

cation, Extracts from Lectures before the Johns Hopkins University, 1877-78," by John S. Billings, M.D., in 1878.

Beside, many anniversary addresses at college commencements and before learned societies have from time to time made additions to the literature of medical education in this country. What is done in the medical and surgical practice of to-day, is recorded in our hospital reports, in medical journal correspondence and in the practical works of American authors.

RACHITIC CHEST DEFORMITY IN TWINS, WITH EXHIBITION OF CASTS.

Presented in the Section on Diseases of Children, at the Forty-seventh Annual Meeting of the American Medical Association, held at Atlanta, Ga., May 5-8, 1896.

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These cases are presented because they are unique. They were twins, the mother being a hunchback. The deformity is very nearly alike in the twins. They died of atelectasis and pneumonia at the age of fifteen months. In the case of Sarah Coy, we found a small strip of lung tissue on the left side, the other being of an atelectic character. The other lung was slightly encroached upon. This child just previous to death weighed eight and one-quarter pounds. Its breathing in best physical condition was eighty to ninety per minute, and the respiration during the last illness ran up as high as one hundred and twenty per minute, practically panting. A line drawn through the chest, directly from the central portion of the sternum, would have pierced the inner angle of the cartilages of the ribs as they were bent in, in each case. The other case is of a boy, weight seven and one-half pounds at the time of death. The two cases were almost exactly parallel. They were each subject to frequent bronchial attacks. The respiration in the boy was a little more rapid than in the other; the last illness gave a respiration that could hardly be counted.

Dr. BYERS—How about the limbs?

Answer: There were some evidences of rickets about joints. The head of the girl showed a slight rachitic square shape, and the sutures were only partially closed.

Question: Was the chest born that way?

Answer: It was slightly deformed. I did not see the children until about the third month and there was a slight sinking in at that time, which seemingly increased until their death.

Question: Is there any such thing as congenital rickets? Have you noticed such a thing?

Answer: I have heard reports of such cases, but never saw a case. These cases occurred in the New York Infant Asylum. I made molds for these casts over the bodies of the children, so they are exact reproductions of the chest.

SOCIETY PROCEEDINGS.

Southern Surgical and Gynecological Association.

Abstract of the Proceedings of the Ninth Annual Meeting, held in Nashville, Tenn., Nov. 10-12, 1896.

FIRST DAY—MORNING SESSION.

The association met in the auditorium of the Nicholson House, and was called to order by the President, Dr. E. S. Lewis of New Orleans, La.

An Address of Welcome was delivered by the Hon. JOHN BELL KEEBLE of Nashville, which was responded to by President LEWIS.

There were fifteen new members elected, after which the reading of papers was proceeded with.

The first paper was read by Dr. W. D. HAGGARD, Jr., of Nashville, Tenn., entitled

VAGINAL VERSUS ABDOMINAL SECTION FOR PUS IN THE PELVIS.

He recounted the transitional periods in the treatment of pus in the pelvis: Vaginal puncture superseded by abdominal section and removal of pyosalpinx, total uterine castration per vaginam by the French and through the abdomen by the American school. They have reluctantly given way to modern vaginal section and evacuation and drainage of all pus pockets. It is a distinctly American innovation and will revolutionize the results in pus disease. The abdominal route affords visual inspection of the field. The attack on morbid masses can be made with safety to visceral integrity. If pus accumulations are multiple, rupture and peritoneal soiling are inevitable; that is the supreme disadvantage of abdominal incision. He had often seen the pelvis deluged with pus with impunity. He had also seen patients die within twelve hours from fulminant sepsis, from peritoneal contamination. The cases perishing from sepsis on the third day are classical. There is no way of distinguishing these cases clinically. All should be regarded as virulent. The writer referred to a mortality of 18.5 per cent. in a series of collected cases of laparotomy for pus, done in five metropolitan hospitals in the last year, and asked what must it be in the "unheard from precincts" and in the hands of the great unwashed? The abdominal method offers the best approach in tubercular inflammation of the ovaries and tubes and in small unilateral pus tubes.

The author referred to the advantages of exploring the pelvis for retro-uterine tumors, inflammatory, and adnexa by vaginal section. The geography of pus in the pelvis in most cases makes vaginal incision extraperitoneal, a minor procedure giving major results; no shock, no risk, no disturbance in convalescence. Patients will submit to it who will refuse more formidable procedures. We can change the methods, but we can not change the patient. In prolonged sepsis from huge abscesses posterior section and drainage are a life-saving procedure. The special indications are in: 1, early cases of acute suppurating salpingitis; 2, incipient post-puerperal peritonitis; 3, large pyosalpinx and true pelvic abscess. The first group includes early gonorrheal and abortion cases. The essayist had incised a tense tube and let out serous fluid and curetted a gonorrheal case of a month's standing with pain, temperature and tenderness for three days. The opposite tube was normal. In a week that tube became similarly affected and was similarly treated. He believed those serous effusions in the Fallopian tube were the preceding pathologic condition to pyosalpinx. If this be true and is the embryonal history of suppurating salpingitis in early gonorrheal and other inflammatory cases, the prophylactic value of vaginal section will be the greatest boon yet given to infected woman. In puerperal cases, incipient peritonitis and puddles of pus in Douglas' space imperatively demand incision. Should simple pus-letting in any of these cases not effect a cure, subsequent operation for removal of the relics of previous ravages can be done without the dangers incurred in the presence of pus. The field of vaginal section is to prevent suppuration in early cases, to anticipate it in puerperal cases and to save life in desperate cases. It is simple, surgical and safe. Its application to the pelvic inflammatory processes and to pus in the pelvis is one of the greatest surgical triumphs of the age.

Dr. JOSEPH TABER JOHNSON of Washington, D. C., said that while the vaginal method had a great many points in its favor and was being resorted to more and more in cases of large pus collections in the pelvis, yet those who had been familiar for a considerable time with the abdominal route could operate more conveniently and dextrously by this method and with greater safety to the patient than by the vaginal method. He could not agree with the speaker that the vaginal operation may be done without any risk or damage to the patient. Sometimes in operating through the vagina for the purpose of removing the uterus and its adnexa, or for large pus collections high up in the pelvis, where it is necessary to manipulate the parts a good deal and to do a thorough enucleation, the surgeon was likely to tear the intestines, the bladder, the ureter, or rupture a large vessel which is out of sight. In such cases the abdominal is much safer than the vaginal route. However, the vaginal method had much to commend it in cases of pus collections that are low down in the pelvis.

Dr. CHARLES P. NOBLE of Philadelphia believes we should practice a judicious eclecticism. He did not feel that either the abdominal or the vaginal method possessed all the advantages, but if restricted to one or the other he should choose the abdominal rather than the vaginal route. An objection form-