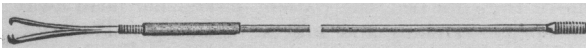


inspection. The central shaft is screwed into the handle so that it can be adjusted to open in any direction, and as the blades are closed by pushing the barrel on to them, not by pulling them into the barrel, they do not draw away from the object to be seized, at the moment of grasping. I have with this instrument by lower bronchoscopy removed a prune stone firmly impacted in the right bronchus.

COTTON CARRIER.

In the esophagus the detachment from the carrier of the cotton used in sponging is of no great importance, but in a bronchus it might be very serious. I have seen the cotton come out of Killian's carrier, in which the blades are held together by a ring pushed down upon them. In order to lock the cotton securely I have had made



instead of the ring, which is pushed down to shut the blades, a section of tube two inches long. On the shaft of the carrier, about two inches from the end, is a collar, cut with a screw thread. The lower part of the barrel being of a larger caliber slides over the collar, but the upper part engages in the screw. The carrier is firmly locked upon the cotton by a half-dozen to a dozen revolutions of the barrel, screwing it downwards upon the blades.

Both of these instruments were made by Codman & Shurtleff, Boston.

Clinical Department.

CARCINOMA OF THE FALLOPIAN TUBES.

BY C. H. HARE, M.D., BOSTON,

Gynecologist to Boston Dispensary and to Woman's Charity Club Hospital and to Out-Patients at Carney Hospital and St. Elizabeth's Hospital.

THE writer's part in this case is short and very ordinary. The entire interest is in Dr. Leary's pathological report and his review of the literature.

Mrs. 3321 entered St. Elizabeth's Hospital in April, 1904. Age twenty-nine; married four years. The family history including four sisters was negative. Menstruation began at fourteen and had always been regular every four weeks save an amenorrhea of eight or nine months when she came from Ireland to America at the age of sixteen. So far as she could remember she had always flowed two or three days using five or six napkins, then stopping two or three days and then again flowing from three to seven days using two or three napkins daily. Dysmenorrhea was bad from the first menstruation and had kept her in bed a day or two when convenient, but for a year there had been no dysmenorrhea. Never had any leucorrhea, never any bloody staining between catamenia; micturition four or five times by day and for six or eight months once or twice by night. Never had dysuria. Constipated. No pain anywhere at present, though about three years ago she was treated in the City Hospital Out-Patient for pain in the right iliac region at which time operation was advised but refused. Weight, 145 pounds and unchanged. Sterility was her only complaint and for this alone she entered the hospital.

This history seems of necessity incomplete, yet it

was not the hasty story of an unknown case, but all that the writer could obtain by much questioning after he knew the pathological diagnosis.

The urine, heart and lungs were normal, and the writer first operated April 14, 1904, supposing it to be the ordinary case of chronic tubes and retroversion. The uterine canal was three inches deep. Curetting yielded a scant amount of curettings, but an unusual bleeding. On opening the abdomen there were solid adhesions everywhere. The omentum was adherent to the bladder, to the anterior abdominal wall in the right lower quadrant and to everything under it in this region and torn pieces were removed. Tubes, ovaries, uterus, intestines, cecum and appendix were matted to whatever each touched in the pelvis, but were freed by good luck without tearing intestine. The left ovary was fair after pricking a few cysts and was not removed. The right ovary was enlarged by small cysts to three times normal size and was resected, leaving a small piece; each tube was thumb size at the fimbriated ends, but the balance, pencil size and hard, and both were removed entire by taking a wedge-shaped piece out of the uterine cornu. A small appendix buried with adhesion was removed. Ventral suspension was done. She was filled with salt solution with the hope of lessening pelvic adhesions and closed in layers. Iodized catgut was used for all the work, save kangaroo for the suspension and abdominal fascia and silkworm gut for the skin, which were removed on the tenth day. She had an unusually easy convalescence, the temperature never being recorded above 100° and pulse never over 90 after leaving the operating room.

The pathological report, Primary Carcinoma of the Fallopian Tube¹ by Dr. Leary was a total surprise to me. The writer did the second celiotomy April 29, or fifteen days after the first, going through the same abdominal incision. The fundus was solidly attached to the abdominal wall. Adhesions were solid everywhere and between everything touching. The general oozing was most troublesome. Uterus, ovaries and a piece of the omentum were removed. Three slight tears of the intestine were all seen when made and at once closed. The vaginal vault was closed and she was then filled with salt solution and the abdominal wall closed in layers without drainage. Iodized catgut was used for all work, save kangaroo in the fascia and silkworm gut in the skin, which were removed on the eighth day. The operation seemed well borne, but moderate shock followed. Convalescence was normal. Pulse was never above 90 after the fourth day. She sat up on the eighteenth day and went home May 24, apparently perfectly well and without complaints.

The patient was examined to-day and nothing abnormal found. Since September she has done her home work except the washing. She has gained four pounds in the last two months. She has had four or five attacks of rectal pain lasting twelve to twenty-four hours. An occasional pain in the right iliac region. These occurred when especially constipated and are her only complaints.

A CASE OF FOREIGN BODY IN THE LARYNX; REMOVAL; RECOVERY.

BY THOS. T. PERKINS, M.D., CLIFTONDALE, MASS.

ON the morning of Jan. 21, 1904, I examined a patient's throat, who sent word that she had swallowed a fish bone or tack while eating bread, and that she had suffered severe pain in her throat since.

¹ The full pathological report will be published by Dr. Leary.

The patient was a strong, well-developed washer-woman, forty-seven years of age. She was lying on a lounge apparently suffering severe pain. She gave the following history: On the preceding Monday, Jan. 18, she bought a loaf of baker's bread and later while eating some of it felt a sharp prick in her throat which developed into a severe pain when she tried to swallow. This pain became a constant, dull ache, in a few hours. On the following day, Tuesday, one of the city physicians sent her to the Lynn Hospital for treatment. The house officers examined her throat for a foreign body, presumably a pin or tack, but failed to find anything pathological there. They gave her a drink of water which seemed to relieve her completely for the time being, and told her to come back Friday if she had any further trouble in swallowing. As soon as she got home, the pricking pain recurred and kept growing worse. She felt chilly and sick all day Wednesday and Thursday.

When I saw her Friday morning she complained of feeling chilly, and had been unable to sleep for three days and nights on account of pain. She could swallow no solid food and had been obliged to live on small amounts of raw egg and milk. Whenever she attempted to swallow, the pain became excruciating. She said "her throat felt as though she had a thorn in it that pricked her severely."

External examination showed no swelling of the throat. Palpation revealed a tender spot on the left side of the neck, opposite the upper border of the cricoid cartilage. She complained of moderate tenderness over the entire cartilage, in fact. On internal examination, with poor illumination aided by head and laryngeal mirrors, I could find no foreign body in the mouth, tonsils, supratonsillar fossæ, nor at the base of the tongue in the glosso-epiglottic fossæ. Nor could anything be found in the region behind the posterior pillars of the fauces, nor in the oro-pharynx. Examination of the larynx, with the head tilted well back, revealed a foreign body sticking straight up from the left ventricular band, directly behind the cartilage of Wrisberg. It was white in color and not more than one-eighth of an inch of it was visible above the ventricular band. What appeared to be the blunt end of a fish bone was sharply outlined against the pink, swollen mucous membrane that covered the arytenoid cartilages.

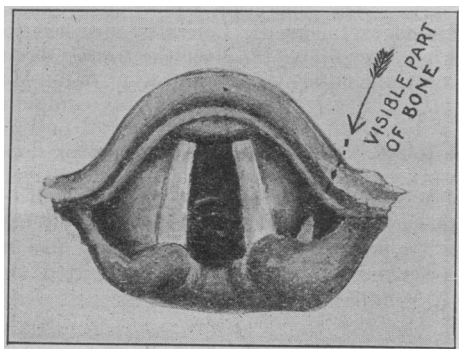


FIG. 1.

The vocal cords were normal in color and their movements were unimpaired in adduction and abduction. The patient's voice was slightly husky. I was thoroughly satisfied that she needed immediate relief, but the difficulties to be overcome where she was were too great. It was impossible to relieve her without good illumination, cocaine and proper throat forceps.

Later at my office, her throat was first thoroughly

anesthetized with a 2% solution of cocaine; then sprayed with an adrenalin chloride solution, strength 1-1000. By use of a twenty-six candle power incandescent light an attempt was then made to remove the foreign body by aid of McKenzie throat forceps.

The bone was seized and an attempt was made to lift it out of its position, but it was so firmly imbedded it refused to yield, and the whole larynx was lifted with the bone up toward the base of the tongue. Three or four subsequent attempts gave the same result; then as there was slight bleeding, it became necessary to spray the larynx with adrenalin and anesthetize again with cocaine. Several following attempts merely succeeded in raising the bone a short distance and in loosening it a little in its bed, where it seemed lodged almost as firmly as ever. The final successful effort came after the patient had had a few minutes' rest. Forceps were introduced and the bone was lifted vigorously upwards. The moment the bone began to move from its bed, the patient jerked her head away and began retching and gagging violently. The bone, which had been freed, was knocked from the forceps,

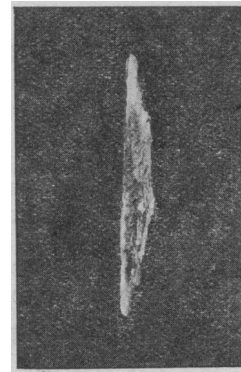


FIG. 2.

but rested fortunately with one end against the posterior surface of the epiglottis, the other on the free surface of the ventricular band. The operator then introduced his right forefinger into the patient's larynx and hooked out the bone.

The bone proved to be an irregular sliver, presumably from a beef bone, smooth on one side and corrugated on the other. It was a trifle over 1½ inches long and barely 1/8 of an inch wide at the broadest part.

The larynx was again sprayed with adrenalin to check slight hemorrhage following the extraction of the bone. The patient was then given an oil spray, told to live on liquid diet and sent to her home.

I saw her the next day. The pain in her throat had ceased and she was able to swallow without difficulty. The following day she came to my office and I had an opportunity to examine her larynx. The swelling had greatly subsided and the mucous membrane had assumed a nearly normal aspect. On external examination there was no longer any tenderness over the cricoid cartilage and her voice was unaffected. I did not have an opportunity to see her again, but learned from her sister that she made an uneventful recovery.

The important lesson this case teaches is that the only safe rule to follow, when a patient believes a foreign body has lodged in the throat, is to assume there is a foreign body there until the supposition has been disproved by a most

careful and painstaking search in every nook and corner of the mouth and throat.

It also illustrates the remarkable tolerance of the human larynx, when it has once become accustomed to the presence of a foreign body lodged within its tissues.

The baking of the bone in the loaf of bread probably rendered it sterile, thus accounting for the moderate amount of inflammatory reaction that had taken place in the ventricular band.

Medical Progress.

PROGRESS IN HYGIENE.

BY CHARLES HARRINGTON, M.D., BOSTON.
Assistant Professor of Hygiene Harvard Medical School; Secretary
Massachusetts State Board of Health.

THE PROTEID NEEDS OF THE BODY.

THE most important contribution made during the past year to the subject of nutrition is from the laboratory of Prof. R. H. Chittenden,¹ whose experiments, which extended over many months, show conclusively that the hitherto accepted requirement of 118 gm. of proteids daily is about twice what the body actually needs. The subjects of his experiments included men engaged in intellectual pursuits, soldiers of the United States army, and student athletes in training. Not only were they able to perform their regular work with the lessened allowance, but they performed it better and showed a marked gain in general excellence of condition. The diminished intake of proteid involved no compensatory increase in carbohydrates and fats; indeed, it appeared that the accepted standards for these components of the diet also are too high.

INTERCOMMUNICABILITY OF HUMAN AND BOVINE TUBERCULOSIS.

Among the large number of papers on the vexed question of reciprocal infectivity of the bacilli of human and bovine tuberculosis, the most noteworthy are the Interim Report of the Royal Commission and the findings of the German Tuberculosis Commission. The former concludes that the two diseases are identical, both in general features and in finer histological details. Seven of the twenty strains of human tuberculosis bacilli employed were found to be acutely infective for cattle, and in some instances the disease was of remarkable severity. Some of the less virulent strains gained greatly in virulence on reinoculation from one animal into another. The German commission tested thirty-nine cultures of human origin and found four that produced general tuberculosis in calves; but these were derived from children, and it was claimed that they must have been of bovine origin, the children having become infected through the milk of tuberculous cows. Thus, in attempting to explain the infectivity of human bacilli for the bovine species, it became necessary to admit the possibility of human infection from bovine sources.

From an experience with several thousand

cases of tuberculosis within the past few years, Raw² concludes that man is subject to two kinds of tuberculosis: the pulmonary form, rare in young children and due to bacilli of human origin; and other forms, as tubercular joints, tubercular meningitis, and abdominal tuberculosis, rare in adults and due to bacilli of bovine origin. Of nearly 300 cases of *tabes mesenterica* seen by him in twelve years, not one of the subjects was a breast-fed child.

According to Heller,³ Wagner found, in the course of 600 autopsies at Kiel, 76 cases of primary tuberculosis of the intestines and mesenteric glands, and Hof found, in 15,000, nearly 2,500 with primary tuberculosis of the digestive tract and no lesions in the lungs. He explains that, while in Berlin it is the rule that milk is boiled before use, in the country about Kiel it is commonly consumed without treatment.

IDENTITY OF MEAT POISONING AND PARATYPHOID.

In the course of a study of an outbreak of meat poisoning at Düsseldorf, Trautmann⁴ isolated a bacillus, which he compared with cultures of the organisms which were proved to have been the exciting causes of a number of extensive outbreaks in other parts of Germany, and also with various strains of paratyphoid bacilli. His observations led him to conclude that while they all offer slight differences in morphology and cultural peculiarities, they show no fundamental difference and are actually varieties of a single organism. It seems probable that the differences in the character, severity and order of appearance of symptoms in meat poisoning, other than botulism, and in paratyphoid depend upon the slight racial differences in the bacteria and upon the degree of virulence and individual susceptibility. Not a few outbreaks of meat poisoning have been indistinguishable from paratyphoid and some of severe form have been mistaken for true typhoid. The typical meat poisoning is believed by Trautmann to be the hyperacute, and paratyphoid to be the subacute, manifestation of an etiologically similar disturbance due to different varieties of an organism for which he proposes the name *Bacillus paratyphosus*.

THREE CASES OF BOTULISM, WITH RECOVERY.

Three interesting cases of botulism in which the symptoms were the same in kind, but different in degree, are reported by Pelzl.⁵ The persons affected were young vigorous men of about the same age. The first to present himself on February 13 had the usual symptoms — double vision, dryness of the mouth and fauces, dysphagia, difficult micturition and constipation. He could think of nothing suspicious that he had eaten, but two days later he recalled that on February 7, he and two companions had eaten a smoked home-made sausage weighing about a pound. He had felt a slight burning sensation in the stomach during the night, but felt perfectly well on the day following. On February 9, he had some pain in the stomach, but the appetite was