

a general amelioration of the symptoms, it was repeated in about a week, removing again about two ounces of fluid, less turbid than before, still containing no micro-organisms.

Internally she took most of the time mercury and iodid of potassium. On March 1 we began collargol inunctions, used twice daily. On March 5 the clinical record showed that patient had a slight chill. In a few days, however, improvement set in and on March 8 temperature dropped to normal, and never afterward rose above 99. The mastoid wound did well from the first, and was completely healed in about two months. The hearing in the affected ear improved and the patient rapidly returned to normal.

This case, I think, is instructive in that it is an instance of a recovery from pronounced leptomeningitis, the clinical diagnosis being confirmed by the results of the lumbar puncture. It is one more to be added to the favorable cases previously reported by Macewen, Gradenigo, Brieger and others, which encourages us not to take an absolutely hopeless view on witnessing this dread disease develop as a complication of middle-ear suppuration. While from the given case I am not able to draw any satisfying conclusions as to the cause of ultimate recovery—whether it should be attributed to the operation on the diseased mastoid, removing the focus of infection, or to the lumbar puncture, relieving intracranial pressure and diminishing the amount of septic fluid, or to the possible beneficial influence of the collargol inunctions—I believe that in a similar case one need not hesitate to use all these measures, as each is indicated and possibly all three may contribute somewhat to the ultimate recovery of the patient.

Attention is called to the comparatively insignificant character of the aural symptoms. While not duplicating the former case in the absence of any history of suppuration, the discharge was slight and of short duration and had ceased completely at the period when the intracranial symptoms developed.

In the bone involvement a strong contrast is presented with the condition noted in Case 1, in which the bone destruction was far-reaching and profound, the dural membrane being in direct contact with diseased bone over a considerable area. In this, on the contrary, necrosis was very slight, the disease not reaching the inner table at any point.

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PHOSPHATIC CALCULUS OF THE POSTERIOR URETHRA

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Patient.—J. H., came to the clinic complaining of difficult urination, increased urination and decided urgency, with occasional attacks of complete retention. One such attack had occurred the day previous, for the relief of which he had been catheterized at another institution. He had had an attack of complete retention one year previously, and gave a history of several attacks of urethritis during his youth. He had been treated for stricture at one time. He had no hematuria and no pain.

Examination.—The patient was a well-preserved man about 55 years old. The urine was very cloudy and contained many long shreds. The catheter met with obstruction in the prostatic urethra. A small woven bougie passed into the bladder. A No. 10 (French scale) tunneled steel catheter guided over a whalebone filiform passed over a long soft calculus on the floor of the posterior urethra. The end of the calculus was seen through an endoscopic tube.

Operation.—Under cocain anesthesia I attempted to remove the stone through the endoscope, using a pair of long forceps with narrow blades, but succeeded only in breaking off small fragments of the stone, as the narrow caliber of the tube prevented the handle of the forceps opening to an extent sufficient to grasp the calculus firmly in the blades. As the pain became intense and hemorrhage profuse, further manipulations were not attempted at the time, since it appeared that an external urethrotomy would be necessary. Soon after arising from the table the patient felt inclination to urinate, and when he tried to do so the stream of urine forced the stone to within one inch of the external meatus, from which position it was easily removed with thumb forceps. After removal it was found to be a soft, friable, phosphatic calculus, 0.5 cm. in diameter and 3 cm. long, cylindrical, conforming to the shape of the posterior urethra. A size 26 steel sound was easily passed into the urethra on the following day. The patient enjoyed complete relief from all urinary symptoms afterward.

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TRANSFUSION OF BLOOD IN A CASE OF PELLAGRA*

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Pellagra, a trophoneurotic disease now appearing in this portion of the country, possesses a high mortality rate in its acute type; 64 per cent. in the cases reported by Searcy.¹ Pellagra may probably be classed as one of the diseases caused by vegetable poisons, pellagrazein, a fatty oil or extractive so named by Lombroso. Pellagrazein is developed in fermenting and decomposing grain in the presence of a fungus. From the ingestion of this poison in corn meal the skin and nerve lesions characteristic of the disease result. As a rule there is associated with the disorder a pernicious dysentery probably of toxic origin. No cure has been found as yet.

For a more complete account of the disease the excellent articles by Bellamy,² Searcy,¹ Merrill³ and that of Randolph⁴ presented at this meeting may be consulted.

Considering the possibility that recovery from an attack of pellagra might produce a certain degree of immunity in the patient, the use of transfusion of blood from such a recovered patient in an acute case of pellagra suggested itself, as all medical means have failed in the treatment of this disease.

It is impossible to state the nature of the immunity until the etiology of the disease is definitely ascertained. If pellagrazein is the etiologic factor, the immunity may be of the nature of the antitoxin (antiricin) produced experimentally in lower animals against ricin.

To lend weight to any positive findings a recipient was found in such extreme condition that recovery was absolutely impossible in the opinion of one who has carefully followed all the cases of a large epidemic. To add further weight to the evidence, all medication was withdrawn after transfusion.

* Synopsis of paper read before the Southern Medical Association at Atlanta, Ga., Nov. 12, 1908.

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2. Bellamy, R. Harilee: Pellagra: Its Occurrence in This Country: Report of Cases, *THE JOURNAL A. M. A.*, Aug. 1, 1908, li, 397.

3. Merrill, T. C.: A Sporadic Case Diagnosed as Pellagra, *THE JOURNAL A. M. A.*, Sept. 14, 1907, xlix, 940.

4. Randolph, James H.: Pellagra and Pellagrins; with Report of Cases, *Arch. Int. Med.*, January, 1908.