

been brought home by one of the neighbor's children. On the same day of the bite the dog was found engaged in his favorite amusement of chasing chickens, and upon scolding him for this, and throwing some missile at him, he started off through the fields, and was not seen afterwards.

On the morning of July 9th, his condition was unchanged until 11 A.M., when he had a slight convulsion and twenty minutes later a harder one, shortly after which time he eluded his watchers and ran to the woods, wandering about a mile and a half and hiding in a dense tamerack swamp, where he was finally discovered, terribly lacerated with briars, etc., begging his friends to kill him. He was then narcotized with injections of morphine, but two hours later had another convulsion in which his attendants say that "he frothed at the mouth and snapped his jaws together, but made no effort to bite or injure any one." Dr. Long unfortunately saw none of these convulsions. Three or four hours later the convulsions recurred and continued to recur frequently until 6 A.M., July 10th, when he died. Dr. Long was unable to obtain an autopsy.

Human rabies in this country is almost invariably contracted from dogs. Now, if rabies may continually exist among animals liable to communicate the disease to dogs, then the constant presence of unmuzzled dogs on our streets, in our yards, in our houses, constitutes a standing danger which may at any time produce disastrous consequences upon human life. This danger can be averted, and human rabies practically stamped out of existence by either annihilating dogs or keeping them muzzled.

One cannot help reflecting upon the significant and menacing fact that a case of hydrophobia can arise in a community like a clap of thunder out of a clear sky. Whence came it? Why do not more cases occur? How soon will some rabid animal, coming from nobody knows where, and going to nobody knows whither, signalize its brief career by leaving behind many cases such as the one which it has been my misfortune to be able to record? As above indicated, there has been no well authenticated case of rabies observed within the memory of anyone who has seen fit to speak upon the subject. May it not be that the disease has been propagated and kept in existence by some of the wild species of our indigenous fauna; such as the rabbit, skunk, squirrel, woodchuck, etc., and by them occasionally transmitted to dogs? These animals would not bite the dog, who is their superior and hereditary foe, except in self defence when attacked by him. This would only occur at rare intervals, and if we may judge by the statistics of human subjects bitten by animals which are known to be rabid, only a comparatively small percentage of those dogs bitten by rabid animals would contract rabies. Again may there not be many more cases of hydrophobia among dogs than is commonly supposed?

It is impossible to tell who, or how soon will be the next victim of a disease which has in its ensemble no counterpart of terror in the entire nosological list. Is it not time that something should be done? If it is too much trouble to keep the dogs muzzled, then dispense with the dogs.

Minimum doses of strychnia act well in nocturnal incontinence of urine.

## A CASE OF COMPLICATED LABOR.

BY J. F. JENKINS, M. D.,

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Mrs. G., aged 21 years, a *primipara*, had suffered some inconvenience, as she stated, on account of her limbs being swollen, but otherwise was in good health. My first visit to the patient was about forty-eight hours previous to labor; the membranes had ruptured previously while the woman was about her work, and a large quantity of water escaped per vagina, although it was not preceded or followed by pain. The patient did not complain of headache, nor were there any nervous symptoms present, yet the face and limbs were *œdematous*, and would pit upon pressure, which was ascertained from examination of the urine to originate from *nephritis*. An examination per vagina found the cervix dilated to the size of a ten-cent piece. I left the patient, after instructing the attendant that whenever a change should take place in the condition of the woman to immediately inform me. The following morning I received a summons to see the patient, but upon my arrival found no change. The next morning I again received a message to visit the patient, and when I arrived, was informed that she had a convulsion a few minutes before. The attendant stated that she had a few labor pains, but that they were not severe. A vaginal examination found the os dilated to the size of a silver dollar, and a slightly fluctuating tumor presenting.

The woman had a few labor pains when under the influence of chloroform, and was again seized with a violent convulsion, which was prolonged for some time. Remaining in a comatose condition, she was placed in position, and after some difficulty the forceps were applied, and I succeeded in delivering the breech, with a large tumor attached, to its surface; or, in other words, I was successful in delivering the tumor with the child attached to it. The forceps slipped from their grasp, but they were readily applied, and the woman rapidly delivered of a viable female child, which was immediately separated from its placental attachment.

Profuse hæmorrhage from uterine inertia immediately followed the expulsion of the child, and a teaspoonful of Squibb's fluid extract of ergot was ordered to be given by the mouth, but the patient had not sufficiently recovered from the convulsions to swallow the medicine. Upon passing the hand into the uterus it was found that the placenta was attached to its walls; the attachment was carefully separated by the finger, and the placenta removed, while the left hand grasped the uterus, making firm but gentle pressure in order to induce contraction. The foot of the bed was immediately raised, and as soon as possible ergot was administered hypodermically. Repeated hypodermic injections of ergot, together with gentle kneading of the uterus, eventually succeeded in bringing about permanent contraction and controlling the alarming hæmorrhage, but not until the patient was almost pulseless at the wrist. Hypodermic injections of brandy were now given, which, after being repeated several times, succeeded in restoring the pulse. From this time forward the patient made a good recovery, without a single unfavorable symptom.

The child lived a few hours, and the following day a post-mortem examination was made, in order to ascertain the nature of the growth. The tumor was oval in

shape, and the skin which covered the greater portion of it resembled that of the body of the child, excepting toward the apex, where it was a light blue color, thickly interspersed with enlarged veins. The tumor measured at its base thirteen inches in circumference, one inch more than the circumference of the head. Its attachment extended over the buttocks of the child, crowding the anus between the limbs and permanently flexing the limbs at right angles with the body. The tumor was larger than the child's head, and sufficiently firm to withstand the strong traction on the forceps which was required in the delivery of the tumor and the breech of the child. There was no pedicle to the growth, and it was impossible to make out the attachment by a mere inspection. The apex was slightly fluctuating, and upon making an incision into it several ounces of fluid mixed with blood escaped. Carrying the dissection toward the coccyx, it was found that the growth was largely composed of multilocular cysts, containing fat and a gelatinous substance. It was attached to the coccyx and the anterior surface of the sacrum, but there was no communication between the tumor and the spinal canal.

The growth may be classified with the congenital sacro-coccygeal tumors, which frequently grow to a large size, according to a number of well-known authorities. In my experience it was unique, not only on account of its size, but the rare complication of parturition.

#### CASE OF CHOLOCYSTOTOMY WITH CHOLOLITHOTRITY: DEATH FROM LA GRIPPE ON THE TWENTY-FIRST DAY.

Read before the American Association of Obstetricians and Gynecologists, New York, September 18, 1891.

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I report this case as a contribution to the operative history of gallstones, and that it may be fairly judged. The patient, Miss W., 56 years of age, and of very large frame, was referred to me by my father, Prof. William P. Seymour, for operation, the latter part of February, 1891. The patient, always in good health, and a hardworking woman, began in October, 1890, to have sudden attacks of atrocious pain in the epigastrium. Vomiting sometimes, but not always, accompanied the attacks, which varied from a few minutes to several days duration, with exacerbations. There was considerable tenderness of the epigastrium and liver border during the attacks, and clay-colored stools always followed an attack. At no time was there any jaundice, although the conjunctivæ had a slight yellowish tinge most of the time. The urine contained bile after severe paroxysms of pain. Owing to the very much increased frequency and severity of the attacks, and especially to the rapidly increasing emaciation, anorexia and loss of strength, my father urged operation, and after deliberation, the operation was accepted. The patient was plucky, but very much enfeebled for one who had been so strong. The tissues were flabby, but I could find no trouble with heart or lungs, and as to the liver, the

examination was negative, save that deep but gentle pressure over the gall-bladder elicited tenderness. The bowels having been freely moved each of the several days before the operation, and a soap bath given daily, I operated on the 20th of March, with the assistance of my friends, Drs. John W. Morris and George Meredith. Squibb's chloroform was used. The anæsthetic was well borne. I made a vertical incision over the gall-bladder, passing through fully 3½ inches of fat in the lax abdominal walls. The gall-bladder was found immediately beneath the upper extremity of the incision. It was contracted, and contained several stones. Protecting the abdomen with sponges, I first removed a drachm of bile by aspiration, and then opened the fundus between two forceps, and removed with Tait's scoop five stones, the size of small buckshot. Another stone the size of a filbert was felt in the common duct, near the junction of the cystic duct, and I found myself confronted with its removal by excision, crushing or needling. Considering the sloppy belly and the great depth of the stone, it seemed to me that excision with subsequent suture of the duct was far riskier than to crush the stone after Tait's method, by forceps applied to the walls of the duct. I accordingly, after failing to break it up with Tait's forceps introduced through the gall-bladder and cystic duct, grasped the duct and stone with a Keith's hysterectomy forceps, and speedily succeeded, with but moderate pressure, in comminuting the stone. Examination disclosed no injury to the duct, and the belly being clean, after washing out the gall-bladder, I stitched it to the abdominal walls with interrupted silk sutures, introduced a rubber drainage tube into the gall-bladder, and closed the abdominal incision with silkworm gut. The wound was dressed with absorbent cotton, the tube shielded with a rubber dam, and over all a four-tailed flannel bandage was placed. The patient bore the operation well, but two hours later had a terrific paroxysm of colic, due to the passage of the fragments of the stone. For this I was obliged, very much to my regret, to give several large hypodermatics of morphine and atropine. The pain was relieved, but obstinate vomiting came on the next day, and I gave repeated doses of calomel. No food was given by the mouth. As the vomiting continued, Monday, the second day after the operation, I gave several doses of salts, which operated and completely changed things for the better. Bile was found in the passages, and but a small amount in the dressings each day for three days, and then the amount reached its maximum, not to exceed 4 ozs. a day, for five days. From this time it rapidly diminished to a mere trace after the eighth day. The appetite returned, with the entire absence of the previously constant pain, and the patient ate and enjoyed chops, steaks, and other substantial things which for months she had been unable to eat. In short, her condition was excellent, and she expressed herself as delighted with the operation. The tube was removed the sixth day. The temperature, which before the operation had been two or more degrees above normal, never exceeded 101° save once, and became normal at the end of a week. The stitches in the abdominal wound were removed the seventh day, and the patient sat up a little the eighth day. Each day she was gaining, and on the thirteenth day was to have gotten out of bed, but in the morning complained of pain all over her, and a very trying cough. Her temperature was 101.5°, and