

"dyspepsia" and occasionally vomiting of food. Has never been jaundiced; has lately been nursing her husband, who has typhoid; has had pain in head, back and legs for nine days. The entrance temperature was 105°, pulse 120; Widal reaction positive and marked.

From this date the disease ran the usual course, the temperature reaching normal on April 18th. On May 1st had an abscess of the thigh which was opened and had healed in a few days.

On May 27th had severe pain in epigastrium and vomiting, and on the next day was deeply jaundiced. The temperature rose to 101°-102°, and on June 6th, as the symptoms continued severe, she was transferred to the surgical service and the abdomen was opened.

The gall-bladder was of moderate size, and on being opened was found filled with turbid bile and about thirty gall-stones. After the gall-bladder had been emptied two stones were found in the common duct which were removed by incision. The duct was not sutured. A glass tube was tied into the gall-bladder, which was packed about with gauze, which was also packed down to the incision in the duct.

During the operation considerable bile escaped into the abdominal cavity in spite of walling-off gauze. The abdomen was carefully washed and wiped out and the external incision partly closed.

The recovery was uneventful, the wound wholly closed and the patient discharged well July 19th.

Cultures from the gall-bladder at the time of operation gave a pure culture of typhoid bacillus.

Medical Progress.

RECENT PROGRESS IN THORACIC DISEASE.

BY GEORGE G. SEARS, M.D., AND JOHN W. BARTOL, M.D., BOSTON.

DIAPHRAGMATIC PLEURISY.

ZUELZER¹ calls attention to the slight notice that has been given in text-books and systems to the diagnosis of this affection occurring as an encapsulated empyema. Having seen two cases himself and studied the reported cases, he concludes that the one pathognomonic symptom is the presence of the "bouton diaphragmatique," or de Massy's point. This is a spot of extreme sensitiveness to pressure, situated at the intersection of lines drawn in prolongation of the tenth rib, and the left parasternal line. Other symptoms of less specific significance are: the presence of pleuritic pain, which is sharper and more widely distributed than in ordinary pleurisy, sensitiveness to palpation in the entire circumference of thorax at level of insertion of diaphragm, and also in the neck at the point where the phrenic nerve crosses the scalenus anticus, and at times pain radiating in the course of the intercostal nerves. Percussion over the base of the lung gives for perhaps a finger's breadth tympanitic resonance — auscultation is practically negative; in addition, ordinary signs of suppurative inflammation may or may not be prominent. Exploratory aspiration when negative is not conclusive, on account of the difficulty of reaching the location of the pus.

The cause of the sensitive points he is inclined to ascribe to pressure on the phrenic nerve, but does not commit himself thereto.

¹ Münch. med. Woch., November, 1898.

TYPHOID PLEURISY.

Achard² says that many cases of pleurisy which occur in typhoid patients are undoubtedly due to an accidental secondary infection, but others, which are perhaps the more numerous and are certainly the more interesting, are the result of a local action of Eberth's bacillus. The pleura, as has been shown by a case of Fernet, may even appear to have been the initial seat of the infection, the typical typhoidal symptoms not appearing till later. Such cases are comparable to those of typhoid-pneumonia in which the first clinical manifestation is shown in the lungs. In two such cases, one reported by Bruhl and the other by himself, the bacillus of Eberth was demonstrated during life in the hepatized area. More frequently pleurisy appears as a later complication, and two such cases are reported by the author which show that the typhoid germ is capable of producing a sero-fibrinous, a hemorrhagic or a purulent effusion. The first was a man twenty-six years old, with undoubted typhoid symptoms, who at the end of about a week developed a slight effusion at the left base. An exploratory aspiration showed the presence of a slightly turbid fluid, which, microscopically, contained red globules and a considerable number of leucocytes. During the following eight days he was aspirated twice more, the fluid showing the same characteristics except that it had become somewhat sanguinolent. About four weeks later a fourth puncture was made and the effusion found to be clearer, with but few formed elements. It was also sterile, while that withdrawn in the first three instances gave a pure culture of Eberth's bacillus. An injection of twenty cubic centimetres of the exudate into a guinea-pig failed to produce tuberculosis, thus ruling out all other causes for the pleural inflammation.

The second case was a girl of twenty, who had already been ill three weeks before she came under observation. She developed a pleural effusion in the left base which on the first aspiration was found to be very bloody. A second puncture withdrew a cloudy, chocolate-colored liquid containing many pus cells and a few bacilli, which in culture proved to be exclusively those of Eberth. On a third attempt greenish pus was obtained. Later the pleural cavity was drained and complete recovery followed. Observations like the latter are still quite rare, and it is impossible to say whether an empyema of typhoid origin has a distinctive character; but it is to be noted that the process was much less acute than in most cases due to the streptococcus or pneumococcus, a characteristic which is shown by other suppurative processes of similar origin, notably in the one which has been most studied, osteomyelitis.

Certain peculiarities of the pleural exudate in the first case deserve mention; since, contrary to what is generally expected, the blood serum in the early part of the disease had an agglutinative power of only one in ten, while in the pleural fluid it was one in a hundred. The latter also possessed marked bactericidal power, although containing the specific bacillus in a state capable of cultivation, yet the cultures were obtained with difficulty and grew only on special media.

A CASE OF CHRONIC FIBRINOUS BRONCHITIS.

Harbel³ reports a case of this disease which is noteworthy in being secondary to mitral trouble, since

² Sem. Méd., October 19, 1898.

³ Centrblt. f. in. Med., 1898, No. 1.

only a few have been recorded, but so similar in its details to an essential fibrinous bronchitis that it is scarcely possible to make a distinction. He gives the results of a chemical examination of the bronchial casts, together with those of a similar examination in two other cases. In none of them was more than a trace of fibrin to be found, while the reactions for mucin were characteristic. An easy explanation of their formation is found in the fact that the casts had an acid reaction, as it is well known that mucin coagulates in acid solutions. One can therefore assume with great probability that any cause leading to the production of an acid secretion in the bronchi, of which the most probable is the action of bacteria, would lead to its coagulation. If this explanation is correct, a so-called fibrinous bronchitis would result from any catarrh of the respiratory passages in which the secretion becomes acid. But what the circumstances are has not yet been determined.

CHRONIC HYPERTROPHIC PULMONARY OSTEOARTHO- THROPATHY.

Massalongo⁴ has published a typical case of this disease of which MacKenzie⁵ gives a full abstract.

The patient was a man fifty-two years old, of robust constitution, who was not addicted to alcohol and had not had syphilis. The hands and feet were deformed and of enormous size, while in addition the bones of the forearms and of the legs appeared to be enlarged, and the knee and shoulder joints were painful on active and passive motion. The increase in the size of hands and feet had attracted the patient's attention before he had noticed any signs of mischief in the chest.

He died two and one-half months after his entrance to the hospital. In the left lung there was diffuse catarrhal bronchitis, fibrosis and bronchiectasis, and the pleura was much thickened. The other lung was highly emphysematous.

From a review of sixty-seven recorded cases Massalongo concluded that there is no reason for considering this disease as a distinct pathological entity. It may present itself independently of any affection of the respiratory organs. Marie's view that it results from the absorption of putrid and toxic substances produced in morbid foci in the lungs or pleura is not admissible, since the articular changes may occur without any pre-existing pulmonary trouble, and in the greater number of observed cases in which the two were associated they preceded the pulmonary lesions. Furthermore, analogous conditions with production of putrid and toxic substances in other organs are not associated with similar joint changes, nor does it result from disturbances of the peripheral circulation, because in most cases there is no such disturbance, and conversely in most cases of disturbance of the circulation there is no osteoarthropathy. The relation between pleuro-pulmonary lesions and the joint affection is purely accidental. The condition should be called secondary, and not pulmonary, hypertrophic osteoarthropathy.

The frequent history of antecedent rheumatic affections of the joints and the common alteration of the larger joints and character of the pains rationally lead one to admit the influence of the arthritic diathesis in these cases, but syphilis and other humoral dyscrasias must also be included among the predisposing causes.

⁴ Il Politecnico, vol. iv, 1897.

⁵ Practitioner, October, 1898.

CASES OF PHTHISIS WITH PECULIAR CARDIAC PHYSICAL SIGNS.

Under the above heading Ewart contributes a note to *Lancet*, February 11, 1899, commenting on cases of his own, and others previously reported by two observers where an evident considerable displacement of the heart to the right as a result of fibroid excavations of the right lung was not substantiated at autopsy. He suggests that these findings may have been only in appearance contradictory, and that a conclusion is unjustifiable that "we must not assume that when the heart's impulse is seen and felt far on to the right side of the chest the organ is necessarily dragged or pushed over or altered in size." He holds that with the left lung and heart unbound by adhesions the effect of contractions in right lung due to excavations may be not to cause a falling in of the thorax on that side but to produce an "encroachment of the heart and of the left lung into the right chest." If autopsy fails to bear out physical signs, he suggests that it is because, with the opening of the thorax, the heart drops backward and to the left by its own weight and on account of the subsidence of the overstretched left lung.

He concludes that, "Taking the view that these were instances of mobile hearts held in the right chest by atmospheric pressure owing to extensive destruction of the right lung without compensating collapse of the chest wall, it may perhaps, be suggested to clinicians that skiagraphy might place their diagnosis of displacements of the heart beyond any chance of scepticism, and to pathologists that they might in investigating cases of this kind modify their method of section in some suitable manner likely to afford a view of the heart before there had been any possibility of its relations having been disturbed."

POINTS ON PHTHISIS.

Bowditch⁶ calls attention to the importance of being on one's guard against the impression that definite physical signs are necessary for diagnosis. He regards as most suggestive and often of grave import for prognosis the occurrence of (a) weak rapid pulse, (b) more or less elevated temperature, (c) disordered or weak digestion. He reiterates his earnest protest against the brutal isolation of tubercular patients, which often comes at the hands of the laity as a result of the overzeal of the profession in promulgating the possible dangers of association; and notes in particular the exaggerated importance that has been given to Flüggé's statement regarding the possibility or probability of bacilli being carried in small droplets of mouth-fluid into the air during the act of coughing.

Meissen⁷ puts great weight in the early diagnosis of phthisis on a very thorough investigation of the history, both family and personal, in great detail. As suggestive points before appearance of physical signs he notes: Easy fatigue and weakness, irritable or depressed temperament, failure of appetite and gastric catarrh, pain in the side (stitch), and shortness of breath. He calls attention to the danger of drawing prognostic conclusions from the number of bacilli on the basis of Gaffky's tables, or of assuming that there is no tuberculosis because repeated examinations of sputum are negative.

Tuberculin is a dangerous and not conclusive aid to diagnosis; it may stimulate latent foci: some con-

⁶ Transactions Climatological Association, 1898.

⁷ Thorapentische Monatsh., Nov., 1898.

ditions of tuberculosis do not react: other non-tubercular conditions may react. X-rays do not promise so much for the early diagnosis as was at first hoped.

Loomis⁸ at the close of a short paper draws the following conclusions: (1) it is possible in many cases, especially in chloro-anemias, to diagnose phthisis previous to the appearance of physical signs or of bacilli in the sputum; (2) weight, respiratory capacity and test measurements have no value in establishing the possibilities of the development of phthisis in themselves, but must be considered in relation to the height of the person, when they furnish three important aids to diagnosis; (3) corpulence is obtained by dividing the weight in pounds by the height in feet, and in a normal man should equal 26, in a woman, 23; (4) thoracic perimeter is found by taking two measurements of the chest, one at the end of forced inspiration the other at the end of forced expiration—the average of these two measurements should never be less than one-half the height; (5) vital capacity is the amount of air in cubic inches that can be exhaled after a full inspiration. Normally it should bear the relation to the height of 3 to 1 for a man, and 2 to 1 for a woman—that is, for every inch of height there should be three inches of vital capacity; (6) chloro-anemia and persistent and unexplained disturbances of the digestive system are symptoms of the pretuberculous stage of phthisis; (7) there are two characteristics of the pulse found in the pretuberculous and early stages of phthisis: (a) change of position has practically no influence on its rhythm; (b) there is relative feebleness of arterial pressure.

SERO-THERAPY IN TUBERCULOSIS.

Stubbert⁹ gives a brief but fairly satisfactory review of the history and present standing of this method of treatment, with a short account of his personal experience at the Loomis Sanitarium. He notes the fact that the trend of opinion is away from the sera, like tuberculin and antiphthisin, which are composed of the toxins and exert their forces when injected against the bacilli; and is turning to the so-called *antitubercle* sera like Maragliano's, which are antitoxic and lead to a greater or less power of resistance or immunity.

He is led to hope that antistreptococcic serum is going to prove of assistance in combating the cases of mixed infection which form so large a proportion of the total; and as a result of the observation of eighty-two cases he reaches the conservative conclusions: that there would seem to be established a certain immunity in subjects treated with serum and remaining cured at the expiration of periods varying from six months to a year and a half; that present investigations are along the right line; that serum treatment is more satisfactory than treatment by any one drug, but that there is as yet no specific.

Of the eighty-two cases, the physical signs improved in 78 per cent., bacilli disappeared in 16 per cent., apparent immunity was established in 21 per cent.

THE INHERITANCE OF TUBERCULOSIS.

Hauser¹⁰ gives an elaborate study on the transmission of tuberculosis from one generation to another. The arguments in favor of its occurrence are: the

analogy of other diseases like syphilis and the pébrine disease of silkworms; the localization of lesions in parts not susceptible to external infection; the microscopical and experimental demonstration of tubercle bacilli in the sexual glands; the discovery of tuberculosis in the fetus of man and animals; direct experimental demonstration, and the development of tuberculosis in chickens after inoculation of the egg.

He subjects all these arguments to very sharp criticism, throwing out the last altogether, since the albumin only is infected, and it is not a true embryonal inoculation. He gives a series of elaborate and apparently exhaustive tables, the *first* showing all the cases of tuberculosis occurring in new-born children and in the human fetus; *second*, similar conditions in cattle; *third*, the discovery of tubercle bacilli in the testicles and semen of men; *fourth*, their discovery in the corresponding organs of animals; *fifth*, the discovery of tubercle bacilli in the ovary, and *sixth* and *seventh*, the results of experimental investigation.

The observations of tubercle bacilli in new-born children are not all indubitable; indeed he is only able to discover 18 certain cases, 9 of developed tuberculosis in the new-born, 5 in which bacilli were found in the fetal organs and 4 in which they were found in the placenta. In all these cases the mother only was diseased, in 6 she suffered from general miliary tuberculosis and in only 2 did she survive the birth of the child. He therefore concludes that tuberculosis is capable of transmission in both men and animals, but no satisfactory evidence is presented of its transmission from the father. In nearly all cases the mother has been very severely infected, but even in cases of general miliary tuberculosis only about 10 per cent. of the children are tuberculous.

The transmission of bacilli exclusively from the mother is opposed to the general tendency of hereditary diseases. It occurs infrequently, and when found the lesions in 80 per cent. of the cases affect the liver and the portal system, so that it is impossible to draw positive conclusions regarding the nature of tuberculous transmission. Clinically it is generally admitted that when the children of tuberculous parents subsequently become tuberculous the disease usually manifests itself in its severest forms, although often these children are born at a time when the disease of the parents is latent. In order to solve the question, Hauser has carried on a series of experiments with rabbits and guinea-pigs. Some of the animals were infected before and some after conception. Altogether he obtained 30 young which could reasonably be suspected of hereditary infection—12 rabbits and 18 guinea-pigs. All the rabbits had infected parents on both sides, while 14 guinea pigs had an infected father. Four mothers were infected during pregnancy. Eight of these young died during the first seven weeks and none were tuberculous. All of the remaining 22 were kept alive for periods varying from four to twenty-two months. One was killed accidentally and found to have general tuberculosis. The rest remained unaffected. They developed normally, and of 25 descendants obtained from them none showed the presence of the disease. These results are very different from those observed clinically in connection with syphilis in the human race and are not analogous to the pébrine disease of silkworms. Hauser therefore concludes that "the bacillary inheritance of tuberculosis not only lacks a sufficient foundation but appears to be

⁸ Medical Record, vol. 54, No. 24.

⁹ Medical News, March 11.

¹⁰ Dent. Arch. f. klin. Med., October 27, 1898; Philadelphia Medical Journal, February 4, 1899.

irreconcilable with many important observations, and contains, moreover, internal contradictions that cannot be satisfactorily explained by the theory of actual heredity." He is compelled to assume that there is a peculiar hereditary predisposition in certain animals to the virus, which is not, like syphilis, maintained in the human race by a congenital transmission of the specific poison, but is the result of perpetual reinfection by tubercle bacilli from the outside.

TRACHEAL TUGGING AS A SIGN OF AORTIC ANEURISM.

A. Frankel¹¹ gives a brief review of the first description of this sign by Oliver in 1878, and the further notice it has received at the hands of various observers. He calls attention to the importance of care in eliciting it, and recommends that the first and middle fingers of the observer's right hand should press gently up against the under border of the thyroid or cricoid cartilage, the patient lying with head thrown back, and cautions that a too powerful stretching of the trachea either by this upward push or by the other method of displacing the larynx to the left may result in rupturing the aneurismal sac. As requisite for the production of a downward tug of the trachea with cardiac systole, he insists that either the aneurism must be situated in the portion of the arch which crosses the primary bronchus, or, if the dilatation occurs in the first portion of the arch as in the case reported by him, there must be firm adhesion between the sac and the wall of the trachea.

Aneurism of the arch occurring under other conditions may not produce the tugging. The value of the sign in establishing a diagnosis is emphasized by his case, where the only other suggestive features were a moderate dilatation of the right pupil, and symptoms of tracheal stenosis with a normal larynx. The patient died three days after admission, of suffocation from pressure.

The only condition likely to mislead would be existence of other tumors, which however, like the aneurism, must fulfil the conditions necessary for the production of the sign.

STRANGULATED HERNIA IN PERICARDIAL SAC.

McDowell¹² gives the post-mortem conditions in the case of a strongly-built Kaffir who died suddenly, thirty-six hours after his first symptom. He complained one afternoon of pain near the ensiform and about the umbilicus, with breathlessness and cardiac oppression. The pain steadily increased and was soon accompanied by frequent vomiting. There was swelling of the abdomen from the first and complete stoppage of the bowels. On the next day but one after the event he got up to micturate, walked a few steps and dropped dead.

At autopsy the abdomen was much distended, and on opening the thorax a marked distention of the pericardium was found, caused by the presence within the sac, below the heart, of eighteen inches of acutely strangulated ileum and a large quantity of blood-like fluid. The hernia was a portion of the ileum, four feet from the cecum, and came through a smooth-edged opening, the size of a sixpence, in the tendinous portion of the diaphragm.

He emphasizes the following points: The sudden

death, due to rupture of intestine, with consequent pressure on the heart, and shock; the absence of any history of injury on straining; and the difficulty of an operation even if a diagnosis could have been made.

PARACENTESIS PERICARDII.

Burtenshaw¹³ puts on record the one hundred and eighth reported instance of this procedure, but gives no analysis of the other cases. The attack developed suddenly in a woman of sixty years who had been subject for some time to periodic attacks of bronchial asthma. Her lungs and kidneys showed no evidence of organic disease. There had been for ten years a mitral regurgitant murmur of slight degree. There was no history of tuberculosis, and she had not been the subject of rheumatism or gout. Having suffered for a couple of days with an exceptionally severe asthmatic attack during which the heart was demonstrated to be in its usual condition, there was noted during a remission of the dyspnea a marked intermission of the radial pulse synchronous with inspiration. Deep inspiration brought on another dyspneic seizure which differed from previous ones in the absence of râles and asthmatic wheeze. Pressure of the stethoscope in cardiac region caused intense pain, which was the first she had felt in that area, and thereafter with one exception she did not complain of cardiac distress except on pressure. Percussion showed enlarged area of cardiac dullness with crescentic lower margin, labored and irregular action, muffled sounds and disappearance of the impulse. About four hours later a needle was introduced one inch from sternum in the fourth left interspace, and half an ounce of bloody serum withdrawn, followed by plugging of the needle. A second larger needle was then inserted for two and one-half inches in fifth space, one inch from sternum, and another ounce withdrawn; during manipulation the heart was scratched with resulting spasm and pain. Marked relief from the withdrawal of fluid did not ensue for an hour, when under influence of whiskey and strychnia the breathing became normal and the heart's action more regular and strong. The further course of the case was marked by frequent attacks of uncontrollable vomiting, and a persisting uncertain action of the heart, with serious sinking spells, finally eventuating, six and a half weeks after tapping, in sudden death. Autopsy refused.

The points emphasized are: The age of the patient, the suddenness of the onset of the pericardial inflammation, the absence of an etiologic factor, the absence of pain in the region of the heart except on pressure, and the freedom from asthma after the development of the pericarditis. The long continued nausea is assumed to have been caused reflexly through the pneumogastric or sympathetic, and an attack of aphonia lasting two days to irritation of the recurrent laryngeal. The relief following withdrawal of so small an amount of fluid is in accord with a number of cases of like result.

TOXEMIC DELIRIUM IN HEART DISEASE.

As a contribution to the study of auto-intoxication, Eichhorst¹⁴ describes phenomena observed by him in certain cases of heart disease where the anasarca had rapidly disappeared, in consequence either of simple rest in bed or of the administration of tonics, of which

¹¹ Deut. med. Woch., 1.

¹² British Medical Journal, January 7th.

¹³ Medical News, March 11th.

¹⁴ Deut. med. Woch., June 23, 1898.

the most frequently used was a prescription consisting of 2 grains of digitalis leaves and 15 grains of diuretin. A surprisingly rapid increase in the daily amount of urine, which may rise as high as 7,000 cubic centimetres, and coincidently a corresponding decrease in the amount of edema often followed. Serious symptoms, more frequently in old than in young individuals, may accompany the increased diuresis, resulting at times in a condition of somnolence so great that the patients are with difficulty aroused, or in disturbances of consciousness in which the patient neither knows where he is nor recognizes his acquaintances. Then delirium comes on, either low and muttering or so wild that the patients tear the bedclothes and destroy the furniture in their neighborhood, and this may be followed by complete loss of consciousness. The pupils are usually small. Disturbances of respiration similar to what is observed in diabetic coma also occur, the patients breathing deeply and rapidly, with participation of the auxiliary respiratory muscles, but without recognizable obstruction in the respiratory tract. The face is not cyanotic but rather flushed and congested. This condition lasts for a number of days, until the edema is gone and the polyuria resulting from the use of digitalis and diuretin has stopped. In some cases recovery takes place in twenty-four hours, in others it is very gradual. So far as his experience goes, the prognosis is always good.

The question naturally arises whether such disturbances are occasioned by the drugs administered, but he is convinced that they can be attributed neither to them nor to uremia, since in none of his cases was albuminuria present. Nevertheless they recalled symptoms described by older physicians, although never seen by himself, as resulting from a too rapid reduction of edema in kidney disease through too energetic sweat cures. The true cause seems to lie in a more rapid absorption into the blood of toxic bodies in the edematous fluid than the kidneys are able to take care of, thus causing an auto-intoxication of the central nervous system. The nature of such bodies must be left to the future to determine.

GALL-STONES IN MITRAL STENOSIS.

Brockbank¹⁶ has studied the results of 1,347 autopsies with reference to the occurrence of gall-stones, and found that of 504 cases in which a decided cardiac lesion existed biliary calculi were present in 10.9 per cent., while of the 843 other non-cardiac cases only 5.4 per cent. were similarly affected. A gross cardiac lesion therefore seems to double the risk of the development of gall-stones. The most striking figures were those connected with mitral stenosis, including under that head all cases in which the mitral valve was stenosed, irrespective of other morbid cardiac conditions. Out of 87 instances they were found 19 times, 5 of 31 males, and 19 of 56 females being affected, a total percentage of 21.8.

Beside finding biliary concretions in the gall-bladders of subjects of heart disease, he has, on several occasions, examined bile obtained post mortem from adult subjects who have died of chronic cardiac affections, and in whom there was no macroscopic evidence of any tendency to the production of an excess of cholesterolin by the mucous membrane. In such cases the bile, when taken from the gall-bladder, was found to be full of epithelial cells, singly and in clumps. Mixed

with these cells may be found a few cholesterolin crystals. If such specimens of bile be kept and examined from day to day, it will be found in many instances that the epithelial cells disappear gradually and that crystals of cholesterolin form in great numbers, until finally no traces of the complete cells remain, and the bile is full of crystals in innumerable profusion. This does not always happen, but it is so frequent as to strengthen his view that there is a strong tendency for the cells of the biliary mucous membrane in chronic heart cases to produce an abnormal amount of cholesterolin. He explains this occurrence by supposing that the lowered vitality of the general system and the passive congestion of the mucous membrane of the gall-bladder, which accompany severe chronic lesions of the heart, predispose to the formation of an increased amount of cholesterolin by the epithelial cells of the biliary passages, and by the enforced inactivity of the patient, this excess of a crystalline substance tends to remain behind in the dependent fundus of a frequently enlarged, depressed and sluggish gall-bladder.

Reports of Societies.

BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.

A. K. STONE, M.D., SECRETARY.

REGULAR meeting, Monday, February 20, 1899, DR. R. H. FITZ in the chair.

DR. S. J. MIXTER presented a paper on

OBSERVATIONS UPON TYPHOID CHOLECYSTITIS WITH GALL-STONES.¹

DR. RICHARDSON: This subject excites a great deal of interest at present among surgeons as well as among physicians. The possibility of a typhoid origin in inflammations of the gall-bladder, except during or soon after the typhoid itself, had never occurred to me. My first case was that of a woman who had not had typhoid fever — or, at least, in whom typhoid had not been suspected, and who lived in a community in which there had been no typhoid. But for the demonstration of the typhoid bacillus, which was made afterwards in the laboratory by my brother, no one would have suspected the origin of the trouble in this case. The patient, a woman of some fifty or sixty years, was supposed to have tumor of the kidney. I explored the gall-bladder, and found a long cylindrical gall-stone impacted in the cystic duct. I removed the stone, and the woman made a good recovery. I thought nothing more about it till it was reported that there was no question whatever about the presence of the typhoid bacillus.

Recently I operated for an acute cholecystitis in a woman of about the same age in a farming district, where, so far as we knew, there had been no typhoid. I was surprised in that case also to learn that the gall-bladder infection was from the typhoid bacillus. These cases have suggested an inquiry as to the formation of gall-stones, upon which Dr. Mark W. Richardson is now at work.

I recall cases of acute infection of the gall-bladder taking place in the course of acute infectious diseases. There were one or two which were fatal. The inter-

¹⁶ Edinburgh Medical Journal, 1898, vol. 46, p. 51.

¹ See page 493 of the Journal.