

amined microscopically. In the main we might say the structure is that of a round-celled sarcoma. The cells are rather large, have large nuclei, some are elongated having the appearance of a so-called oat-shape cell which we see in some tumors. The structure is traversed in a gross way by broad bands of fibrous tissue showing well formed connective tissue in their interiors, but as we pass from the interior of these bands toward the tumor itself, the cells become of the same character as the cells in the tumor proper, indicating that perhaps these have developed by fibrillation and condensation of the tumor structure. There are numerous small blood vessels and these show a distinct endothelial lining and a slight amount of connective tissue wall. From the number of blood vessels and the fact that the round cells are arranged rather in groups about these vessels, one might think it likely that the tumor had its origin in the vascular system, and I consider that perhaps this was the fact, because in other portions there are distinct trabeculated areas in which there are rather large spaces and the trabecular walls are lined with endothelium, very much like other angiomas, so we may consider that it is probably an angio-sarcoma. It is interesting to note in all the sections prepared and examined, about twenty-five in number, that in no part of the kidney proper was there evidence of invasion of the sarcoma. The kidney was apparently pushed to one side by the process. The sections from the kidney proper, taken from the capsular-like portion show simply an atrophic condition of the glomeruli, some slight thickening of the walls, compression of the renal tubules and increase in the interstitial tissue. Considering the apparently profound changes and the size of the entire structure the kidney is really very little altered. The renal changes would not be considered very grave if found in a kidney not compressed by a tumor of this sort. In no portion of the structure were there found any of the striated muscle cells which are said to occur often in some congenital sarcomata of the kidney, the so-called myo-sarcoma. So it seems that we have not to deal with that variety of tumor, but a round-celled sarcoma probably developed in the course of the blood vessels.

DISCUSSION.

DR. GRAHAM—Many of these cases of sarcoma in young children are accounted congenital. There was a year of life elapsing between the time of birth and the time this tumor was discovered. There was nothing in the history or appearance of things that would lead us to believe that this was not a congenital tumor and I am inclined to think the disease was present at birth.

DR. E. R. LE COUNT—In reference to congenital sarcoma of the kidney of a malignant character, as reported by Dr. Graham, it is very probable that they have their origin in the remains of the Wolffian bodies, while with tumors that appear later in life there is a tendency to consider their origin as having some connection with remnants of the supernumerary adrenal glands.

DR. BISHOP—Dr. Le Count speaks of the Wolffian bodies in connection with these tumors, and I ought to add that in some of the sections are tubular-like structures lined with columnar celled epithelium, suggesting that they are the remnants of the ducts of the Wolffian body, and should not be overlooked, but they were so few in number and had no apparent relation to the tumor so were not considered as having any etiologic significance. The tumor perhaps, but not necessarily, occurred from that structure. I did not mean to say that this tumor was not in my opinion congenital. I simply stated that the striated muscle cells which are often present in such tumors were not present in this; a congenital tumor may be round-celled as well as any other variety.

A CASE OF TUBAL PREGNANCY.

Read before the Chicago Pathological Society, Jan. 14, 1895.

BY BERTHA VAN HOSEN.

CHICAGO.

Mrs. S., aged 22, married three and one-half years had a miscarriage after being married five months. Three months after the miscarriage had an attack of pelvic inflammation, and a pyosalpinx on the right side was diagnosed by Dr. Bayard Holmes, who was caring for the patient at this time. She was confined to bed for six months at this time, and spent six

weeks of the time in Mercy Hospital. She improved while under hospital treatment and was told that she might fully recover if she continued the hot douches after leaving the hospital. Sept. 19, 1894, two years later, the patient came to Dr. Hickey-Carr complaining of nausea and with the history of having missed two monthlies. Examination of the pelvis showed the uterus enlarged and a mass was felt on the right side. Liquid diet was ordered; September 23, the patient was feeling well and took an eight-mile ride on the cable car. September 24, the following day at 3 A.M., she was seized with pain in the pelvis and a neighboring physician was called in. He gave her three doses of codeia $\frac{1}{2}$ gr. each. At 8 A.M. on same morning Dr. Carr was called and found her still in pain; slight hemorrhage from the uterus but no sign of membranes, pelvic tenderness and the mass on the right more distinctly outlined.

September 24, 25, 26, patient kept in bed on liquid diet without anodynes and efforts made to move the bowels with calomel, castor oil, olive oil, glycerin and water enemas but with no success. Up to and including September 26, the fourth day of the attack, the pulse was 90 to 96, temperature 99 to 99 $\frac{1}{2}$, and the pain constant. September 27, at 4 A.M., the patient had a third violent attack of pain and by 9 A.M. the pulse had risen to 120, temperature 100. Dr. Carr was obliged to leave the patient to attend court, and did not see her until 2 o'clock in the afternoon. At 1 o'clock she had been seized with pain and went into collapse. When Dr. Carr saw her at 2 P.M. there was dullness in the lower segment of the abdomen and the mass of the right was very indefinite. I saw the patient two hours later in consultation with Dr. Carr. The temperature was then 100, and the radial pulse 160. The patient was blanched and appeared to be sinking rapidly.

Ectopic gestation was suspected and an exploratory operation was decided upon; at 6:30 P.M. the patient was taken to the Chicago Hospital, a distance of four blocks from her home. Dr. F. Byron Robinson saw the patient at 8 P.M., confirmed the diagnosis and at 8:15 with the assistance and consultation of Dr. Robinson, I opened the abdominal cavity, the lower portion of which was packed with loose black clots of blood. These with a quantity of liquid blood were turned out, the appendages on the right side were removed, the cavity freely irrigated, glass drainage tube inserted and wound closed with silkworm gut. At 9 P.M., a few minutes after the operation the pulse was 152, temperature 101.4. From this time the pulse dropped until on the seventh day it did not go above 100. On the fourth day the decidua was expelled entire. Drainage removed on the sixth day and stitches tightened; the wound closed by figure 8 ligature and the patient left the hospital on the fourteenth day. I saw her last week and she asserted she had not been so well as now, since her marriage. Since the operation she has gained in weight, menstruates regularly, and is at all times perfectly free from pain.

The specimen is a very typical one and shows what a violent effort was made to accomplish tubal abortion during the four days before tubal rupture took place.

Such a mishap as this illustrates, fortunately does not occur every day, because nature has practically castrated such women by closing the tubes, or so modifying the secretion that conception can not take

place, but my reading leads me to believe that there are many undiagnosed cases. In fact, it does not seem to be the etiology, the pathology or the treatment that balks us in dealing with this condition, but the blunders in regard to it seem to be confined mainly to the diagnosis. Some of the most typical diagnostic points are well brought out in this history. Before rupture we have history of sterility and severe tubal disease; mass felt on right side; rapid increase in size of mass; symptoms of pregnancy; uterine hemorrhage. After rupture we have sudden pain and collapse; slight elevation of temperature; rapidity of pulse; physical signs of internal hemorrhage. To save a patient after such an accident as tubal rupture seems to me more good luck than good management, but to prevent such an accident from occurring is worthy of the most ambitious efforts.

In this case, salpingotomy should certainly have been performed after the first miscarriage two years ago, as earnestly advised by both Dr. Holmes and Dr. Carr. An infected and diseased tube can never be anything but a source of danger to a woman's health, both on account of its relation to the peritoneum and its inaccessibility to treatment; and for the same reasons I see nothing but salpingotomy that can be relied upon to permanently restore to health a woman with diseased tubes.

If, however, the patient does not give us the opportunity to remove the diseased tube before such a condition as ectopic gestation can occur, should a suspicion of pregnancy in the uterus prevent us from interfering with any mass that could be felt in the pelvis, the conditions that might most easily be mistaken for ectopic gestation are pyo- or hydrosalpinx or an exudation about the tube complicating normal pregnancy. If we had any one of these conditions without pregnancy, an abdominal section would certainly be indicated, and the co-existing pregnancy can not have any but a deleterious influence upon these conditions, by increasing congestion and stopping drainage through the uterus. The effect of any of these conditions upon pregnancy is to constantly threaten aborting before full term is completed, to cause rupture of the tube or prevent natural delivery at the time of confinement, and after the uterus is emptied to increase the danger of sepsis and pelvic peritonitis.

There are so few of even the most distinguished gynecologists who are able to make an accurate diagnosis of any pathologic condition in the pelvis, outside of the uterus, before an incision has been made in the abdominal wall, that the general practitioner in whose hands these cases first fall must feel himself very inadequate to meet the possible emergency. But every practitioner should be able to say whether the uterus was enlarged, and that there was a mass at one side and on finding such a condition should he not advise an exploratory operation at once? A few cases with personal responsibility in ruptured tubes has increased my courage in prompt action and my admiration for the judgment of the man who says conservative surgery means increased mortality.

DISCUSSION.

DR. E. F. GAVIN—I have been strongly tempted to suspect abdominal pregnancy of an ectopic nature in a number of cases of acute peritonitis in married women, and I think so-called cases of peritonitis are frequently cases of ectopic gestation.

DR. D. W. GRAHAM—This is a very good report of the case

and is sound teaching. I know the author of the paper is not the author of the last remark; that it is a quotation in regard to conservative surgery. I always feel like fighting when I hear the term used as it is used nowadays. Conservative surgery means that kind of surgery which will save the life or health of the patient. That is my definition of conservative surgery. I know the author of the paper did not use the term in an improper sense, but I want to protest against the phrase being employed every time we are discussing subjects which have to do with removing something from the body. It might be proper to say conservative treatment, or do-nothing treatment, or temporizing treatment, but conservative surgery means conserving the patient's life or health and all the organs compatible with these two conditions. I want to put myself on record as giving that interpretation to conservative surgery.

DR. J. L. MCCOLLUM—I feel that too much can not be said in praise of this paper. I have had some experience in operative gynecology, and I must say that I indorse most heartily the ground the Doctor has taken in not hesitating to mutilate, as this method has been termed by a great many writers who cry out against the removal of the tubes. I have had a clinic in gynecology for the last six years and have had an opportunity to watch cases, some of them being under treatment for two years. I would have them discharged as cured but they would come back in a few weeks with the same trouble, which if not as bad was in the way of becoming so shortly. I can not see any reason why we should hesitate to remove the tubes after a reasonable course of treatment is unsuccessful.

DR. F. B. EARLE—I certainly think the author deserves congratulations, both on the paper and the result of her treatment. The diagnosis of ectopic gestation is very difficult before rupture of the sac; in fact, some authors state that it is impossible. However, when we have a history as in this case, of previous disease of the tube with probable occlusion we have one of the principal factors in the etiology. Amenorrhea and a period of sterility so frequently precedes ectopic gestation that the usual symptoms of pregnancy following a condition of that kind should always excite our suspicion. When there is a bloody discharge from the uterus with the negative symptoms of pregnancy, with a tumor presenting at the side of the uterus and pain at the site of the tumor, particularly if that tumor presents a soft boggy feeling, then there is every reason in the world to suspect extra-uterine pregnancy. As to treatment, there can be no doubt as to the indications when the diagnosis is properly made. The ovum at that site is of dangerous omen and the sooner it is gotten rid of the better. The use of electricity to destroy the ovum has many advocates but laparotomy is comparatively safe and inasmuch as it is, and may be called for even after death of the ovum, probably the best method is to resort to it as the primary treatment.

DR. BERTHA VAN HOESSEN, in closing the discussion, said: I would like to say one word about conservative surgery. I suppose by conservative surgery we mean as simple an operation as possible to save the woman's life; that depends a good deal upon the judgment. I saw an extra-uterine pregnancy operated upon at the Post-Graduate Hospital; the patient had been consulted over by several doctors and each one proposed curetting, until it happened that one consultant thought it might be better to see exactly the condition inside the pelvis. Abdominal section was made and it was found that she had an ectopic gestation on one side and a very large pus tube on the other. I think if curetting had been resorted to it would have been what Dr. Graham would call conservative surgery.

ORIGINAL INVESTIGATIONS ON THE NATURAL HISTORY, (SYMPTOMS AND PATHOLOGY) OF YELLOW FEVER. 1854-1894.

BY JOSEPH JONES, M.D., LL.D.
NEW ORLEANS, LA.

(Continued from page 553.)

CHAPTER VIII.

Case of gastritis, fever and jaundice, resulting from exposure and bad diet. John Austin, age 16, laborer, admitted to Charity Hospital Nov. 30, 1876. Says that he had felt unwell for three or four days before admission. Complained