

The clinical evidence would seem to be in favor of an effusion into the labyrinth as a cause of the particular group of symptoms we are considering.

The early tertiary or late secondary period seems to be the favorite time for this particular lesion, although some cases are reported as early as the fourteenth day of the disease. In all of the cases I have observed, the first symptoms of the involvement of the auditory apparatus have been from three months to five years after the original infection. In some twenty cases I have never seen one earlier than three months. One case occurred in the course of hereditary syphilis in a child of eight years. Some points in the differential diagnosis are of importance. The majority of the cases that I have seen have had a diagnosis of cranial trouble made, and had consequently been given a bad prognosis; this mistake is not an unnatural one from the fact that, in the mind of the average practitioner, even a high grade of deafness is considered relatively unimportant, and the chief attention is given to the symptom, vertigo. This vertigo and its accompanying nausea is frequently quite severe. In extreme cases, the patient may be confined to his bed for several days, unable to raise his head without vertigo and vomiting; occasionally he will say that he sees double, and even in the less severe forms the patient will stagger perceptibly in walking. There should, however, be no difficulty in establishing the absence of any other cranial lesion, as a careful examination will fail to reveal the implication of any other nerve than the auditory.

As will be observed in two of the three cases quoted, this complication of syphilis frequently comes on in cases that have received careful and thorough treatment; this was especially so in Case III, who had very thorough treatment under a member of this Society from the very start of the disease. Under these circumstances the administration of mercury and iodide to the maximum limit will often be of no avail. Here the subcutaneous administration of pilocarpine up to its full physiological limit will be of great service.

The improvement in hearing and the diminution of vertigo following the administration of this drug is in acute cases little short of marvellous; for example, Case II, when I first saw him, was so dizzy that he was unable to walk to and from his place of business, and his hearing was reduced to zero in one ear, and whispered voice at two twenty-fifths in the other. One injection of pilocarpine (one-sixth of a grain) raised his hearing to ten twenty-fifths, three injections to normal; and at the end of a week, having been given in addition iodide of potassium, he was free enough from vertigo to return to work, which he had not been able to do before for three weeks.

Case III had, in addition to his regular treatment, five or six injections of pilocarpine, which raised his hearing for both tuning-fork and voice to normal, where it now, after the lapse of two years, still remains. The pilocarpine in Case II was continued over the space of two weeks, when his hearing in one ear was normal; the other ear did not respond to treatment. This was about four years ago; he continued treatment with iodide of potassium for about six months, and his hearing at that time was still good in the better ear. Since that time he has neglected treatment both for his ear and for his systemic syphilis; and in a letter received from him some months ago I

was informed that he was practically totally deaf and much troubled with vertigo.

From a fairly large experience in the administration of pilocarpine in these cases I think we may safely conclude that the drug is an absolute specific in all acute syphilitic cases presenting this complex of symptoms; that where the deafness and vertigo have persisted for over a month, the prognosis is very doubtful; that it is of great value in cases where iodide and mercury are of little avail; but that it has no permanent value, and should be used in conjunction with other syphilitic treatment. In neglected cases where the pilocarpine may have failed to improve the hearing to any appreciable extent, it will almost never fail to relieve the accompanying vertigo.

There is nothing especially new about the pilocarpine treatment; but it certainly is a very valuable drug, and its use has been curiously neglected. I have for two or three years used it as a routine treatment in all cases of progressive deafness and obstinate vertigo and tinnitus which I have seen in my service at the Eye and Ear Infirmary; but although very favorable reports by eminent aural authorities on the use of this drug in other than syphilitic cases have been published from time to time, I have, in over a hundred administrations of the drug, never seen a favorable result follow its use in a non-syphilitic case.

STERCORAL ULCER.¹

BY J. G. MUMFORD, M.D., BOSTON.

THE bibliography of stercoral ulcers is scant. Many standard authors do not so much as give it a name. Having had a few cases with similar symptoms suggesting this condition, I have been led to think that this class of phenomena has a greater importance than is credited to it by others.

Of the cases I have observed I shall detail but one, however, which is the most striking and interesting.

Doubtless in recent years, the stercoral ulcer which eventuates in what we call appendicitis has absorbed attention to the exclusion of much else, but that these ulcers are found elsewhere in the intestine there is abundant evidence.

As is now generally recognized, the presence of an impacted fecal mass is the commonest and important causative factor in appendicitis, the usual sequelæ being localized enteritis, swelling, malnutrition, necrosis, ulceration, perforation.

The older medical writers, while failing to recognize the great frequency of these processes in the appendix, did mention them as occasionally occurring in other portions of the intestines, notably at the flexures of the colon, the caput cæci, and the rectum, and referred them to that unusual and rather mysterious disease "mucous colitis," or to chronic constipation. I doubt the importance of the former, but am convinced that a chronic constipation, especially when complicated with a long-continued local impaction, may and does give rise to ulcerations more frequently than the pathologists tell.

Naturally, when impactions, inflammations, necrotic patches and ulcerations in the course of the large intestine do not lie in the cul-de-sac appendix, they often do not result seriously.

¹ Read before the Warren Club, December 1, 1896.

However, that an extensive conflagration may start from such a focus is evident from the following case:

Mr. F. M., about forty-five years of age, has been under my care for a year. His general health has been only fair, though he is a vigorous, well-developed and active man, mentally and physically.

He has been for some ten years subject to occasional attacks of epigastric pain, which sometimes have required up to three-fourths of a grain of morphia to quiet them. A free use of salines has put a limit to each attack, in one of which only had I attended him previous to the illness to be described. He had never been a hard drinker or smoker, though he has been subjected to the ordinary American boarding-house diet. For the past year he has lived in Nahant, and has indulged moderately in the abominable drinking-water of that region.

On the 17th of last August I was called to see him in the afternoon. He was in bed, writhing with pain referred to the epigastrium. His bowels had operated that morning, but he had had much malaise for upwards of two months, owing, he thought, to sluggishness of peristalsis.

His temperature was 100° F., pulse 80. Abdomen soft, face anxious, tongue furred. A doughy mass could be felt, presumably in the transverse colon. This was very tender on palpation. Elsewhere the abdomen was soft and free from pain. I quieted him with a hypodermic of morphia, and ordered an ounce of castor oil, to be repeated in twelve hours. He passed a restless night. The next morning he was still very restless, but somewhat more comfortable; the abdomen was slightly distended.

He had had two enormous solid evacuations of the bowels—"Pounds," his nurse said. With these, however, his general condition did not at once improve, as I had anticipated. The urine was scanty, high, specific gravity 1.036, loaded with albumin and casts.

On the third day there was a change for the worse. Exquisite spasmodic pain in the perineum and the passage of blood were complained of.

There were three or four stools daily, of a gruel-like consistency and muco-purulent character. Small shreds of tissue could be seen in them.

An examination of the lower rectum showed a small hemorrhoid, with the neighboring mucous membrane velvety and intensely congested. Abdominal palpation had become very painful. The knees were drawn up. There was greatest tenderness over the course of the transverse and descending colon.

The face was anxious and the tongue thickly coated with black fur. Enormous eructations of gas were frequent, and there was absolute anorexia. Flatus passed freely; but there was no diminution of the distention. In other words, we had here a marked, acute gastro-enteritis, with possibly a mild peritonitis, and an acute nephritis. The temperature ran along at about 100°, with a fairly steady pulse.

All this went on with but little change till the seventh day. On that day I found the following conditions: Decubitus the same; great restlessness; abdomen enormously distended and tympanitic. In some considerable experience with abdominal surgery, I have never seen such distention. It seemed as though he would burst if touched. The greatest tenderness was still in the region of the splenic flexure; and at this place there was an area nearly as large as one's

palm, of great pain. If possible the distention at this place was more pronounced than elsewhere.

The face was haggard, the mind confused. Vomiting came on in the morning and towards night the character of the vomitus became fecal. At 6 p. m. he regurgitated freely the contents of the jejunum.

In twenty-four hours he had passed twenty ounces of high-colored urine; in which I roughly estimated over two per cent. of albumin. The specific gravity was 1.038, and there were innumerable casts with free blood. The temperature had reached 101° F. The patient would have been pronounced *in extremis* by any tyro.

My only hope clung to a full regular pulse of 90. This was at 6 p. m. Two hours later the pulse became more rapid and irregular—100 to 120. The patient was in mild delirium, and sinking fast. I told the nurse to give him a large hypodermic of morphia—one-half a grain, for he stood large doses—and to make his last moments as comfortable as possible.

I made a midnight visit. He was asleep. There had been no more vomiting. The pulse was steady at 100.

From that time on he began to improve. The stomach began to take care of food, the pain to diminish, the urine to clear up, and the temperature to come down.

The convalescence was rather slow. He had several slight relapses, and the abdominal distention was apparent after four weeks. However, he got well and is now in Europe.

I have described these symptoms in some detail, because the diagnosis was for a time obscure and the course unusual.

Of the initial fecal impaction there was evidence enough. The doughy mass first felt disappeared with the enormous dejections, but the enteritis and gastritis quickly supervened. The presumption is that the onward movement of the foul fecal masses over a sensitive mucous membrane accounts for the implantation of pathogenic bacteria in numbers sufficient to cause a rapidly spreading inflammation. Then, too, a stercoral ulcer at the seat of impaction undoubtedly existed and served as a nidus for fresh infection. It is a well-ascertained fact that such ulcerations are the result of a long-continued irritating impaction. The rapid spread of the inflammation was doubtless due to the man's lowered general condition.

I have said that there was a gastritis also present, and I base my belief in that on the fact that the stomach itself was distended and that the eructations of gas were enormous after the third day. At the same time flatus and feces passed *per anum* until the day of fecal vomiting. The whole course up to that day is certainly not very suggestive of a peritonitis.

Fortunately, there was no autopsy to confirm the diagnosis, but the onset of acute pain in the region of the splenic flexure, the subsequent increased distention, obstipation, and fecal vomiting leave one no other conclusion than that there had been a perforation and a localized peritonitis on that day.

Then there came the usual symptoms of approaching death and the large hypodermic for the relief of pain.

I admit that I had in mind the thought of checking peristalsis by morphia, and possibly assisting self-limitation of the peritonitis; but with almost no hope. From the result I believe the drug saved the man's life.

The question naturally arises, Why did I not do an immediate abdominal section? Because when the evidence of perforation was established the patient was obviously dying, and I was alone in the country, at least two hours from assistance. Ether would certainly have killed him.

There is in all this a curious analogy with the development of an acute appendicitis, but with the important distinction that the peritoneum is not so immediately threatened as in the case of an ulcerative appendicitis.

In the latter case necrosis and perforation into the peritoneal cavity are often rapid and fatal, but, *a priori*, it seems probable that an ulcer of the colon would be so slow in perforating as to give more time for a circumscribing peritonitis.

Certain it is that in my case peritonitis was limited in extent and quickly subsided. The etiology of the condition in this case is interesting. Let me premise this by saying that, in sixteen months, I have seen in Nahant seven cases of fecal impaction and a very unusual number of cases of obstinate constipation, especially in children. I have come to feel that the town water of the region—known as "Marblehead water"—is largely at fault. The exact analysis I cannot give, but it contains a very large proportion of lime salts in solution. It is so "hard," as the term is, that only the boldest can successfully bathe or shave with it.

It has become my routine practice to forbid the drinking of it by children. With this conviction about it in mind, I was much interested the other day to read in the *Lancet* a passage from an article by Lauder Brunton, in which he attributes much constipation to the improper quality of drinking-water as well as to its improper quantity; and he deprecates the use of water from a chalky soil, such water being very conducive to constipation.

In the treatment of this and similar cases it is better to use salines with plenty of water rather than oil or drastic cathartics.

I have usually done so, as the intestinal contents are thus very largely diluted and irritation of the gut is less. Frequently repeated doses of salts in plenty of water has been my rule. In this case I gave oil disguised in paregoric, as the patient was in great pain and I wanted to obtain as soon as possible the soothing influence of that excellent combination. Throughout the course of the disease the further treatment consisted of salol, lithia, milk and champagne, with morphia as indicated.

Clinical Department.

ABDOMINAL HYSTERECTOMY COMPLICATED WITH DOUBLE OVARIOTOMY: RECOVERY.

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My patient Miss —, age between thirty and forty, came to me for examination in May, 1896. She had been examined by me in the spring of 1893, at which time she was (examination without ether) supposed to have three small fibroid tumors of the uterus. Examination now revealed one large tumor, the size of a football, solid to the touch, and a second smaller one, the size of the fist, in front of and

below the first. Both seemed closely adherent to each other, firm on manipulation, and moved with the uterus as one mass. I supposed two of the fibroids found three years before had gone on enlarging, and had obscured the third.

The patient was operated upon at St. Luke's Hospital, Denver, in June, 1896, Dr. E. J. A. Rogers, of Denver, assisting. The patient was in the Trendelenburg position. An incision was made from above the umbilicus to the pubes, and the large tumor on coming into view proved to be an ovarian cyst. In passing the hand around the cyst to see if adhesions existed, it was ruptured at its pedicle, and a brownish fluid with black flakes escaped into the abdominal cavity. This was rapidly flushed out with sterilized water; and an incision in the collapsing cyst wall drained off the remaining fluid over the edge of the abdominal incision, the cyst wall being drawn up to overhang the abdominal wall. The cyst was freed of adhesions by dissecting off with the thumb-nail about nine inches of small intestine, after which the pedicle could be secured in the usual manner and the cyst wall cut off.

The right side furnished a slightly adhering and easily detached ovarian cyst the size of a very large kidney, which had a pedicle easily ligated and divided. The uterus had attached to its fundus a fibroid tumor the size of a fist, and it was amputated at the level of the internal os in the manner originated by Dr. John Homans, and so clearly described by him in the *Boston Medical and Surgical Journal*.¹ The broad ligaments were tied off as low as possible with two ligatures on each side, one inch apart, care being taken to avoid the bladder; and the broad ligament was divided on both sides between the ligatures; then peritoneal flaps before and behind were made and reflected back. The uterine arteries were ligated by the aid of an aneurism needle; the uterus was divided by a V-shaped cut, forming anterior and posterior uterine flaps, which were sewed together; and the peritoneal flaps were brought together over the stump.

The abdominal cavity was flushed out; the incision was sewed up; gauze and rubber-tube were used for drainage, extending from the fossa of Douglas to the lower end of the incision.

A hand-to-hand fight with shock followed for twenty-four hours in which figured brandy, strychnia, digitalis, nitroglycerine and oxygen, after which the patient rallied and made a steady and complete recovery. The drainage was gradually removed, and the patient was up in four weeks, and in six weeks went East for the summer.

November, 1896. Patient has since returned to Denver, has gained twenty pounds, and is in perfect health.

RESTRICTION OF THE MECCAN PILGRIMAGE.—All the European Governments are thoroughly aroused to the danger of infection, and the powers ruling Mohammedan subjects are placing restrictions upon the pilgrimage to Mecca. The movement of the French subjects in Northern Africa is just now a matter of French legislation, and the Mohammedans in Eastern Europe—in Albania, in Herzegovina, etc.—are being told that restrictions are to be placed upon their intended visit to Mecca. The Indian Government has closed its infected ports to the departure of pilgrims.

¹ Vol. cxxxii, Nos. 10, 11.