

come by the use of pelvic and abdominal belts after the manner of Longstreth, and the relief which follows this treatment is often surprisingly great.

"Rheumatic" pains in the ankles, knees and hips are frequently another expression of this class of secondary strains resulting from attitude and faulty weight-bearing lines. When these persons, by local and general exercises, proper shoeing and temporary supports are made to stand and walk correctly, the "rheumatic" symptoms disappear without the employment of drugs.

Chronic rheumatism is no longer an entity. More and more will specific infections, definite disturbances of metabolism and analyzed mechanical causes be found to be existent, and our treatment will progress as we grow to understand these underlying conditions.

In regard to rheumatism an axiom of Hippocrates may well be quoted: "Experience is fallacious and judgment difficult"; but it should also be an axiom that investigation is productive and the cause of unsuccessful treatment is in large measure a failure to understand.

REFERENCES.

- ¹ Bouillaud: *Traité Clinique du Rhumatisme Articulaire*. Boston, 1905.
- ² McCrudden: *Chemistry, Physiology and Pathology of Uric Acid*. Boston, 1905.
- ³ Hirsch, Augustus, Prof. Med., Berlin: *Geographical Pathology*. Poynton and Paine: *London Lancet*, 1900, p. 861 and p. 932.
- ⁴ Cole: *N. Y. Med. Jour.*, 1906, lxxiii, p. 534-538.
- ⁵ MacLagan: *Lancet*, March 4 and 11, 1876.
- ⁶ Stricker: *Berl. klin. Wochenschr.*, Nos. 1 and 2, 1876.
- ⁷ Riess: *Ibid.*, No. 7, 1876.
- ⁸ Menzer: *Deut. mil.-ärztl. Gesch.*, 1905, vol. xxxiv, p. 146-153.
- ⁹ Verhandl. d. Kong. f. inn. Med., 1904, vol. xxi, p. 355-374.
- ¹⁰ Die Ätiol. d. akuten Gelenkrheumatismus, Berlin, 1902.
- ¹¹ Sinnbrüher: *Chanté-Ann.*, Berl., 1904, xxviii, 128-141.
- ¹² Bibergeil: *N. Prog. Internaz. med.-chir.*, Napoli, 1905-6, ii, 30.
- ¹³ Brackett: *Boston Med. and Surg. Jour.*, April 20, 1905, p. 457.
- ¹⁴ Poynton: *Last edition Osler*.
- ¹⁵ Georg Hauffe: *Die Therapie der Gegenwart*, vol. xlvii, p. 54, 1906.
- ¹⁶ Bannatyne: *Rheumatoid Arthritis*.
- ¹⁷ Schueller: *Berl. klin. Wochenschr.*, 1907, nos. 5-7; Oct. 2, 1905.
- ¹⁸ Fayerweather: *Am. Jour. Med. Sc.*, December, 1905.
- ¹⁹ Goldthwait: *Boston Med. and Surg. Jour.*, Nov. 17, 1904, p. 529; April 7, 1904, p. 363. *St. Paul Med. Jour.*, September, 1908.
- ²⁰ McCrae: *Jour. Am. Med. Asso.*, Jan. 2, 9, and 16, 1904; Oct. 8, 1904.
- ²¹ Nichols: *Keen's Surgery*.
- ²² Painter: *Boston Med. and Surg. Jour.*, Nov. 28, 1901. *Med. News*, Nov. 28, 1901. And W. G. Ewing: *Boston Med. and Surg. Jour.*, March 19, 1903.
- ²³ Fuller, E.: *Ann. Surg.*, Phila., 1905, xi, 902-913.
- ²⁴ Herter: *Jour. Am. Med. Asso.*, March 23, 1907, p. 985.
- ²⁵ Hoke and Andrews: *Am. Jour. Orthop. Surg.*, October, 1907.
- ²⁶ Cole: *Johns Hopkins Bull.*, June-July, 1907.
- ²⁷ Rogers and Torrey: *Jour. Am. Med. Asso.*, September, 1907.
- ²⁸ Levi: *Bull. de l'Acad. de Méd.*, March 10, no. 10, 1908.
- ²⁹ Lancereaux: *Presse Méd.*, July 15, 1908, no. 57.
- ³⁰ Sergeant and Menard: *Abstract, Jour. Am. Med. Asso.*, March 30, 1907, p. 1139.
- ³¹ Bier: *Hyperemie als Hilfsmittel*. Leipsic, 2. ed., 1905.
- ³² Wakefield: *Practitioner*, London, Nov. 19, 1908.
- ³³ Bannatyne: *Rheumatoid Arthritis*.
- ³⁴ Luff: *Brit. Med. Jour.*, Oct. 26, 1907.
- ³⁵ Baer: *Am. Jour. Orthop. Surg.*, October, 1907.
- ³⁶ Bädinger: *Wien. klin. Wochenschr.*, 1904, no. 17.
- ³⁷ Murphy: *Jour. Am. Med. Asso.*, May 20, 27, June 3, 1905.
- ³⁸ McCrudden: *With Drs. Goldthwait, Painter and Osgood*, *Am. Med.*, April 2 and 9, 1904.
- ³⁹ Albee: *Jour. Am. Med. Asso.*, June 13, p. 1977.
- ⁴⁰ Brackett: *Trans. Am. Orthop. Asso.*, 1897, p. 123.
- ⁴¹ Lund: *Boston Med. and Surg. Jour.*, 1902, vol. cxlvii, p. 345.
- ⁴² Codman: *Ibid.*, 1906, vol. cliv, p. 613.
- ⁴³ Codman: *Ibid.*, 1908, vol. cliv, p. 533 (continued through six numbers).
- ⁴⁴ Baer: *Bull. Johns Hopkins Hosp.*, June-July, 1907.
- ⁴⁵ Painter: *Boston Med. and Surg. Jour.*, March 21, 1907.
- ⁴⁶ Baer: *Ann. Surg.*, November, 1907, p. 694.
- ⁴⁷ Goldthwait and Osgood: *Boston Med. and Surg. Jour.*, May 25, June, 1905. *Goldthwait: Jour. Am. Med. Asso.*, Aug. 31, 1907, p. 768.
- ⁴⁸ Painter: *Boston Med. and Surg. Jour.*, Aug. 13, 1908, p. 205.
- ⁴⁹ Goldthwait: *Am. Jour. Orthop. Surg.*, April, 1908.

INFECTION WITH THE BACILLUS AEROGENES CAPSULATUS, FOLLOWING ABORTION. A REPORT OF TWO CASES, IN ONE OF WHICH THE BACILLUS WAS RECOVERED FROM THE CIRCULATING BLOOD DURING LIFE.

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CLINICAL REPORT.

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THE following two cases of puerperal infections with the bacillus aerogenes capsulatus are reported because of the comparative rarity of this form of infection after labor or abortion.

The bacillus aerogenes capsulatus is not normally found in the vagina, and in the great majority of infections with this organism it is introduced from without, either by operative procedures on the part of the attendant or by attempts to produce self-abortion. We know that uterine sepsis in rare instances may arise from auto-infection, and it is perhaps fair to admit the possibility in the second of the two cases reported in this paper. In the first, the patient acknowledged a criminal operation.

Cases of uterine sepsis in which the gas bacillus has been demonstrated, usually associated with other organisms, have frequently recovered, but a generalized infection seems always to be fatal.

At least one of our cases suffered from a general septicemia with the bacillus aerogenes capsulatus.

The first case is noteworthy for the fact that a pure culture of the gas bacillus was obtained from the circulating blood during life. Clinically, the second case is interesting on account of the extraordinary extent of the cutaneous emphysema during life, and the high leucocyte count, 126,400; also in view of the possibility of an auto-infection, as she persistently denied any vaginal examination or attempt at criminal abortion.

The skin of both women was of a deep copper color, with spots of dark purple, analogous to the appearance sometimes seen after the long use of hot applications. This characteristic appearance has not been noted previously, so far as I have found. Lenhardt mentions jaundice as present in a patient dying after a criminal abortion at about the second month of normal gestation. Whether the peculiar discoloration of the skin noted in the two cases reported in this paper is ordinarily present it is impossible to say, but in both it was present to a marked degree. In our two cases the presence of the bacillus aerogenes capsulatus was suspected from the appearance of the skin alone, even before the crepitation was felt (in Case I crepitation was absent), as it had been my fortune to have previously seen those suffering from infection with the gas bacillus presenting the same appearances. In neither instance were the lochia

frothy, as has been often mentioned in reported cases.

A review of the literature of this subject is unnecessary, as the article by Little, published in the *Johns Hopkins Bulletin* during 1905, contains an excellent résumé of the subject, together with a report of ten cases of gas bacillus infection, in seven of which other organisms were present.

CASE I. S. S., age thirty-seven. Married twenty years; widow four years. Nativity, England. Occupation, housewife. Entered Boston City Hospital Aug. 20, 1906.

History. — The last menstrual period was two months previous to entrance. She had had four labors at term, two instrumental — eighteen and sixteen years — and two normal — fourteen and ten years previously. She also acknowledges two miscarriages during the last five years, both at about the second month. Two days before entrance she was seized with severe pain in the lower abdomen, accompanied by diarrhea and vomiting, and at about the same time blood began to come from the vagina. When first seen she acknowledged that she was having a miscarriage, but at that time denied its induction. She had suffered from chills and fever, and the diarrhea and vomiting had continued, the patient becoming rapidly prostrated.

Physical examination. — A well-developed and well-nourished woman, moderately stout. There was great prostration, restlessness and vomiting. The patient's whole face and trunk, and, to a lesser degree, the arms and legs, were of a bright bronze color. The tip of the nose, finger-tips, and, to a slight extent, the toe-nails, were of a deep purple color, which did not disappear upon pressure. The pupillary reactions were normal; the knee jerks absent; there was no loss of motion, or any anesthesia. The tongue was moist and showed a white coat. The pulse was slightly irregular, very poor volume and tension; rate 110. The temperature was 105. There was a general puffiness of the entire face, trunk and extremities, but no pitting on pressure, and no crepitation anywhere. The heart action was weak and rapid, but there was no murmur. The lungs were negative. The abdomen was not distended, but there was a slight general tenderness without spasm, and tympany throughout.

Vaginal examination showed the cervix to be patulous, and there was a piece of placental tissue in the vagina. The uterine body appeared to be somewhat enlarged. The appendages were apparently normal. The white count was 25,000. In spite of all treatment, the patient's condition steadily failed, the temperature rising to 104° or 105° just before death. There were involuntary movements of the bowels and the patient was restless and mildly delirious. She complained of pains in both lower extremities, but nothing was to be found except a slight puffiness. The discoloration of the face and trunk noted on entrance deepened rapidly, extending to the limbs as well. The entire body became of a deep bronze color. The purple discolorations extended from the nose and finger tips to the entire face, neck, hands and wrists, so that just before death these parts were a deep purple, not disappearing upon pressure, while the rest of the body was of a deep brown color. Death about twenty-four hours after entrance.

CASE II. M. F., age thirty-three; married eleven years. Nativity, Norway. Occupation, housewife. Entered Boston City Hospital, Jan. 25, 1903.

History. — The last monthly period was Oct. 23, 1902. She had given birth to six children at term (all normal labors), and had one miscarriage two and one-half years before. Six days before entrance, being three months pregnant, the patient began to flow after heavy exer-

tion, and continued to do so off and on for three days, when the flow ceased. About twenty-four hours later it began again and continued to the time of entrance, a fetus being discharged about twenty-four hours before she entered my ward. The previous evening a yellow color spread all over the body, and she suffered from severe pain in the arms, front of chest, small of back, and vomited a few times.

Physical examination. — The patient was a well-developed and well-nourished woman, very sick, with marked icteric hue over the entire body, conjunctiva and mucous membranes. Temperature, 98.8; pulse, 140 and of poor quality. Pupillary reactions normal. The tongue was fissured and covered with a thick, dark-brown coat. The heart sounds were normal in rhythm, but very weak and rapid. The lungs were normal. There were dark reddish areas in both axillæ and all over the body, being more of a copper color, with a dark icteric background in some places, while in others the background was bronze with dark purple spots. Both the bronze and purple color deepened as death grew near. The entire body was puffy, and over the chest, arms and legs a fine crepitus was obtained on pressure — in fact, the patient could hardly open her eyes. The abdomen was pendulous and normally tympanitic. The spleen was palpable, but there was no tenderness over either liver or spleen. The knee jerks were absent. Dark blood was oozing from the vagina in small amount. The uterus was enlarged half way to the umbilicus, containing a large amount of placental tissue. This was gently removed with a curette, and was very foul. In spite of all treatment, the patient died four or five hours after admission to the hospital. White count, 126,400.

PATHOLOGICAL REPORT.

DR. RHEA:

CASE I. (W-06-24.)¹ The autopsy findings in this case are reported through the kindness of Wm. G. McDonald, M.D., medical examiner for Suffolk County, Boston, who placed his records and tissues from the case at my disposal. The body was kept at 32° C. for three hours before the autopsy was made.

The body is that of a robust, well-nourished and well-developed female. The body generally is swolled. The eyelids extend out even with the supra-orbital ridge. The lips are swollen, dry and everted. The whole body has a deep brown to copper color, which varies in intensity in different localities. It is most pronounced over the abdomen, inguinal region and the face; of these, it is most marked on the face. In some portions of the body the areas of discoloration described above have an icteric background of varying intensity. On palpation the body generally has a boggy feel and pits on pressure, especially over the thorax and face. Crepitation is present, most marked in those portions of the body where the subcutaneous tissues are normally loose, as the eyelids and axillæ. The breasts are slightly enlarged; on pressure, a small amount of thin yellowish fluid escapes from their nipples.

The abdomen is distended, tense and tympanitic. The subcutaneous tissues generally contain a considerable excess of clear straw-colored fluid, in which gas bubbles appear at the initial incision of the autopsy, and when pressure is applied to the surrounding tissues. Abdominal fat is well developed.

The peritoneal cavity contains 200+ ccm. of cloudy fluid, in which particles of fibrin are seen. The peritoneum has lost its luster, and in places fibrin adheres to it. This is most marked in the pelvic region. Mes-

¹ A brief report of this case was included in a paper by Drs. Rhea and Emmons: "Ninety-one Consecutive Blood Cultures." *Boston Med. and Surg. Jour.*, vol. clvii, pp. 1809-1813.

enteric lymph nodes are slightly increased in size and consistency. On section, they are pale red.

Pleural and pericardial cavities are normal.

Lungs. — Crepitation generally is more marked than normal. On section, a considerable amount of thin blood-stained gas-containing fluid escapes, especially from the lower lobes.

Spleen. — The organ is four or five times its normal size. It is very soft; the capsule is smooth and tense. On section the pulp, which is dark red, soft and very abundant, bulges beyond the capsule. Large amounts of it adhere to the knife blade on scraping. The normal markings of the spleen are not made out.

Pancreas. — Is somewhat softer than normal.

Gastro-intestinal tract. — Stomach contains a small amount of partially digested food. Intestines contain a small amount of fecal material.

Liver. — It is considerably increased in size. Its capsule is tense and numerous small gas bubbles are seen shining through it. On section the normal markings of the organ are not made out. The liver substance is honeycombed with vacuoles of varying size; the smallest are barely visible, the largest about 1 cm. in diameter. Between these cavities the liver substance is light brown and feels boggy. Gall bladder and ducts are negative.

Adrenals. — Normal.

Kidneys. — Somewhat increased in size. Small gas bubbles are visible beneath the capsule. The capsule strips easily from the underlying kidney substance, leaving a smooth surface. Cortex, dark red; Malpighian bodies not made out; pyramids light red. The whole organ is very moist and feels boggy.

Genitalia. — Uterus measures 11 cm. in length; uterine wall averages 3 cm. in thickness. In the center of the fundus there is an opening which extends through the uterine wall and connects the peritoneal and uterine cavities. This opening measures 2.5 cm. in diameter. On the peritoneal surface its edges are everted and covered with fibrin. A layer of moist, shaggy material lines the canal connecting the peritoneal and uterine cavities. The myometrium is dark red, moist, has a boggy feel and on pressure is emphysematous. The uterine cavity contains a considerable amount of grayish-colored, semi-necrotic material, which in places is firmly adherent to the uterine wall. This grayish material is thickest and most firmly adherent over an area of 2 x 5 cm., situated in the left upper portion of the posterior wall of the uterine cavity.

ANATOMICAL DIAGNOSIS.

Perforation of uterus (traumatic).

Acute endometritis.

Acute metritis.

Acute general peritonitis.

General septicemia (bacillus aerogenes capsulatus).

MICROSCOPICAL FINDINGS.

CASE I. (W-06-24.) Tissue fixed in Zenker and formalin. Stained with eosin, methylene blue and Gram Weigert.

Large Gram-positive bacilli which morphologically correspond to the bacillus aerogenes capsulatus are present in the blood vessels and to a varying extent in the tissues of all the organs examined. There is no inflammatory reaction in the tissues about these bacilli except in the uterus.

Only the heart, liver, spleen and kidneys show prominent lesions caused by the bacillus aerogenes capsulatus.

Heart. — Many of the blood vessels are distended with large bacilli. There are focal areas where the heart muscle shows marked fragmentation and degen-

eration. The fragments are separated by edema, in which are many bacilli.

Liver. — The liver cells are generally swollen, granular, stain poorly and show a moderate degree of fatty infiltration. Numerous blood vessels are packed with large bacilli. There are large and small vacuoles. About the periphery of most of them there is a narrow border of closely packed serum and large bacilli. The liver cells immediately surrounding these vacuoles stain very poorly, are flattened out and between them there is considerable serum and many large bacilli.

There are areas where the liver cells are separated, compressed, fragmented and degenerated without cavity formation. The accompanying sinusoids are distended with serum and bacilli. No acute cellular reaction is seen in the liver.

Spleen. — Shows marked congestion. There are numerous round and irregularly shaped cavities which occur singly and in groups. They are present both in the trabeculae and in the pulp. There is a narrow border of serum in the peripheral portion of some of the larger ones. The tissues immediately surrounding these cavities are more compact than elsewhere. In the trabeculae and less definitely in the pulp the cavities are due to distended blood vessels. Rarely a blood vessel contains a large bacillus.

Kidney. — There are numerous vacuoles similar to those described in the spleen. Some of the large blood vessels are packed with bacilli.

Uterus. — The mucous membrane is absent. Necrotic material is adherent to the inner portion of the myometrium. A good many cocci are seen in the deeper layers of this necrotic material. The most superficial muscles of the myometrium are separated by the products of acute inflammatory reaction in which are numerous large bacilli and a few small groups of cocci. Some of the polynuclear leucocytes are packed with cocci. An occasional one of the large veins, especially those in the inner portion of the uterus, are distended and practically empty. Others contain recent thrombi in which are many large bacilli.

BACTERIOLOGICAL REPORT.

Smears made from a swab taken from the uterine cavity at the time of entrance showed organisms which morphologically corresponded with the bacillus aerogenes capsulatus along with a few cocci and Gram-negative bacilli. From cultures made from this swab the bacillus aerogenes capsulatus, staphylococcus pyogenes albus and the bacillus coli communis were recovered. A blood culture was taken eighteen hours before death. Anerobic and aerobic cultures were made and, in addition, a few drops of fresh blood were injected into the ear vein of a rabbit. The rabbit was killed in two minutes and placed in the thermostat at 37° C. for eight hours. From both sources the bacillus aerogenes capsulatus was recovered in pure culture. The aerobic cultures were sterile. No gas bubbles were demonstrable in the patient's blood at the time of its removal. Cultures were made from the uterus, heart's blood, liver and kidney at autopsy. The bacillus aerogenes capsulatus was recovered from each of these sources. The staphylococcus pyogenes albus and bacillus coli communis were recovered from the uterus and the liver.

CASE II. (A-03-14.) Autopsy by Dr. Williams. Twenty-four hours post-mortem. Since death, the body has been kept in a refrigerator at a temperature of 32° C.

Body is that of a moderately well-developed and moderately well-nourished female. There is no edema. The sclera and the skin in general have a distinct yellow color of moderate intensity. Over the chest and

thighs emphysema is quite marked, crepitating distinctly on pressure. On section, through the tissues covering the sternum, numerous bubbles of gas escape. Smears from this tissue show an organism which morphologically corresponds to the bacillus aerogenes capsulatus. The pectoral muscles are pale, have a distinct spongy feel, and from them numerous gas bubbles escape when pressure is applied. The bubbles ignite and produce a slight crackling sound.

Peritoneal cavity. — The mesenteric lymph nodes are normal. Pressure applied to the psoas muscle reveals distinct crepitation.

Heart. — Weight 420 gm. The myocardium has a distinct brownish discoloration and a spongy feel. The inferior vena cava, right auricle, right ventricle and pulmonary artery contain large, brown colored clots; they are spongy in appearance as well as to the touch.

Lungs. — Crepitation is greater than normal.

Spleen. — Weight 640 gm. The capsule is tense. On section splenic pulp wells over the edge of the capsule. The parenchyma is dark red, semi-diffuent and from its cut surface a large amount of rather thick, brownish-red fluid escapes.

Liver. — Weight 495 gm. It is spongy to the touch. Just beneath the capsule there are numerous small vacuoles. There are numerous vacuoles, large and small, scattered throughout the liver substance. The anatomical markings of the liver are not made out.

Kidneys. — Weight 630 gm. There are small vacuoles throughout the capsule. On section, the parenchyma has a mahogany-brown color. The cortex averages 8 mm. in thickness; its capsule is adherent to the underlying kidney substance. The kidney substance has a distinct spongy feel. The glomeruli are not visible. The pyramids are made out with difficulty.

Genital organs. — The uterus is enlarged and is spongy to the touch. The myometrium is light brown in color, and on section many gas bubbles escape from it. Placental remains and blood clot are adherent to the uterine wall. The lower third of the endometrium has a distinct greenish color.

Brain. — The subpial vessels are distended. No vacuoles are found in the brain substance.

ANATOMICAL DIAGNOSIS.

Acute endometritis.

Acute metritis.

General emphysema (bacillus aerogenes capsulatus).

MICROSCOPICAL FINDINGS.

There are large Gram-positive bacilli in the vessels and to a slight extent in the tissues of all the organs examined. Blood clot from the left auricle shows polynuclear leucocytes and very many large bacilli. The uterus only shows acute inflammatory reaction.

Heart. — Similar to Case I.

Spleen. — There is marked congestion. An occasional blood vessel is packed with large bacilli. No vacuoles were found in the sections examined.

Liver. — The liver is generally similar to that of Case I. In one area which shows marked fragmentation, with separation and degeneration of the liver cells, there are occasional polynuclear leucocytes in the tissues.

Kidney. — There are very few vacuoles. They are similar to those described in the kidney of Case I. A few of the larger blood vessels contain large bacilli. Practically every glomerulus shows distention of its capillaries by large bacilli.

Uterus. — Sections of the uterus are in general similar to those of Case I. There is not so much involvement of the myometrium. Only the internal portion shows acute reaction. Large Gram-positive bacilli and small

groups of Gram-positive cocci are present in the interstitial tissues of the inner portion of the uterine wall, and in the lumen of the larger blood vessels (veins) in this locality.

BACTERIOLOGICAL REPORT.

Both anaerobic and aerobic cultures were made from various organs at the autopsy. All of these cultures were sterile except the aerobic culture from the liver. From these the bacillus coli communis was recovered.

PATHOLOGICAL SUMMARY.

Both the gross and microscopical findings in the two cases reported in this paper are typical of those produced by the bacillus aerogenes capsulatus. From the first case the bacillus aerogenes capsulatus, bacillus coli communis and staphylococcus pyogenes albus were recovered from a swab taken from the uterine cavity eighteen hours before the patient died. A culture taken at the same time from the circulating blood showed a pure culture of the bacillus aerogenes capsulatus. This organism was also recovered from cultures taken from various organs at the autopsy. The uterine cavity showed the bacillus aerogenes capsulatus, staphylococcus pyogenes albus and bacillus coli communis. In the second case, cultures were taken at autopsy from various organs. The bacillus coli communis was recovered from the liver; the bacillus aerogenes capsulatus was not obtained. The inability to recover the bacillus aerogenes capsulatus from this case may be accounted for from the fact that the body had been kept in the refrigerator at 32° for twenty-four hours. Welch and Flexner and Pratt and Fulton have noted the fact that the bacillus aerogenes capsulatus may not be recovered in tissues which have been exposed to low temperature for some time.

TUBERCULAR PERICARDITIS.*

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TUBERCULAR pericarditis is not a new disease. Its various phases have been iterated and reiterated in a rather voluminous and comprehensive literature. Case reports are frequent. Yet the disease often deludes or eludes us in practise. Osler¹ was able surely to diagnose only one out of seventeen cases that he reported in 1893, despite the fact that "tuberculosis follows hard upon rheumatic fever as a cause of pericarditis." It occurs many times as a disease of the autopsy room.

We have had recently under observation three cases of tubercular pericarditis, two of which are reported below in condensed form. Of the two, as will be seen, one died and came to autopsy; the second is still living. Both cases exemplified the acute type of the disease, with effusion.

CASE I. S. P., male. Age, nineteen. Greek. Entered State Hospital July 4, 1908.

Family history. — Unimportant.

* Prepared for a clinical meeting at the State Hospital Dec. 3, 1908.