

Eleventh day. Temperature 104° , respiration 34. Small area of pneumonic involvement of lower lobe of left lung. Characteristic expectoration, which lasted three days. Patient weaker.

Twelfth day. Deafness has continued, and patient's mind is wandering more or less all the time. Physical examination shows effusion in left pleura.

Thirteenth day. No extension of pneumonia. Slight bilateral effusion into pleura. Less pain in joints.

Fourteenth day. Epistaxis about one ounce.

Fifteenth day. Epistaxis. Mind wandering. Patient very restless. Temperature 105° . Pack given for half an hour, after which temperature went down to 102° .

Sixteenth day. Epistaxis slight. Temperature 103.8° . Pack. Complaints of pain in elbows and knees.

From this time to the twenty-first day the symptoms remained about the same. Diarrhœa, rapidly varying temperature, with wandering and restlessness.

Twenty-second day. Moaning and crying all the time. Less diarrhœa.

Twenty-third day. Fairly quiet slept three hours, which was unusual.

Twenty-fourth day. At 6 A. M., had a severe rigor, which lasted fifteen minutes. Temperature rose to 105° , pulse 104 (weak), respiration 36. This was followed by a drenching sweat. At 10 A. M., temperature 100° , pulse 106, respiration 28. At 2 P. M., temperature 99° , pulse 90, respiration 24. Quiet, rational, and slept well. That evening the temperature began to rise, and at 8 o'clock it was 103° . Passed a restless night. Physical examination shows slight hypostatic congestion posteriorly. Involvement of valves increasing, the murmurs becoming harsher in character. At this time we decided that the case was one of ulcerative endocarditis.

Twenty-fifth day. Temperature ranged from 100° – 103° . Patient restless and at times wild. Involuntary evacuations.

Twenty-sixth day. Temperature 105° , pulse 125, respiration 40. Was put in a pack for half an hour but as the packs did not reduce the temperature greatly and the patient was very weak, they were discontinued. Wild delirium and involuntary evacuations.

Twenty-seventh day. Temperature varied from 101° – 103° , pulse 116, respiration 40. Dr. C. P. Putnam was called in consultation and he concurred in the diagnosis of ulcerative endocarditis.

Twenty-eighth day. Temperature 102.2° . Restless and wildly delirious. Diarrhœa ceased and urine passed freely. Toward evening she seemed to be going into a collapse, but she rallied under stimulation. At 7 P. M. temperature 106.5° . Examination of heart at this time showed that a new sound had developed. It was loud, shrill and sharp — heard during diastole and systole and at any point over the left chest.

She died at 1 A. M. at the beginning of the twenty-ninth day.

Treatment. — From the beginning the treatment was sustaining, the greatest care being taken in the regular and frequent administration of food either by mouth or by rectum. When rheumatism declared itself on the fifth day the salicylates were given; but in a few days deafness, delirium and wandering ensued, and the potash salts were substituted. The pain under these was severe and the temperature high, and antipyrine with aromatic spirit of ammonia was administered for

a short time. No lasting improvement was noted under any of these remedies. Salol and the ammonium salts were then given without favorable result. Aside from the remedies mentioned, quinine, alcoholic stimulants, etc., were used.

Various drugs were used to check the diarrhœa; but the best result was obtained from the salicylate of bismuth, suggested by Dr. Putnam.

Autopsy, ten hours after death:

Rigor mortis had set in.

Lungs normal, except hypostatic congestion posteriorly.

Pericardial fluid slightly increased. On opening the heart, the mitral and tricuspid valves were found bordered with recent inflammatory deposits. Back of one of the aortic cusps was the remains of an abscess, which had undoubtedly been the cause of the rupture of the cusp, as the tissues were soft and friable, and which was covered with a grayish film over which there was thin pus. Strings of fibrin were hanging like a fringe from the edges of the rupture.

The intestines, liver and spleen were normal in size and texture.

The left kidney contained one small abscess.

The ovaries and tubes were normal.

No adhesions about the uterus.

Marked endometritis, with one small red spot in the fundus which was soft and friable.

No examination of the brain was made.

Taking into consideration the temperature, chills, sweating, etc., we were assured of the presence of a septic process. There was no indication from examination of marked trouble in the pelvis. Owing to the fact that an abortion was suspected, and that the patient constantly referred to this in her delirium, there was a chance that this might have been a source of septic infection, especially as the presence of endometritis was shown by the autopsy.

A CASE OF ACUTE VEGETATIVE (MALIGNANT) ENDOCARDITIS.¹

BY F. C. COBB, M.D., BOSTON.

Mary S., colored, twenty-two years of age, entered St. Monica's Home, November 14, 1891, complaining of rheumatism. Six years previous she had her only child, and since his birth has had attacks of rheumatism, sometimes accompanied by articular swelling. Two years ago she had typhoid fever. Examination on entrance showed no evidence of inflammation in the joints and was negative as regards the heart. She was discharged, apparently well, in two weeks.

January 28th, she again entered the hospital, complaining of pains in her limbs and back. She had been feeling tired and feverish, with loss of appetite, for about two weeks, during which she had been sometimes confined to bed. No clear history could be reached, owing to her dull mental condition.

A thorough examination failed to show any cardiac murmurs or evidence of enlargement. A few ronchi were heard over both lungs and there was considerable albumen in the urine. Otherwise the examination was negative.

The temperature, 104° on entrance, rose to 106° in the evening. In the absence of any definite symptoms,

¹ Read before the Section for Clinical Medicine, Pathology and Hygiene, of the Suffolk District Medical Society, April 20, 1892.

a probable diagnosis of typhoid was made, and baths and phenacetin were given. In a few days, however, the irregular temperature curve led us to suspect a septic process.

The patient still showing no murmurs or enlargement or irregularity in action, the abdomen was examined carefully; and as there seemed some tenderness about the pelvis, a vaginal examination was made, with a negative result. Vomiting began about the 31st, and the vomitus under the microscope showed pus-cells. The vomiting was preceded by a chill and considerable epigastric pain and tenderness.

The possibility of sub-diaphragmatic abscess which had broken into the stomach, was considered; but as there was no tumor to be felt, this was left in doubt since the pus might have been due to a chronic gastritis. On February 15th, she began to have convulsions, each lasting three to four minutes, at intervals of about four hours. In the intervals she lay in a comatose condition and died February 17th.

Autopsy, by Dr. F. B. Mallory.

Body thin, emaciated. Rigor mortis present.

Head not opened.

The heart was normal in size. The mitral valve was studded with numerous cauliflower-like masses (the largest the size of a chestnut), almost blocking up the lumen. The chordæ tendineæ and the upper portions of the papillary muscles were likewise covered by numerous small papillary masses from the size of a pin-head to that of a pea, pinkish-gray in color and quite firm. The aortic valves were likewise covered (one cusp on both sides) with numerous masses (the largest the size of a bean); they were also attached to the endocardium below the valves. The tricuspid valve presented an appearance similar to the mitral, except that there was no one especially large mass, but, instead, half-a-dozen the size of peas. There was no thickening of any of the valves, or interadherence indicative of a chronic endocarditis. Pulmonary valve normal. Muscular substance of the heart pale. Pericardial sac everywhere obliterated by fibrous adhesions.

The lungs were adherent on both sides by dense fibrous adhesions to costal pleura; on section, markedly oedematous.

The spleen was normal in size. Two small areas of ischaemic (embolic) necrosis present.

The kidneys were about twice their normal size. The capsule peeled off readily, leaving a smooth white surface; on section, the cortex was increased in thickness; of a general grayish-white cast, but showing numerous translucent, glistening, elevated areas, most marked in the pyramids, looking as if the kidneys had been soaked in glycerine. Microscopic examination of a fresh section showed but a slight amount of fatty degeneration.

The liver and pancreas were normal.

There was considerable mucus on the surface of the stomach.

Intestine not opened.

The ovaries and tubes were bound down by numerous fibrous adhesions, into which, on the right side, considerable effusion had taken place, giving rise to several small cysts.

The mucous membrane of the bladder was covered with a thin layer of grayish material.

Microscopic examination of the kidney showed areas of round-cell infiltration, thickening of the capsule of some of the glomeruli and filling, with moderate dilata-

tion of many of the tubules (most marked in the pyramids) with a homogeneous hyaline material (casts). The vegetations on the valves were composed of round-cells, blood, finely granular material, and numerous large colonies of micrococci.

Diagnosis: acute vegetative endocarditis (of bacterial origin) of mitral, aortic and tricuspid valves; chronic adhesive pericarditis; chronic adhesive pleurisy; oedema of lungs; embolic infarctions of spleen; chronic interstitial nephritis; chronic pelvic peritonitis.

Dr. George Sears and Dr. Augustus Thorndike saw the case with me; and I am indebted to them for verifying the examinations and for valuable suggestions.

The most interesting feature in this case was the difficulty in diagnosis, caused by the absence of any cardiac symptoms. At no time was there any irregularity in the action of the heart, oedema of the extremities, dyspnoea, increased cardiac dullness or murmurs.

Reports of Societies.

MASSACHUSETTS MEDICAL SOCIETY,
SUFFOLK DISTRICT.
SECTION FOR CLINICAL MEDICINE, PATHOLOGY AND HYGIENE.

A. N. BLODGETT, M.D., SECRETARY.

MEETING of April 20, 1892.

DR. GRACE WOLCOTT read a paper on

ULCERATIVE ENDOCARDITIS.¹

DR. C. P. PUTNAM: I have nothing to add to the description of the case. Such cases are called by the name of "ulcerative endocarditis," but of course we should all recognize that septicæmia covers the ground, excepting so far as the local manifestation is concerned. The patient had symptoms, which, had they occurred alone, one might have called rheumatic, but, in connection with all the rest, it seemed hardly possible they could indicate anything else than septic processes. I think one is impressed in seeing such a case as that, with the idea that we may not be very far wrong, in recognizing, that all cases of acute articular rheumatism are similar in character though of course not exactly the same; that is to say, they are caused by some organism. This case ran through a number of different diseases, that is to say, if we call them separate diseases; rheumatism and skin disease; pneumonia, pleurisy and endocarditis.

DR. G. B. SHATTUCK read a paper on

TWO CASES OF ULCERATIVE ENDOCARDITIS; ONE FOLLOWING TYPHOID FEVER, WITH DEATH AND AUTOPSY.²

DR. C. F. FOLSOM: I have been very much interested in the report of these two cases. Through the kindness of Dr. Shattuck I saw the second case several times. The diagnosis which I made was that of infective endocarditis—and it seemed to me it was the only possible one—with an embolic infarction of the right lung. The last time I saw the patient there were the typhoidal aspect and the physical signs which Dr. Shattuck has described. I had the impression that the spleen became considerably enlarged, but that was not in the notes. I supposed that I should very

¹ See page 290 of the Journal.

² See page 277 of the Journal.