULLOUS DERMATITIS (DERMATITIS HERPETIFORMIS) IN CHILDREN.

DR. J. T. BOWEN, of Boston, detailed 5 cases following vaccination and exhibited photographs. He referred to the ease and frequency with which the laity ascribe any succeeding ill to vaccination. Of these 5 cases, in 3 the eruption appeared within two weeks after vaccination, in 1 within a week, while in another it did not show itself until after the lapse of a month. In 4 of the cases there appeared to be ground for the assumption that the vaccination in

some way influenced the appearance of the eruption. In attempting to classify the cases, certain characteristics that have not been emphasized as usual features of dermatitis herpetiformis force themselves upon our notice. The localization of the lesions was striking, as there was a marked tendency to grouping about the mouth, chin, nose and ears, and upon the backs of the hands and feet. Besides this, the extensor aspects of the extremities were in general more prominently affected. In all the cases the trunk was affected but slightly as compared with the other regions of the body. The itching was not very pronounced. In the present state of our knowledge of the bullous dermatoses it is wise to go slowly and imprudent to draw deductions from any but a large number of carefully reported cases.

DR. GEORGE T. JACKSON, of New York, read a paper on

#### LOSS OF HAIR.

This was a study of 300 private cases. Elaborate statistical tables were presented. His conclusions were as follows: Loss of hair is far more frequent among men than among women. Neither the unmarried nor the married state exerts any influence on the hair. Intellectual occupations and worry and strain are predisposing causes. Sixty-six per cent. of the cases begin before thirty years of age. In women general thinning of the hair is the most common form, while the receding forehead is uncommon. In men the whole top of the head is most often affected, and the receding temple is common. The great predisposing cause of loss of hair is heredity. Most of the women who lose their hair show a well-marked history on the maternal side; the men show it on the paternal side. All disorders of the general nutrition of the body are predisposing causes. The greatest exciting cause is dandruff, a term used to include seborrhea sicca, pityriasis, seborrheal eczema or dermatitis. As to treatment, the best drugs are sulphur, resorcin and the mercurials. The only stimulant worth mentioning is massage, and this should not be employed until the dandruff is checked.

The paper was generally discussed by Dr. A. Ravogli, Dr. Isadore Dyer, Dr. J. N. Hyde, Dr. Joseph Zeisler, Dr. T. C. Gilchrist, Dr. Wm. A. Hardaway, Dr. Samuel Sherwell, Dr. Joseph Grindon, Dr. Henry W. Stelwagon, and Dr. George Thomas Jackson.

#### AN UNUSUAL PHENOMENON OF SYPHILIS: OTHEMATOMA.

DR. JOSEPH ZEISLER, of Chicago, read this paper. Othematoma consists in a rather suddenly appearing effusion of blood between the cartilage of the auricle and the perichondrium, separating this latter from the former. It is situated on the upper half of the anterior aspect of the organ, and the swelling is considerable. The chief occurrence of othematoma after traumatism is well established. The writer carefully searched the authorities as to the possible connection of othematoma with syphilis, and the only reference he could find to it was by Bouvier, in 1889.<sup>1</sup> Dr. Zeisler's attention was called to this possibility by the following case: Dr. X, about forty years old, had a small wart-like lesion on his right thumb, which was removed by excision and cauterization with nitric acid.

<sup>1</sup> Archive for Dermatology and Syphilis, vol. xx, 1890.