

Present Illness.—Four months ago the patient called me at 3 a. m. While indulging in sexual intercourse a few hours previously he suddenly felt as though some insect with a sharp mandible had bitten him on the left side of his scrotum. On arriving home he found the skin of that side of the scrotum quite red; he put on at once Pond's extract and camphor, but the itching became intense and large bullæ formed. I saw him in a few hours and diagnosed a dermatitis from the irritants applied. The skin of the left side of the scrotum was swollen and red and bore large vesicles containing seropurulent fluid. Under or in spite of treatment the condition subsided in about a week, and I was extremely puzzled as to what the initial trouble had been.

A few weeks later, while lying in bed, he experienced the identical sensation in the scrotum and foreskin and sent for me. I found the entire scrotum and foreskin enlarged to elephantine size, red, edematous, but no lesions of any kind. Frightful itching was present. Antipruritics and purges were given, and the condition subsided in a day. The testicles themselves could be made out and were normal.

Since then the patient has had three attacks, all similar in their feature to the second attack, i. e., with no vesicular formation. Parasitic disease was excluded, and it was palpable in the attacks following the first that we were dealing with an angioneurotic edema.

A suggestive feature in the case is that shortly before the onset of these attacks, the patient had gone through a typhoid-like seizure of short duration and subsiding suddenly. Could not this case in its latter features belong to that growing field of clinical entity, the erythemas and purpuras with visceral crises? If so, what relation, if any, has it to the luetic infection, or better still, did he ever have lues?

To settle these questions would require a more detailed history, for abundant as the above data are, they represent but a small portion of those at hand. The angioneurotic edema is the main reason for the publication of the case. Its general clinical aspects, however, assume a remarkable interest for those in touch with the patient.

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CASE OF LEFT SCROTAL HERNIA CONTAINING THE CECUM AND APPENDIX.

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The following case is reported because of the comparative rarity of the anatomic findings, beyond which it presented no points of special interest.

History.—Patient, aged 3 years, a twin and a 7 months child. The parents informed me that the hernia was present at birth, but it is fairly reasonable to suppose that it may have appeared soon after birth. They also stated that the hernia varied in size, but never disappeared entirely. The child was well nourished and apparently normal, except that it had never walked, and in the recumbent position had developed eversion of both legs to practically 90 degrees.

Examination.—The left side of the scrotum was filled with a mass the size of a lemon, a part of which was easily reduced, with audible signs of gas. I was not, however, able to accomplish complete reduction, either at that time or later, under anesthesia, and as the remaining mass felt doughy, I diagnosed a hernia of the small bowel and omentum.

Operation.—On opening the sac the small bowel, which was thought to be the ileum, was found uppermost. On attempting to draw this up from the bottom of the scrotum, some resistance was encountered, but after a little perseverance the adhesions gave way, and the entire cecum and appendix presented, and the underlying loop of gut proved to be part of the ascending colon. The cecum was thick and friable, and

tore on attempted reduction, which was very difficult, necessitating one suture. The cecum and appendix were very much congested. The appendix measured 7 cm. in length and 8 mm. in diameter after three days' hardening in alcohol.

Owing to the length of time taken by the appendectomy, and the reduction of the thick-walled, friable cecum, it was not deemed wise to subject the child to farther examination at the time, and the herniotomy was completed in the usual manner. Subsequent examinations, however, revealed nothing abnormal and the child made an uninterrupted recovery.

FOREIGN BODY REMOVED FROM RIGHT BRONCHUS BY LOW TRACHEOSCOPY.

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History.—March 6, I was hastily called to see Mary P., aged 10 years, who for some time had suffered from laryngeal dyspnea, which had gradually increased in severity until radical measures were necessary. She was taken to a laryngologist who promptly made a diagnosis and inserted a No. 3 hard rubber tracheotomy tube into the trachea to give better breathing space. He dilated the stenosis successfully so that the patient was much improved.

At 2 o'clock in the afternoon March 6 the tube was removed, cleaned and replaced. Two hours later, while eating cake, she had a sudden attack of coughing and cyanosis which passed off in a few moments. A little later, the attack was repeated. The nurse, much alarmed, immediately summoned a physician, who attempted to remove the tube. He succeeded in getting only the outside plate; the tube was missing. In the absence of the attending laryngologist I was asked to see the patient.

Examination.—She was lying on her back, breathing with some difficulty and coughing incessantly. Finding her in no immediate danger, I turned my attention to the plate, and found that in some way the tube had become unscrewed until it was almost off the plate. During the acts of swallowing the cake it had evidently dropped into the trachea, giving rise to the sudden cough and cyanosis. Immediate operation for the removal of the tube was advised.

Operation.—The patient was chloroformed, with the mask over the nose and mouth, and the tracheotomy wound was cleaned and enlarged for half an inch. Jackson's 5 mm. tracheoscope was passed through the tracheal wound, the mucous membrane touched with cocain and adrenalin, blood and secretion wiped away and careful search made for the missing tube. After we had reached almost to the bifurcation, the dark edge of the foreign body could be seen. The tube had worked its way down into the right bronchus while the upper end was in the trachea close to the bifurcation. With each pulsation of the heart the dark edge moved from side to side. Forceps were introduced through the tracheoscope, the edge of the tube was seized, and tube and forceps were pulled out together through the tracheal wound. The entire operation lasted about fifteen minutes. The patient was nauseated the next day, but with this exception recovery was uneventful. There was not the slightest rise of temperature.

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Staining of the Negri Bodies.—L. Frothingham, in the *American Journal of Public Hygiene*, states that the stain should be made freshly every day, as the Negri bodies fail to take up the red readily after the solution is from six to eight hours old. The Negri bodies stain from a pale pink to a purplish red, and often contain numerous minute dark blue dots. The cells stain more or less blue, the red blood corpuscles not at all or are yellowish in color, rarely pinkish. He calls attention to the fact that not infrequently the Negri bodies in the Purkinje cells stain a very pale pink, while those in impressions of the cornu Ammonis, made on the same slide and stained at the same time, are deeply stained. He has observed this same peculiarity in the sections.