

amount of radium and the pocket used depend on the point of radiation desired—whether prostate or left or right vesical area—and on the type of case and previous treatments. The pouch is then inserted while collapsed, and the radium pocket or pockets are accurately placed at the desired position by a finger in the rectum. Collargol, or some solution impermeable to the rays, is then injected into the pouch, the amount of distention desired being known by previous measurement, and the injection tube is clamped. The distended bag pushes the radium pocket snugly against prostate or vesical wall and holds it in place irrespective of the position of the patient. The rectal tube perforating the bag allows the passage of intestinal gas, so that the bag may be retained for hours without discomfort. The solution in the bag furnishes a filter which thoroughly protects all portions of the rectum except the small area directly in contact with the radium pocket.

For intravesical treatments the catheter method has likewise proved unsatisfactory in my experience. The method as illustrated in Figure 2 has proved simple and efficient in the treatment of three cases of bladder

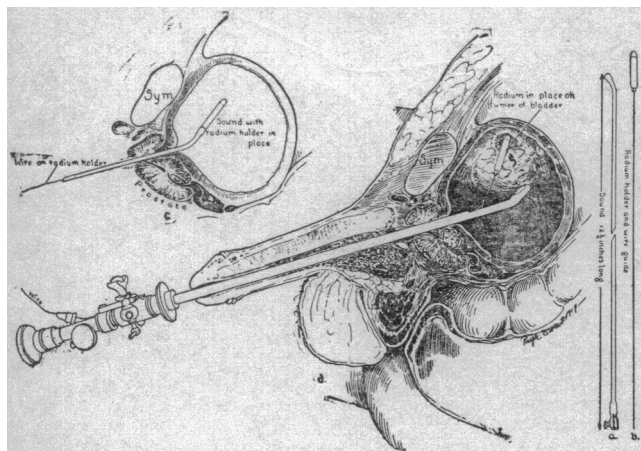


Fig. 2.—Apparatus for the treatment of vesical cancer; *a*, holder for radium capsule; *b*, wire, with the radium capsule attached, to be threaded into *a*.

cancer during the last year. The instruments consist of a brass capsule, with a screw cap, for holding the radium. At the other end is a square shoulder into which a wire 25 inches long is firmly fastened (*b*). The wire is threaded into a holder (*a*), curved near the end, at which is a square socket into which the square shoulder of the radium capsule firmly fits. At the other end is a screw which, by compressing the wire, holds the capsule firmly in the socket of the holder and forms a solid radium sound. This sound is first inserted into the bladder (*c*), and for radiation of the trigone or areas near the vesical neck can be accurately placed with the finger in the rectum as a guide, and held in position by a mechanical arm. For tumors on the apex or other portions of the bladder, however, more accurate placement is desired. The screw of *a* is loosened and the wire pushed through the sound so as to displace the radium holder from its socket. The sound can then be withdrawn through the urethra, leaving the holder in the bladder with the wire guide through the urethra. A No. 16 F Brown-Buerger single catheterizing cystoscope is then threaded on the wire into the bladder and, by means of its lever, the radium holder can be guided, as if it were an ureteral catheter, to any portion of the bladder desired (*d*), and

held in this position by fixing the cystoscope to the table with a mechanical arm. The flexibility of the wire allows the holder to take a parallel position to any portion of bladder wall or tumor area.

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ANGIONEUROTIC EDEMA

REPORT OF CASE

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The case reported, while in the main one of angioneurotic edema, differs from the type commonly seen in that it embodies in its manifestations almost all the features of this disease. Its decided hereditary tendency, its appearance early in life, its persistent and frequent attacks, with pronounced local and general manifestations and a clinical course at times suggestive of an acute infection, stamp it as unusual. The possibility of confusing it with the expression of some sudden severe systemic derangement, the protean manifestation of some vascular disturbance such as acroparesthesia, or classifying it as the familial type of edema described by Edgeworth or even as Milroy's disease is not unlikely.

REPORT OF CASE

History.—L., a white man, aged 24, born in Missouri, where he resided until his induction into military service, entered the base hospital at Camp Dodge, July 24, 1918, with the provisional diagnosis of "edema, origin undetermined." The attacks, he stated, began July 22, 1918, two days before admission, with a feeling of fulness and tension of both palms and soles accompanied by slight tingling and numbness. The following morning he awakened to find both hands, forearms, feet, legs, and thighs one-half again their natural size. The genitalia also were very much swollen. On the afternoon of the same day both upper and lower eyelids, cheeks, and, to a lesser extent, his tongue, became involved so that sight was almost impossible and speech and mastication difficult. The parts previously described continued swollen. The condition gave rise to but little discomfort, although the inconvenience of being unable to put on his clothing and shoes and the inability to use his hands incapacitated him for his routine duties.

Physical Examination.—On the third day, that of admission to the hospital, the swelling subsided to some extent. The patient was 5 feet and 10 inches in height, weighed 175 pounds, and though not robust was not of an unhealthy appearance. All organs such as the eyes, ears, heart, lungs, and abdominal viscera were free from any palpable abnormalities. The eyelids exhibited an appearance such as one might expect in an edema the result of an acute diffuse nephritis. The cheeks and skin of the neck were puffy, but did not pit on pressure, while the tongue was grossly thickened but otherwise normal. The skin of the chest and abdomen, while of a fine texture, appeared thickened. It was somewhat blanched, dry and tense, with slight pitting on pressure. The skin of the upper and lower extremities presented much the same general phenomena, but the feet and hands were shiny, having a tense, slick appearance. They felt cold and clammy, and were a dark, dull, purplish red, with here and there a bit of white mottling. Moderately firm pressure resulted in some pitting, lasting from one to three minutes, while the subsequent blanching disap-

peared immediately, leaving a decidedly erythematous area. There was no dermatographia or itching.

This attack lasted in all six days, disappearing gradually. Subsequent to this he had five attacks of from one to three days' duration during the six weeks of observation in the hospital. All were less severe, and each differed in some respect from the one described. In some the onset and duration covered only a few hours, while in others merely the hands were involved. These sometimes were very white and warm, at other times red and cold with numbness, tingling, and formication.

On the day of his admission, his temperature was 101.6 F., pulse 78, respiration 20. The red blood count was 4,780,000, hemoglobin 100 per cent. (Sahli), and the white blood count 20,000 with no noteworthy changes in the differential count. The blood pressure was 115 systolic and 85 diastolic. The following day the temperature, pulse and respiration were normal, and the white blood count fell to 9,000. In the second and fourth attacks there was again some rise in temperature and a moderate increase in the number of leukocytes. The urine, stool and blood Wassermann test were repeatedly negative, as were roentgenographic examinations of the gastro-intestinal tract, the sella turcica and the bones of the extremities. Neurologic examination was negative.

Past History.—The patient had been free from previous diseases, including nervous and venereal diseases, nor could there be elicited any history of dietetic or gastro-intestinal disorders. He was told by his parents that even in early childhood he had had similar attacks, occurring as frequently as two or three times a year. His own recollection dates back to the age of 14 years, at which time an attack not unlike the present occurred; but at that time he had in addition a markedly swollen tongue which seemed to fill his mouth completely, severe dyspnea, so that he feared choking to death, and abdominal cramps, without, however, any diarrhea. This attack fluctuated in severity from day to day, lasting in all fifteen days and undergoing a gradual decrudescence. He had had but one other such attack, which occurred when he was 17. Minor attacks, however, as the one described above, have been frequent, occurring as often as once a week. The onset of these covered from two to twenty-four hours, and lasted, in all, from twenty-four hours to three days.

Family History.—The grandparents on both sides died in old age. The mother and father are living and well. One uncle, the father's brother, has three children; the second, a boy of 24, has had several attacks of the same disorder. In the immediate family there are seven children.

The oldest, a sister of 36, occasionally has manifestations in which only the feet and hands are involved. A brother, aged 31, has attacks similar to those of this patient, with frequent involvement of the chest, marked dyspnea, "choking spells," and abdominal cramps. Another brother, aged 29, is living and well. A sister, aged 26, having at present pulmonary tuberculosis, is affected with the same disease to only a moderate extent. Two other brothers, aged 18 and 10, have always been in good health.

Triumph of Medicine in the War.—How important is the part that medicine plays in national welfare has been strikingly shown in the recent war. Whatever may be the verdict of history on the diplomatic, political, naval, military and economic phases of the war, there will be no hesitation about the brilliant triumphs of curative and preventive medicine. These triumphs have been partly the outcome of the researches and investigations of contemporary workers, not only in the science and art of medicine but also in the allied sciences of chemistry and physics and biology; but the victory was eventually ensured by the thousands of trained workers who knew how to make full use of all the resources which these sciences had placed at their disposal. Medical men of different nationalities, sometimes of different races, reared under different educational and social systems, were able to cooperate in the common endeavor, because they had all alike inherited the same traditions of rational medicine.—*Tweedy, Brit. M. J.* 2:597 (May 17), 1919.

THE OPHTHALMOLOGIST AND THE PHYSICIAN *

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Each decade presents to the medical man a new problem; that is, the advancing edge of his science is ever shifting. Progress at one point permits of progress at other, formerly quieter zones. Twenty years ago a large group of medical patients were not well treated. "Neurasthenics" they were called, or, if they seemed likely to resent that name, they were assured that they were "only nervous," that they "had no organic trouble." The average general practitioner did not know how to help them, and so by his unsympathetic attitude he drove them into the churches and offices of various sects antagonistic to medicine.

The improved methods of diagnosis and the great recent advances in our knowledge of the functional neuroses have, however, proved to us that very many of these patients can be helped, some very easily. Many complain of easy fatigability alone, which may be due to various common diseases in their earlier stages before any characteristic symptoms have appeared, usually diseases of the central nervous system or of the cardiovascular-renal organs. Several other groups may be separated; but only one interests us now, a large group of patients with no real disease but who are handicapped by some mental or physical defect, often permanent in character, which leads to symptoms which the patient accepts as a part of his life and which may in time, because of the fatigue and suffering produced, lead to nervous or even to mental breakdown. The conditions which this group of patients presents are very complex. Several factors work conjointly in the production of symptoms, but one is so important that I invite you to discuss it now with me. I refer to eyestrain in persons whose nervous makeup is such that this strain alone can lead to results of greater or less importance, or at least can modify a syndrome produced by some other injuring factor. I would avoid emphasizing eyestrain as the sole cause of any symptom. In these cases it usually is not. The real cause is more likely to be in the neuropathic disposition of the patient himself. These patients all deserve careful and sympathetic study, since many are greatly relieved by the proper correction of errors of refraction. The point, however, which now I would make is that these patients cannot be helped by the ophthalmologist alone any more than by the internist alone. He requires their combined efforts. I invite you today to such consultation with the subject of eyestrain as our patient. I would not for one moment claim that the subject is new. Nearly every symptom and disease from heterodoxy in religion to ingrowing toenail has been ascribed to eyestrain. It would not be wise before this audience to increase this list without good reason, but an intensive study of certain indirect results may be timely, for only by such studies can we improve our methods of diagnosis and increase our efficiency in treatment.

* Read before the Section on Ophthalmology at the Seventieth Annual Session of the American Medical Association, Atlantic City, N. J., June, 1919.