

its former size, and the pupil dilated fully and freely. There are still the synechial remains on the capsule of the lens, but no trace of the condyloma remains.

CASE 3.—Mr. P. E., aged 26, Irish, gave a history of having chancre about three months before and had taken treatment for syphilis for a few weeks. He came to my clinic at the Manhattan Eye and Ear Hospital. There was some swelling of the lids of the right eye, marked pericorneal injection involving the ciliary vessels. The cornea was slightly hazy, and the aqueous cloudy. The iris showed effects of inflammation, being discolored and the pupil 2.5 mm. Down and out there was a circumscribed elevation about 3 by 4 mm. at its base and about 2.5 mm. high, extending forward toward the posterior surface of the cornea but not in contact. This mass was pinkish-gray, and no distinct vessels were noted; but there was apparently some synechia formation. There was some photophobia and lacrimation. The Wassermann test was positive (++++). Two days later neosalvarsan was given, and after thirty-six hours a decided decrease in the size of the condylomas was noted. Inside of four days there was almost complete absorption of the mass. The iris cleared and the inflammatory symptoms were entirely relieved. A small synechia remains on the outer side of the iris above the location of the condyloma.

The very rapid response of this special syphilitic lesion in Cases 2 and 3 to the neosalvarsan was remarkable, and its use would seem to be especially indicated in this sort of syphilitic manifestation.

The diagnosis of the syphilitic lesions of the iris has been made much easier and surer by means of the serologic test. Where a definite history of the syphilis can be obtained, diagnosis of these lesions is a simple matter; but in the cases in which such a history is not obtained, the Wassermann reaction has added a most important factor in the diagnosis. It might be well to mention here that at times it has been difficult to differentiate between a papule or condyloma and a tubercle of the iris. It is in this sort of a case that the von Pirquet test and the subcutaneous tuberculin test become of great importance. Recently I have seen several cases of tubercle of the iris which have been treated for syphilis of the iris in spite of a negative syphilitic history and a negative Wassermann reaction with no improvement. For those who have not been especially interested in the tuberculin tests and therapy, I can readily see why such a line of treatment would be persisted in. It might be argued that previous anti-syphilitic treatment has been employed; hence the negative Wassermann; or that the patient may deny syphilis for reasons best known to himself, and therefore without any further search for the cause, anti-syphilitic treatment is used.

The microscopic examination of the iris and the ciliary body when affected with gumma or condyloma reveals about the same changes as are noted in chronic inflammation of these tissues. There is nothing definite and characteristic which would make it possible to say that syphilis was the factor which caused the growth. The blood vessels show fairly constant involvement and microscopic changes in syphilis of the

iris. There is an endarteritis especially of the smaller vessels with an apparent increase of the endothelial cells. This is partly due to the increase of pressure on the highly sensitized cells which line the lumens of the vessels. The adventitia also shows a proliferation or new deposition of cells with a marked increase of epithelioid cells outside of the adventitia.

Fuchs found the iris of normal thickness infiltrated with round cells, and these chiefly in the anterior limiting membrane. This inflammatory exudate of the leukocytes was also in the reticulum, and in some of his cases he found typical giant cells present. The presence of giant cells has been noted by other observers, but in none was there any caseation present. There are always a number of capillaries seen inside or around these syphilitic nodules, which is not the case in the tubercular nodules of the iris.

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SUPPURATIVE CHOLECYSTITIS FROM THE PARATYPHOID BACILLUS

REPORT OF A CASE

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History.—The patient is married, aged 25; occupation, electrician. His family history is unimportant, except that he had one aunt on the paternal side who died of tuberculosis at the age of 40. He had the usual diseases of childhood, including spinal meningitis. He never had pneumonia, typhoid fever, tonsillitis or rheumatism. At the age of 13 he developed malaria of the tertian type, which recurred for three summers. He uses tobacco to excess, and occasionally beer and whisky. Venereal history is negative. About once a year he becomes badly constipated, and this is usually associated with cramps in the abdomen. These cramps continue for several days, unless relieved by a purgative. His digestion has always been perfect. There is no history of any accident or injury, although he has a cataract of his left eye, which has produced a loss of sight in that eye.

Monday morning, Aug. 16, 1915, he went to his work in his usual good health. In two hours' time, however, a severe headache came on, which was followed by pain in the abdomen and this in turn by nausea. He continued at his work, however, for the remainder of the day and returned home about 5:30 p. m. About 6 o'clock the pain in the abdomen was so severe that he called his physician, Dr. W. E. Reynolds. After making a careful examination, Dr. Reynolds told him that his symptoms were suspicious of intra-abdominal trouble, and asked to bring in a surgeon as a consultant, to which the patient consented. I saw the patient for the first time in consultation with Dr. Reynolds about 9 p. m. He was then complaining of pain on the right side of his abdomen. The temperature was 102 and the pulse was 100. An abdominal examination showed a marked rigidity of the right side and a localized tenderness most acute midway between the navel and costal margin, about 2 inches from the median line. He had, however, some tenderness all over the right side. The symptoms were rather suggestive of appendicitis, but we decided to wait until morning. Meanwhile he was ordered to abstain from all food, liquids or medicine. He continued to suffer in the night, and the next morning when his physician saw him, a localized pain was found in the region of the gallbladder. This pain continued with moderate severity during the forenoon. When the physician examined him again at midday, it was discovered that the localized pain had shifted from the region of the gallbladder to the region of the

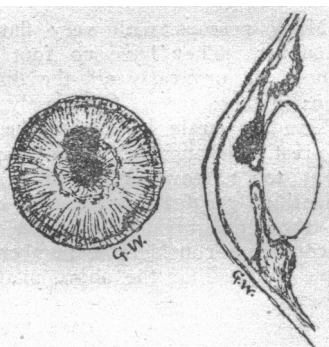


Fig. 2.—Right eye; growth was up and out, but did not reach to the cornea as in Figure 1. There was a grayish white exudate between the retinal pigment layer and the stroma of the iris.

appendix. The temperature at this visit was 101, and the pulse had gone up to 120. He was advised to go to the hospital for a more careful study of his case, and an operation, if necessary.

He was brought to my infirmary about 8 p. m. His pain was somewhat better, although there was a marked rigidity on the right side and a point of acute tenderness two finger breadths beneath the costal margin on that side. A urinalysis was made, which was negative. Blood examination revealed: hemoglobin 85 per cent., white blood cells 12,000. Temperature, 99.6. We had now had the case under observation for twenty-four hours, and as no appreciable improvement was present and as the symptoms were very suggestive of an intra-abdominal lesion, either the appendix or the gallbladder, an operation was advised, to which the patient consented.

Operation and Result.—A right rectus incision was made in order that a thorough exploration could be carried out. The appendix was enlarged and somewhat inflamed. We felt, however, that this could not be the entire cause of the trouble, and further search of the abdominal viscera was instituted, although the appendix was removed. The gallbladder was found in a state of marked distention. It was quite red, covered with lymph in numerous areas, and on the fundus were several small patches that were almost black. A needle was introduced, and about 5 ounces of cream-colored pus were drawn off. The gallbladder was then packed off, opened, cultures from the interior were taken, and a drainage tube inserted and the abdomen closed. The next morning the patient stated that he had been perfectly comfortable since he regained consciousness. The temperature, however, was 102, but the pulse had dropped to 100. The drainage from the gallbladder was copious and of a black color.

For the next few days the patient continued to feel well. His abdomen was flat and he complained of no pain at all except a headache. The temperature continued to run between 103 in the afternoon to 101 in the morning. On the fifth day after the operation the temperature was 104 and a blood count was made which was as follows: red blood cells 6,200,000; white blood cells 8,000. A careful examination of the patient's throat, lungs and abdomen was made, all with negative result. The Widal was also negative. The laboratory report at this time had not been received, and for this reason we were unable to account for the continued temperature with almost a normal blood count. The temperature continued to drop gradually, and reached the normal on the morning of the tenth day after the operation. It continued to run up in the afternoon for four days, ranging from 99 to 100.2. Fourteen days after the operation, for the first time, the temperature remained normal for the whole twenty-four hours, and continued to do so for the remainder of the patient's stay in the hospital. The wound healed by first intention, the tube was removed at the end of the tenth day, and the drainage tract was closed at the end of three weeks. At the end of five weeks and a half the patient returned to his business, feeling in first-class condition, although a little weak.

Laboratory Report.—The following report was received from the Department of Bacteriology, Vanderbilt University, Medical Department:

"Cultures made from the pus obtained from the gallbladder showed that there was but one organism present. This organism was found to be a short bacillus, irregular in length, actively motile, and gram-negative. When grown in litmus milk the medium became acid after twenty-four hours, but by the twelfth day had become alkaline again. The milk was not coagulated. There was marked gas formation after twenty-four hours in glucose bouillon. On Russell's medium the surface was bluish-white in appearance, while the lower layer became red and contained considerable gas. On endomedia the colonies formed a pale, bluish-white, translucent growth.

"The bacillus was not agglutinated by stock serums which had been obtained from patients suffering from infection with the typhoid bacillus and with the paratyphoid bacillus B,

but was strongly agglutinated by the serum from a patient suffering from infection with the paratyphoid bacillus A.

"The serum of the patient did not agglutinate stock culture of the typhoid bacillus or the paratyphoid bacillus B, but did agglutinate the paratyphoid bacillus A, in a dilution of 1:200.

"From the cultural reactions and the agglutination tests, the organism isolated in pure culture from the pus is probably the paratyphoid bacillus A."

COMMENT

The interesting feature of the case was the early involvement of the gallbladder, as the first symptoms presented by the patient were due to the cholecystitis. I am unable to find in the literature of paratyphoid how early and how often cholecystitis occurs. With the typhoid bacillus it is not unusual, but comes up later in the disease. I am of the opinion that a careful culture made in all cases of noncalculous suppurative and gangrenous cholecystitis will clear up, to a great extent, the uncertainty concerning the etiology that now exists in these conditions.

PAINFUL WEAK FEET

REPORT OF CASE

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Many persons with very flat feet have no discomfort whatever. They have no foot strain, and strain is what causes all, or nearly all, the distress and secondary symptoms in these cases. Conversely, in those who have pain, to relieve the strain is to cure the patient. Usually, a period of rest, a change of shoes (especially shoes that are too tight, too narrow, or too short) "arch supports," or more scientifically constructed braces, or a combination of several of these measures, will afford the patient great relief. I encounter a considerable number of patients, however, who have tried all of the above methods and who are still not relieved.

CASE REPORT

History.—A young man, 23 years of age, consulted me last July with a history of disability on account of painful feet, which had been increasing for about three years. From January to July, 1915, he had been able to do only three weeks' work at his trade, that of a foundryman. His feet were swollen and acutely tender. He had leg ache, with pain in the knees and hips. At times there was much cramping of the muscles of the legs—so much sometimes that he could not sleep at night. He had a family dependent on him and was extremely anxious to resume work. The feet were markedly everted and there was pronounced spasm of the peroneal muscles. He came to me seeking braces, but I dissuaded him from this and advised tenotomy of the peronei with a period of fixation of the feet in inversion in plaster of Paris.

Operation.—He accepted this advice and the operation was done the next day. An attempt to forcibly invert the feet under anesthesia before tenotomy was not successful. Accordingly all of the peroneal tendons were divided just back of the external malleolus and then the feet could easily be strongly inverted.

Plaster casts were put on with the feet in this position and the patient kept in bed for about two weeks. Then he was allowed to get around, still wearing casts for a total of six weeks. During the seventh week after operation the casts were removed, ordinary shoes were put on, and he went home.

Result.—He now (November, 1915) reports that at first he walked with his feet in an extremely inverted (over-corrected) position, but that there is only a slight tendency in that direction in one foot at present.

He stands and walks perfectly well and can even walk on tip toe (an impossible feat for most of these patients). He