

phenomenon, ulceration of the valves, often gives rise to no sign, no abnormal sound. The patient dies in many instances, as in our second case, before this process has culminated in severe valvular lesion or rupture; but the wart-like valvular growths (endocarditis verrucosa) often contain the bacterial colonies.

In both these cases the starting-point of infection may have been the Fallopian tubes. The condition was diagnosticated, in Case II, with considerable confidence during life.

TWO CASES OF SEPTIC ENDOCARDITIS.¹

BY ALBERT N. BLODGETT, M.D.

G. W., aged twenty-one years, was seen for the first time January 15, 1892. Patient has always been in good health and comes of a long-lived family. Present illness is stated to have commenced in December; but he continued his work as expressman, until Christmas. From that date he has been in bed most of the time, though he sometimes lay on a sofa. He has been recently treated for a venereal disease accompanied by a purulent discharge from the urethra, from which he is not at present fully free. A definite history of the case is difficult to obtain, but he is said to have fainted on Christmas day, to have become ghastly pale, and to have remained very weak, and later to have passed stools of very dark color, of tarry consistency, and of intolerably offensive odor. At the time of my first visit, patient was in bed, the skin of the face, hands and visible mucous membranes was blanched, the tongue dry, the lips parched, the voice husky, throat dry; swallowing was painful and difficult, and the general appearance was that of profound anemia. Liver dulness increased, urine scanty, otherwise normal. There are dark patches on the cheeks, eyelids, lips and other places, consisting of minute ecchymoses or extravasations beneath the skin, giving the parts a dusky appearance which does not disappear on pressure. There are large dark-greenish-brown ecchymoses beneath the ocular conjunctivæ of each eye. Vision not impaired. Belly is prominent and tympanitic. No exanthem is present, though the mother states that there was a rash on the trunk when the patient was first taken sick. There has been earlier in the disease a moderate diarrhœa, but that has given place to constipation. There is complete anorexia, with a feeling of weakness and some pain in the stomach. Patient's condition is said not to have materially changed in the last three weeks. He is at present conscious and rational, but is rather dull; there is no active delirium. Pulse 120, temperature 5 p. m. 102° F. No further abnormal condition noticed.

Treatment advised: sponging with solution of bicarbonate of soda. Enema when necessary to relieve lower bowel; a moderate amount of bromide of potassium was administered to diminish the restlessness, and digitalis was prescribed for the evident cardiac weakness, with whiskey and milk in small quantities at intervals of two hours. Half a drop of carbolic acid was given in repeated doses to control the gastric uneasiness; with absolute rest in bed, and heat to abdomen. Urine passed voluntarily, not characteristic.

January 18th. Condition much the same. Bowels were evacuated by enema, but there is still tympanites

and stupor. No efflorescence is visible, and the ecchymoses noticed at first visit have begun to fade. Tongue and lips parched; sordes on teeth; pulse 120; morning temperature 101° F. Has retained nourishment, and seems somewhat stronger. There is at times active delirium. The general condition of the patient strongly suggests typhoid, but some of the more characteristic signs of that disease are not present, and the period of illness does not correspond to the usual chronology of typhoid. The appearances resemble those of progressive septic poisoning, though any known origin for this condition is lacking unless the theory of infection of the general system from the gonorrhœal virus be accepted. Treatment now comprised nuxvomica, grt. five, with continuance of the gentle sedative p. r. n.

January 20th. Patient seems materially improved. Takes food regularly. Pallor of the surface not so marked; has slept naturally, is conscious and rational. Pulse 112, temperature 100° to 102.5° F. Large dark-colored, horribly offensive dejection occurred during the night.

January 25th. Patient has been gaining until last night, when from no ascertainable cause, he had a severe rigor, lasting about an hour. There was then high fever, thirst, restlessness and pain in left chest over cardiac area. Auscultation now for the first time revealed a mitral systolic murmur of rough character and constant occurrence. Pulse small and jerky, the so-called "Wasser-hammer pulse." There is constant thirst, anorexia, restlessness, and at times nausea. Treatment comprised synapisms to cardiac region; tincture of digitalis every three hours, with whiskey and milk, an ounce every hour; with heat to the extremities. Glycerine lotion was ordered for the mouth and throat, which are parched, fissured and painful. Patient is delirious, and at times tries to escape. Friction and artificial heat to extremities.

January 27th. There is now a distinct double friction murmur, synchronous with movements of the heart's apex and heard most distinctly over the area of normal cardiac dulness. In rhythm the first sound is slightly presystolic in its commencement, and continues through the entire period of systolic contractions, ending with the termination of the first sound of the heart. The second friction sound commences almost at the end of the systolic sound and is of shorter duration and of lesser intensity than the sound just described. Repeated and careful study of the heart led to the conclusion that the adventitious sounds were due to a grave interference with the organic cardiac structures followed by acute disability, and insufficiency of the mitral valve, with subsequent extension to the pericardium, and possible involvement of the muscular structures of the heart itself. The description of the pain over the cardiac area was like that of rheumatic distress in other muscular structures of the body, the patient expressing himself in this manner when asked to locate the seat of the pain.

January 29th. Patient is evidently sinking. Refuses all nourishment and has occasional violent attacks of explosive vomiting. Emaciation is progressing rapidly. Cardiac action weak. Pulse 130, temperature not ascertained, on account of restlessness. His general appearance was that of profound septic poisoning. Cardiac valvular murmur more pronounced, and distinctly regurgitant in character with pulsation in jugulars. General surface cyanosed, expression dull. The

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patient can be momentarily aroused, but at once sinks into a stupor again. Urine voided involuntarily; bowels constipated. Consultation suggested but declined by the family.

January 30th. Condition less favorable in every way. No pulse in malleolar arteries, and very weak and thready in radials. Respiration quick and jerky, with considerable mucus râle. Moist râles of pulmonary œdema of both lungs. Is totally unable to take nourishment. Restless and delirious, though not apparently in pain.

January 31st. Died at midnight from exhaustion, without agony.

No autopsy was obtained.

CASE II. R. E., male, twenty-one years of age, had always been healthy and strong till the present illness. In the early part of December, 1890, he contracted a gonorrhœa, which pursued an ordinary course so far as is known, and to which the patient paid no more than the ordinary degree of attention. At about Christmas he was suddenly prostrated by severe pain in various regions of the body, which the attending physician attributed to rheumatism, though there seem to have been none of the usual accompaniments of that disease attending this attack. That is, the pains were not confined to any special articulation, nor to any particular groups of muscles, nor to any special portion of the body, but were of diffused character and excruciating in intensity. The feet and legs, and later the trunk and face, were the seat of œdema, and apparently there was also evidence of exudation in the cavities of the thorax and abdomen. There was great impairment of the heart's action, with supervention of mitral regurgitant and (later) obstructive murmur, which continued with increasing distinctness till death, which occurred during the last week in January of 1891, from exhaustion with hyperpyrexia.

No autopsy could be obtained, and the pathological condition is in so far uncertain as the organs could not be examined; but the clinical picture is plainly that of septic poisoning, with involvement of the heart, and death from the usual progress of the septicæmic process, as illustrated in other undoubted cases of septic poisoning.

An analysis of these two incomplete cases, in addition to the extraordinary group of complete and indisputable cases, presented at this meeting, demonstrates conclusively the septic character of this malady. In all these instances the disease in question has been distinctly traceable to previous septic invasion of the body by some form of bacterial organism, not always nor necessarily the same, and possibly not always determinable in the present state of our knowledge, but at present comprising various known forms of septic or infective germs. I venture to urge the adoption of the term "septic endocarditis" in place of the various names at present indiscriminately applied to the invasion of the cardiac structures by the septic organisms attending a variety of processes affecting other portions of the body, and possibly including causes which are at present not suspected to be of threatening character in relation to the cardiac structures. The term "ulcerative endocarditis" is undoubtedly correct in some cases, as illustrated by the rare and interesting specimen presented by Dr. Ingraham; no doubt the term "malignant endocarditis" is also clinically correct in designating the general course of this class of infective disorders, but it is not always correct, as some cases

which were diagnosed "malignant endocarditis" have recovered. In these cases the disease was certainly not malignant, though undoubtedly septic. All known forms of this disease are traced to invasion of the heart by septic organisms of some form, and I cannot but think that classification of this group of diseases under the general name of "septic endocarditis" would be a distinct gain to a correct understanding of the process involved, and would tend to prevent confusion, and to simplify the existing conception of this most alarming and usually fatal complication.

REPORT OF A CASE OF ULCERATIVE ENDOCARDITIS, WITH RUPTURE OF CUSP; AUTOPSY; SPECIMEN.¹

BY LENA V. INGRAHAM, M.D., AND GRACE WOLCOTT, M.D.

On October 15, 1891, the patient, a single woman twenty-three years of age, was admitted to the Vincent Memorial Hospital. She had been under the care of Dr. Godfrey Ryder, of Malden, who wrote: "Patient well until four weeks ago, when she began to have pain in abdomen, which became so severe as to cause her to faint several times."

When seen by him, two weeks previous to admission, her temperature was 102°, and examination by vagina showed "great tenderness over uterus and right ovary, tympanites, nausea and vomiting." She was examined by Dr. Ryder for suspected miscarriage; and "the uterus was found retroverted, normal in size, but with slight laceration of cervix." There was too much tenderness for a thorough examination.

On admission to the hospital, the heart and lungs were normal. Uterus retroverted; cervix soft; right side of uterus not freely movable. Urine scanty, high colored, acid, with a trace of albumen. Temperature 99°. She was put upon douches, fomentations (if needed to allay pain), and liquid diet.

On the morning of the third day, she complained of stiffness of the right knee; and on the same afternoon the temperature rose to 103°. Nothing new could be found upon careful examination of chest, abdomen or pelvis. Next morning (October 18th) there was a discrete, papular and pustular eruption on palms and soles, about the joints and on the soft palate and pillars of the fauces. She complained of sore throat, malaise and pain in the joints; and she had vomiting and diarrhœa and a temperature of 103°. She was promptly isolated, as we feared one of the eruptive fevers was developing.

On the fifth day, both knees, elbows, hands and feet were swollen and excessively painful; the sweating was profuse, and the diagnosis of acute rheumatism was easily made. The eruption gradually disappeared remaining longest about the joints.

On the seventh day, the general condition was about the same, but she became deaf and delirious. The diarrhœa continued.

Eighth day. Less pain, quieter, temperature 103°+.

Ninth day. More pain, first one joint then another being affected. Restlessness marked. Physical examination showed first aortic sound obscured, and a soft, blowing, mitral murmur.

Tenth day. Pulse good. Bowels moved three times. Took nourishment well.

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