

way, several sets of apparatus being connected with one pump of required strength. The saving of time, which is a factor in the Shaffer procedure, is not then so prominent an advantage over the Folin method. The vacuum-distillation method needs watching, which is not necessary when one is acquainted with the Folin process.

With either method the ammonia is computed as follows: Suppose that 30 c.c.  $n/5$   $H_2SO_4$  is used. At the end of the process, the acid is titrated with  $n/5$   $NaOH$ . Suppose that it takes 24 c.c. of the alkali. Then 6 c.c. of  $n/5$  acid was neutralized by the ammonia. This corresponds to 12 c.c. of  $n/10$  acid, and, assuming that 50 c.c. of urine was employed in the actual determination, equals, in 100 c.c. of urine, 24 c.c. of  $n/10$  acid, which neutralizes 24 c.c. of  $n/10$   $NH_3$ , in terms of which ammonia is nearly always recorded. One c.c. of  $n/10$   $NH_3$  contains 1.7 mg. Therefore the amount of  $NH_3$  in 100 c.c. of urine is 24 times 1.7 mg. or 40.8 mg.

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### A NEW INSTRUMENT FOR GRASPING THE TONSIL PRELIMINARY TO COMPLETE ENUCLEATION.

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Nearly all operators are now agreed that in the surgical treatment of diseased or hypertrophied tonsils, what is desired is to enucleate the gland and not merely to clip off a portion of it. To accomplish this satisfactorily it becomes necessary to have some instrument with which to grasp the tonsil during the preliminary dissection and detachment from its bed.

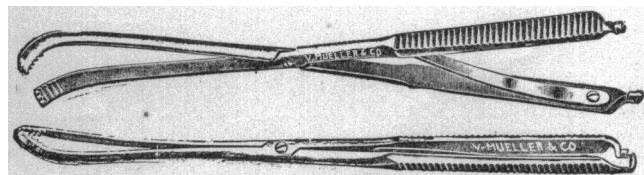


Fig. 1.—New tonsil forceps, open.  
Fig. 2.—New tonsil forceps, closed.

Various forms of instruments for grasping the tonsil have been devised, but I have found them all unsatisfactory for one or the other of two reasons. First, the jaws tear the tonsil or do not hold it well, or, second, the form of the handle is such that after the dissection is complete the instrument has to be detached to allow the enucleating instrument, be it snare or tonsillotome, to be placed over the tonsil. It is then necessary to manipulate the forceps and to grasp the tonsil through the ring of the instrument, a procedure somewhat difficult in the case of small and submerged tonsils.

I have attempted in the instrument here illustrated to overcome both of these difficulties. The jaw has considerable bearing surface and will hold without tearing if the tonsil is properly grasped. The handle will allow the ring of any tonsil instrument in the market to be passed over it while *in situ*. The lock is one that holds, yet it can be instantly released; and the tonsil, once grasped, can be held by this instrument during all the processes of dissection. After the tonsil is properly dissected out in accordance with the special technic of the operator it is grasped with the forceps, the detaching instrument is then placed over it, traction made by the forceps and the tonsil then detached by the tonsil

instrument. Should there be any hemorrhage the forceps acts as a good hemostat, since it will hold and not tear the vessel. The ligature can be thrown over it just as over any artery forceps. The curve is one well adapted to tonsil work.

To one accustomed to use a tonsil forceps of the scissors handle type, this instrument will at first feel awkward to the hand. In using, the forceps should be held with the tips of the thumb and fingers and not grasped with the whole hand, and the tonsil engaged in its vertical diameter.

I have had two sizes made, although the larger one will probably answer all purposes. Should a small fragment be left, the smaller size is admirably adapted to grasping it without there being much danger of injuring the pillar.

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### TREATMENT OF GONORRHEA IN THE FEMALE.

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As the treatment of gonorrhea in the female is frequently unsatisfactory on account of its liability to recurrence, I regard a recent experience as at least an innovation and one which may point the way to a satisfactory solution of the question of treatment.

*History.*—The patient had just completed an abortion at the second month. She had complained for a period commencing two weeks after her marriage of a continuous smarting on urination and severe tenderness about the introitus vaginae, and also of the presence of a purulent vaginal discharge.

*Examination.*—The introitus was red and very tender, so much so that it was with difficulty that a virgin-size speculum could be introduced. About the cervix, which was red and not eroded, was about a dram of pus containing a pure culture of gonococci. The tubes and ovaries were apparently not affected; the meatus urinarius was red but no pus could be expressed.

*Treatment.*—This was begun March 4, 1906, consisting of the application of a 1 per cent. solution of silver nitrate to the vagina and cervix every other day. By April 9 it was possible to use a large speculum without causing discomfort. At this time a thread of mucopurulent material wiped from the external os contained large numbers of gonococci. About April 30, gonococci ceased to appear in the vaginal secretions. This date just preceded the regular menstrual period, and at the first treatment afterward gonococci were abundant and continued to be present, though in lessening numbers, until May 30.

In spite of treatment being continued through the next menstruation they again appeared on June 16, 17 and 18. On June 19 the smear showed an absence of gonococci. The vagina at this time was now inoculated with normal vaginal secretion—that is the secretion from a normal, healthy vaginal wall. On June 21, 22 and 23 Doederlein's bacillus (the non-pathogenic bacillus inhabiting the normal vagina) was present in increasing numbers to the entire exclusion of the gonococci. By June 25 the vaginal bacilli were present in great numbers and the patient was discharged, stating that she felt "perfectly natural," a condition which had been absent since the time of infection.

This treatment by inoculation was based on the assumption that the field had been swept of its chief defense, viz., the Doederlein bacillus, and had been possessed by the gonococcus. Finding it impossible to eradicate entirely the gonococci, I determined to try to subject this pathogenic organism to the greatest possible

discomfiture and then artificially to restore the normal vaginal bacillus, hoping thereby to complete the extermination of the gonococci. In this I was not disappointed.

It would seem that the same reasoning might be employed in the case of other infections of the genital tract when its protector has been totally destroyed. I think it is not known what effect the healthy vaginal flora has on the parts of the tract farther up. This might with profit be determined.

### A CASE OF ARTHRITIC PURPURA.

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*Patient.*—Boy, aged 6, of German parentage.

*History.*—Father of a very nervous temperament; mother subject to chronic stomach trouble and constipation. No history of any hemorrhagic diathesis. Patient had mild attacks of spinal meningitis when five months old but made rapid and good recovery. Never seriously ill since, though he had frequently had mild attacks of indigestion accompanied by fever, lasting a day or two. Extremely nervous temperament and very active physically. Never had rheumatism of any form. For the past two or three weeks patient had complained at various times of pains in the ankles, knees and elbows, accompanied by slight swelling, tenderness on pressure but no redness. This condition would persist for a few hours and then disappear. A week before I saw him a rash, in all respects similar to the one described below, but discrete, appeared on both legs and thighs. This gradually faded until it could be seen only as a faint yellowish discoloration. Four days previous to my seeing him this rash appeared on the left buttock and is now the size and nature described below.

*Examination.*—When I first saw the patient early in the morning he complained of considerable pain in the stomach, was nauseated and had vomited a small amount of greenish mucus. Pulse and temperature normal. Examination revealed nothing abnormal in chest or abdomen aside from slight tenderness over stomach. There was no enlargement of spleen, liver or lymph glands. Over the left buttock there was a confluent hemorrhagic rash covering an area the size of palm of hand. It was made up of papules varying in size from a pin-head to a split pea, did not disappear on pressure and was not accompanied by any subjective symptoms.

*Course.*—On the afternoon of the same day there was a recurrence of swelling and pain in the ankles to such an extent that he could not stand. This lasted but a few hours. Four days later another discrete eruption of the same rash appeared on both legs accompanied by pain in ankles and knees. As before the pain and swelling disappeared in a few hours and the rash, after persisting a few days, gradually faded. During the week following my first visit there were occasional attacks of nausea and vomiting, especially after breakfast. After this time the patient quickly regained his usual spirits and strength and at the present time six weeks later, is apparently as well as ever. Urine: Specific gravity, 1.034; acid, no albumin nor sugar; indican, a trace; a few squamous and round epithelial cells, few cylindroids and few red blood cells. Blood: Reds, 5,520,000; whites, 19,500, hemoglobin, 60 per cent. (Tallquist).

*Treatment.*—For the acute pain in the stomach chloroform anodyne in gtt. vii doses was given. For the acute joint symptoms, aspirin gr. iii and acetphenetidin gr. i, were given, both of which remedies promptly had the desired effect. Two days after the first visit patient was put on full doses of Fowler's solution before meals and calcium chlorid gr. v. after meals, the latter to be continued for four days only. After ten days Fowler's solution was discontinued because of stomach irritation and Bland's pills, gr. iii, given three times a day, which treatment is being continued.

### CASE OF EXTRAUTERINE PREGNANCY AT FULL TERM.

SUCCESSFUL DELIVERY BY OPERATION.

A. L. BLESII, M.D.,

AND

HORACE REED, M.D.

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*Patient.*—Mrs. R., mulatto, aged 24, in the service of Dr. Conrad, was seen Aug. 3, 1907.

*History.*—Patient had one child, aged 3, which had been delivered normally. Menstruation ceased December, 1906, and in January, 1907, there was nausea and frequent pains in the hip and back accompanied by slight vaginal discharge. Movements were felt about March 1 and these rapidly became stronger and painful. Indigestion had been constant since the beginning of pregnancy and for the first five months she was constipated. Six days before she was seen there were paroxysmal abdominal pains which increased in severity for three or four days and then gradually subsided. The pains were described as originating in the region of the stomach and radiating to the spine and coming on at intervals of 15 or 20 minutes. The pains having ceased, the colored midwife advised calling in a physician and Dr. Conrad, who was called, diagnosed abdominal pregnancy and advised immediate operation.

*Examination.*—Patient, who was poorly nourished and weighed about 110 pounds, had the appearance of being pregnant at full term. Position of the child was easily determined through the thin abdominal walls. The vagina was relaxed and the hand was easily introduced; the uterus was located above the pubes and slightly to the right of the median line; the cervix admitted two fingers. The head of the child presented in the pelvis behind the uterus.

*Operation.*—An incision was made through the left rectus from the level of the umbilicus to the pubes. The sac containing the child was easily separated from the peritoneum and a child, weighing  $5\frac{1}{4}$  pounds, was extracted and passed to the attending physician, who, after considerable difficulty, resuscitated it. There were three or four pints of fluid in the sac. The cord was ligated close to the placenta and removed and redundant portions of the sac were cut away with scissors. The intestines were pushed upward and outward by the placenta, which was firmly attached to the mesentery of the small intestines, and the colon on either side was hidden by it; no attempt was made to detach the placenta. The margins of the sac were stitched to the parietal peritoneum and the cavity, at the bottom of which rested the placenta, was filled with gauze; two or three interrupted sutures taken at the upper angle of the abdominal opening completed the operation. The lower angle of the wound for about three inches was left open.

*Postoperative History.*—Convalescence of the mother was satisfactory and she left the hospital in four weeks with the placenta not yet detached. She returned four weeks later, when the placenta was removed without hemorrhage. On April 4, 1908, she was in good health and the child, which weighed 18 pounds, was thriving.

**Fetid Non-gangrenous Bronchitis in Children.**—E. Gaujoux thinks that we should distinguish three clinical forms of fetid bronchitis in children, as he illustrates by 10 examples, including 5 from his own experience. The only lesions are those of catarrh of the bronchi; the decomposition of the stagnating mucous secretions is alone responsible for the fetid odor. In the acute form the aim should be to promote expectoration and modify the secretions. In his communication in the *Annales de Méd. et Chir. Infantiles*, January 1, he states that he has obtained the best results with sodium benzoate and hyposulphite every two hours. In recurring forms, if drugs fail, others have reported good results from intratracheal injections of peroxid of hydrogen and mentholized oil. Good results have also been obtained with continuous vaporization of a 5 per cent. solution of carbolic acid. General treatment is of equal importance, with an alcoholic or dry rub of the entire body morning and evening.

[Please read the editorial on the Index on page 2138.]