

physician living in New Jersey. He had become very much concerned about the future of the child, and rightly, I think, insisted on the operation being done early. In one case which occurred in a young man I was able to bring both testes down and anchor them in the scrotum in the way indicated by Dr. Bevan. I am glad to say that the results have been very good, although I believe the testicle, even if brought down into the inguinal canal, will never become functionally active.

DR. ARTHUR DEAN BEVAN, Chicago—In regard to the question raised by the last speaker, I think that we must always be guided by the conditions which are present. The operation is performed, of course, with the idea of giving relief to the individuals who have undescended testicles. Of course, these cases are almost always complicated by hernia, and the point I wanted especially to make is that by this method we have only to bring the testicle down and do not have to apply any tension. My experience has been rather limited in this work, about twenty cases, but I have not seen more than one where we could not bring the testicle down without any tension.

### APOPLEXY.

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On account of some peculiarities in the way of symptoms, I report a case of apoplexy.

A female, aged 81, was stricken Sept. 10, 1902, with all the symptoms of cerebral hemorrhage. She was unconscious and paralyzed, which condition continued nearly twenty-four hours, when consciousness returned. In a short time she could move her left foot, and we soon discovered that she had hemiplegia of the right side.

In a short time she could use her left extremities, so that she could feed herself, lying on her right side. She remained in bed about two months, when we allowed her to sit up a few hours at a time in the morning and afternoon.

In three months she was able to walk with a little assistance. She now ate her meals at the table, and sat up nearly all day. Her appetite and digestion were nearly as good as before she was taken sick.

At first we had no hope of her recovery on account of her advanced age and the severity of the attack, but now she was so much improved we began to entertain great hopes of her final recovery.

She could not use her right hand in feeding herself, but could stoop down and pick up light things, such as a paper, requiring but little grip.

In about four months from the time of attack, she could pull herself up and walk alone through the rooms and hall, which she frequently did during the day for exercise.

She was perfectly conscious of her surroundings and recognized friends who called to see her; but she never recovered the ability to command language to express her feelings, or to converse with her friends. She endeavored to talk, but could speak very few intelligible words. This is one of the rare symptoms attending apoplexy.

There is frequently inability to talk immediately after an attack due to paralysis, but I have not met with a case where this condition existed after regaining the use of the muscles of the tongue, etc. One singularity in her case attended this condition, which was, if you requested her to count, she could do so up to any number, and enunciate the words distinctly. She could also repeat the letters of the alphabet very distinctly. This seemed unaccountable when we could not understand a word she tried to say when endeavoring to talk to her friends. This condition might perhaps be accounted for on the ground that she knew the alphabet and numbers by heart, but was unable to originate language in the way of conversation.

The extravasation of blood in the brain must, in her case, have compressed the origin of the nerves, the function of which enables us to command language.

About ten days before her second attack she began to lose the use of herself, and could not walk without some assistance,

although her appetite remained as good as usual, still eating at the table.

On the night of February 10, just five months after the first attack, she had the second. I was sitting by the bedside when it came on. I noticed several minutes before that the blood vessels about the head and face were congested; and as she seemed to be losing consciousness, I felt certain another attack was approaching. In a very short time she had a slight spasm, a mere sudden jerk; and she was perfectly motionless and unconscious. She never regained consciousness or any muscular action, and lived only thirty hours.

I spoke, in the outset, of some peculiar symptoms attending this case. I have mentioned one, her inability to command language to express herself in trying to talk with her friends, and the ability to repeat words she had been familiar with all her life, such as counting numbers and repeating the letters of the alphabet.

Another unusual symptom was the change in her habits for about a month before she was stricken down. She was always a great reader and talker, but for several weeks before she was taken ill she had but little to say in the way of conversation and she read but little. Before this, she always read some in the Bible every day and was fond of reading religious papers, but now she would only read a paper a few minutes and lay it down. This change in her habits was remarked by her friends, but, of course, could not be accounted for. From the history of the case I feel satisfied that there was some change then taking place in the brain substance.

The results of apoplexy vary according to the amount of blood extravasated into the brain substance and amount of pressure resulting therefrom.

Hemorrhage in the cerebellum is much more apt to prove fatal suddenly than in other portions of the brain. In fact, many cases fall and die immediately. Those who escape sudden death are afflicted with hemiplegia on the side opposite to that of the hemorrhage, the nerves decussating to the side opposite their origin. Probably half of the cases recover so they can walk, and have good use of themselves, except the hand of the hemiplegic side. Some who recover their health in every other particular never regain the proper use of the hand, but now and then a patient recovers the use of all parts of the paralyzed side. I have had two cases attended with this result. Of course this depends entirely on the amount of blood extravasated into the brain and on the severity of the attack.

The exciting causes of apoplexy are somewhat indeterminate. A person may be in an excellent state of health and be stricken very suddenly. This may occur without any premonitory symptoms or indications. It may occur while sitting, standing or walking, without mental excitement or physical effort.

But, no doubt, in some instances there exists some diseased condition of the brain, or pathologic alteration in its structure favoring hemorrhage.

Then again, the attack may occur during great mental excitement or physical exertion. Whatever may increase the circulation or retard the blood from returning from the brain may result in an attack. The treatment of such cases, of course, is simple but essential. The patient should be kept as quiet and comfortable as possible, with the head and shoulders somewhat elevated by pillows. The room should be well ventilated and kept perfectly quiet; in fact, anything calculated to produce excitement must be excluded from the patient. His diet should be light, but digestible and nourishing.

In old times venesection was practiced in such cases, and at present, if the patient is robust and stricken down in perfect health, there is no doubt that the abstraction

of blood by venesection would prove beneficial. But, by doing so, we would have to revive a lost art in surgery.

It is very essential that the bowels should be kept well relaxed, so as to determine, as much as possible, from the head in the way of revulsions. The kidneys should also be kept active, in order to modify the quantity of blood in the veins.

The action of the heart should be looked after and kept in moderation. If there is apparent congestion about the head, it would be well to apply cloths wrung out of cold water and hot applications to the lower extremities, etc.

Apoplexy is much more common now than formerly. During the census year of the United States, 1900, there were 50,766 deaths from the disease; 27,059 males and 23,707 females; the proportion of deaths from apoplexy and paralysis in 1,000 deaths from all causes was 50.8; whereas, in 1890, ten years before, the corresponding proportion was 37.6 per 1,000 from all causes. In fact, there are other diseases, aside from apoplexy, which are more common now than years ago and, apparently, more fatal. We might name, and very conspicuously so, pneumonia. During the winter and spring seasons we frequently notice in the weekly reports of mortality in cities that more people die from the effects of pneumonia than from the much-dreaded white plague, tuberculosis.

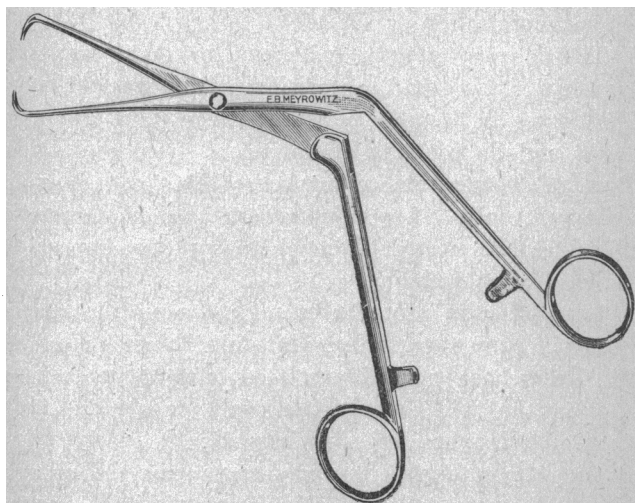
Fortunately, the latter disease is not so prevalent and fatal as formerly, this change taking place within the last decade. It has decreased from 12,146 deaths in 1890 to 10,688 in 1900 per 100,000 deaths from all causes. This happy result has been brought about by the use of preventive means and a better mode of treatment.

## New Instruments.

### A NEW TONSIL SCISSORS, FORCEPS AND TONGUE DEPRESSOR.

C. C. STEPHENSON,  
LITTLE ROCK, ARK.

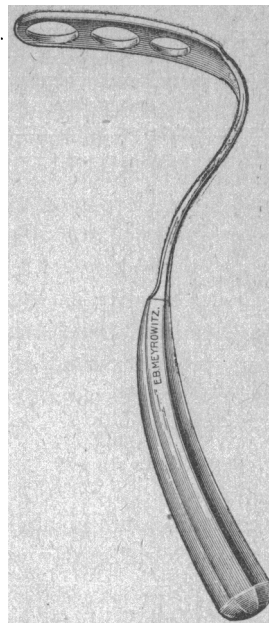
The operation for tonsillotomy with these instruments, and the advantages they possess, are briefly as follows: The forceps are made to seize the tonsil, when the handles are locked with



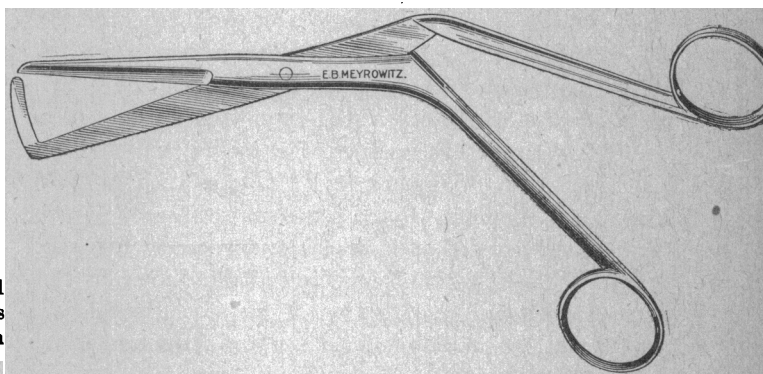
fixation ratchet; the tonsil is then drawn out, the beak of scissors is passed behind, and the gland cut off entirely, as in cutting with an ordinary scissors. The beak prevents the tonsil from slipping from between the blades of scissors, and so much of the tonsil can be removed as is desired. While holding it

with the forceps the tonsil is completely under control of the operator; thus there is no receding of the gland as in the ring of a tonsillotome.

The simplicity and ease in operating commend the scissors and forceps, while with them the removal of entire gland without trouble is a desideratum. The handle of the tongue de-



pressor is octagon, and curves outward, thus allowing an examination of the full-chested class of patients, without the end of

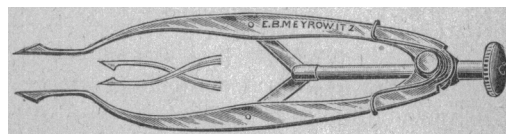


the handle coming in contact with the chest. The blade has three holes for the dorsum of tongue to project through, which prevents it from slipping from side to side while in use.

### IMPROVED TENDON TUCKER.\*

FRANK C. TODD, M.D.  
MINNEAPOLIS.

I desire to show the Section a tendon tucker, which is an improvement over my instrument shown at the session last year. The principle of this instrument is the same, the only



difference being that the adjustment is made at the distal end of the instrument, where it is more easily handled. The operation was described in the *Ophthalmic Record*, February, 1902.

\* Exhibited at the Fifty-fourth Annual Session of the American Medical Association, in the Section on Ophthalmology.