

seen and felt farther to the left than formerly — just beyond the mammillary line. Just over and about the ensiform cartilage, and extending somewhat toward the right nipple, there was a blush on the skin, with slight swelling; over a small and somewhat elongated area over the tip of the ensiform cartilage there was distinct fluctuation. The distinction between the ribs and the interspaces on the right side could not be made out as clearly as before.

I again inserted a needle in about the same place as before, but this time did not meet with any notable variation in resistance, and at a depth of about two and one-half inches obtained a fluid in every way similar to that above described. Only about 5 ii was withdrawn, although I tried different depths, pushing in and withdrawing the needle. After the fluid was removed the external swelling over the right front was seen to have distinctly subsided, that over the left remaining unchanged. I then put another needle under and nearly parallel with the skin over the ensiform cartilage, and took a few drams of similar fluid. The disease is certainly advancing on the right, has invaded the left side, and has apparently infiltrated some of the ribs and cartilages. Nevertheless the patient suffers comparatively little pain, and his general condition is remarkably good. As yet no vital structures have become seriously involved, and, extension taking place laterally rather than inwardly, the great vessels are still unaffected. Perhaps the gastric symptoms are to be referred to the involvement of some branches of the pneumogastric in the growth. Careful inquiry fails to show that deglutition is impaired. Indeed, there are no evidences of pressure except on the right primary bronchus perhaps. This case represents a rare form of disease, so rare as to receive only passing mention in the leading pathological and clinical text-books. The lung is a not infrequent seat of metastatic deposits of chondroma, but no extra-thoracic source can be found in this case. The tendency of the disease to extend outward rather than inward would seem to make it more probable that the disease starts from a rib than from a bronchus cartilage in this patient. It will doubtless prove fatal, but I fear that it will be impossible to secure an examination, as the patient lives in another State.

PUERPERAL METRITIS COMPLICATED BY MALARIA.

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Mrs. S., aged twenty-four, living in Cambridge, was delivered, April 6, 1888, of her first child, female, weighing six pounds.

The first stage of labor was normal, lasting ten hours; second stage severe, of three hours' duration, and completed with forceps under ether, with but little difficulty; third stage of labor unimportant, placenta following in about fifteen minutes; some coagula removed by the hand; the uterus then contracting firmly. Slight laceration of the perineum, less than one-half inch in extent, which was at once brought together by a single silver wire suture, and the patient left an hour later perfectly comfortable.

Patient was next seen the following day, April 7, at 7 A.M. Her pulse was then 120, temperature 104°. The nurse reported a slight chill occurring between 4 and 5 o'clock in the morning. Lochia abundant. Carbolic vaginal injections ordered. That night the patient seemed about as in the morning, expressing herself as comfortable, yet feeling a little nervous; pulse 128, temperature 104½°; lochia abundant but somewhat offensive. Carbolic acid injections ordered every hour till lochia became less offensive and then every two hours. Tinct. veratrum viridis and quinine also prescribed.

April 8, A.M. Pulse 132. Temperature 105°. Tinct. of veratrum viridis continued and twenty grains of quinine in divided doses given. At 6 P.M. the pulse was 140 and temperature 106°. Dr. Morrill Wyman called in consultation. Half-past nine P.M.: Pulse 136. Temperature 105.6°. Treatment continued.

April 9, 1 o'clock A.M. Pulse 120. Temperature 103.4°. Hot carbolyzed douches have been given as directed, with egg noggs, etc. At this time, by suggestion of Dr. Wyman, a vaginal douche of 5 per cent. solution of salicylate of soda was given, with sulphate of morphia ¼ grain internally. Ten A.M.: Pulse 128. Temperature 103.2°. Feeling better. Bowels moved by enema. Vaginal douche continued. Three P.M.: Pulse 112. Temperature 103°. Eight P.M.: Pulse 104. Temperature 101.4°.

April 10. Patient was seen at 2.30 o'clock in the morning. Pulse 100. Temperature 100.5°. Complaints of pain in breasts and lung. Belladonna ordered. Twelve M.: Pulse 104. Temperature 100.5°. Treatment continued. Eight P.M.: Pulse 120. Temperature 101.5°. Milk secreting; lochia improving in quantity and quality.

April 11, A.M. Pulse 100. Temperature 100°. A disagreeable odor was noticed in lower hall on entering house, as if originating from the cellar, and increased at first landing, where a water-closet was located.

April 12, A.M. Pulse 128. Temperature 104.2°. Appears a little flushed and excited. Veratrum viride, which had been omitted during the last two days, now renewed, five drops being given every hour. 4 P.M.: Pulse 140. Temperature 105.4°. Veratrum viride increased one drop hourly up to nine drops. Eleven P.M.: Pulse 120. Temperature 103.2°.

April 13. Patient rested well during night under the influence of opiates. Temperature at 6 A.M. 101°. At 7 P.M. 98.4°. Pulse 98. Urine normal. Treatment continued.

April 14, A.M. Temperature 98.4°. Pulse 92. Veratrum viridis omitted; quinine, brandy, milk continued. P.M.: Temperature 98.4°. Pulse 116.

April 15, A.M. Pulse 120. Temperature 103.5°. Says she feels well. P.M.: Pulse 108. Temperature 103°. Has had a little tenderness over the region of right ovary; no pain except on severe pressure.

April 16, A.M. Pulse 104. Temperature 100°. Silver suture removed from perineum. 2 P.M.: Was suddenly summoned to see patient, and on arrival found her just recovering from a severe rigor, which had occurred at 12.30 M. Pulse 144. Temperature 105°. Ordered veratrum viride, six to eight drops

hourly. On examination found no milk in breasts. No abdominal tenderness. No phlebitis of legs. Ten p.m.: Pulse 120. Temperature 102.5°.

April 17, A.M. Pulse 104. Temperature 101.6°. Patient has had a good night and looks and feels much better.

April 18, A.M. Pulse 88. Temperature 98.4°. Eight p.m.: A severe chill lasting some twenty minutes. Pulse 120. Temperature 104°. Gave brandy and applied turpentine stupes to abdomen.

April 19, A.M. Pulse 108. Temperature 101.4°. On physical examination a slight pelvic cellulitis was found. No fluctuation. Uterus movable.

April 20, A.M. Pulse 108. Temperature 98.6°. Has taken three pints of milk and one of brandy. Looks and feels better. p.m.: Pulse 100. Temperature 100°. Two weeks since confinement. Looks somewhat anxious. Had "symptoms" of a chill at 4.30 A.M. and 1.30 p.m., but no chill. Small cantharidal blister applied over right ovary and opiate given by rectum.

April 21, A.M. Pulse 112. Temperature 99.5°. On vaginal examination the os was found somewhat patulous; with lateral fullness in region of right ovary. No tenderness even by manipulation. Hot carbolyzed douches ordered every two hours at least. p.m.: Pulse 120. Temperature 102.6°. Tinct. opii given by the rectum.

April 22, A.M. Pulse 120. Temperature 102.4°. Patient looks anxious. Mouth dry. Tongue furred. p.m.: Pulse 116. Temperature 101.5°.

April 23, A.M. Pulse 120. Temperature 120°. Codeia, grain i, ordered as required. p.m.: Pulse 112. Temperature 100.8°. Nurse reports some additional show of fresh lochia, red and without odor. There has been no odor for days about the napkins. There was marked odor noticed in the house to-day, above and below stairs; and on personal inspection I found a faulty drain and open cesspool in the cellar, and the water-closet absolutely without ventilation except by a door opening into the hall on the second flat, at the head of front stairway, opposite the door of the lying-in chamber. The cesspool was very offensive, and had not been cleaned for over two years. The sink-spouts in both kitchens, above and below stairs, were foul, with strong odor of sewer gas.

April 24. Ventilator put in water-closet to-day, after approved pattern. Patient sat up in bed five minutes and felt better. Treatment continued, with codeia at night.

From this time on the patient continued to improve in all her symptoms, — on the 27th of April, three weeks after her confinement, being able to sit up for half an hour in an arm-chair. Tongue clean. Countenance good. No lochial discharge. Pulse and temperature normal. Patient and all the people in the house notice the great improvement from ventilation of the cellar and water-closet.

It would lead us too far to consider all the theories which have been brought forward to explain the occurrence of puerperal fever, were it only from an historical point of view. No monograph extant is better than the admirable classical essay of Dr. O. W. Holmes on "Puerperal Fever," published in 1885. Recently two opinions have contended for supremacy. According to the one puerperal fever is due to a miasma formed by the crowding together

of puerperal women, and according to the other it is due to the absorption of septic material. The purely miasmatic theory, that puerperal fever is due to infection with a specific material formed under atmospheric, cosmic, and telluric influence, which acting exclusively upon puerperal women, causes puerperal fever, so that puerperal fever becomes a malarial fever, is perhaps quite tenable. And the opinion is still somewhat prevalent that puerperal fever is, like typhus, of miasmatic origin, and that under suitable conditions the diseased organism may reproduce the virus and propagate it to other predisposed individuals without the original miasma being still active; so that in the course of the miasmatic disease a contagium is generated and propagated to others as the determining cause of the disease.

Possibly "puerperal endometritis" would have correctly defined the pathology of the foregoing case. Dr. T. Addis Emmet, on "Metritis," says: "I have frequently met with congestive hypertrophy among females who had lived in some of the malarial districts of the Southern States. This enlargement of the uterus remained as one of the sequelae of repeated attacks of intermittent fever after the condition of the general system had become impaired. The venous congestion of the pelvis, with the enlargement of the uterus, was brought about after the vessels had lost their tone, from the frequent backing up and obstruction to the return circulation through the portal system." We have in Cambridge a zone or belt of district lying along the borders of marshy land within Charles River Basin, where during the past few years have occurred something like a score of cases of intermittent fever. My case would be classed as coming in that district.

ELEVEN CASES OF OPERATION FOR APPENDICITIS.

BY EDWARD R. CUTLER, M.D., WALTHAM.

I propose to give a very brief sketch and analysis of eleven cases of appendicitis treated by operation during the past two and a half years in my vicinity. I have met during that time a considerably larger number of cases, closely resembling these at the outset, all of which have recovered without operation, though one at least with serious damage.

In several of these latter cases the question of operation has been anxiously discussed. In only one of them do I regret not having operated, and in that one there was really no time even for discussion, my first visit being made late in the evening and discharge occurring through the intestine before morning, the final result being the sloughing out bodily of four inches of the rectum with the recto-vaginal septum and the perineum.

I shall group these cases pathologically, not chronologically.

The first group comprises six cases of abscess, either extra-peritoneal or encapsulated within the peritoneum.

CASE I. June 20, 1886. A. B. C., conductor. Gradual formation of tumor in right inguinal region, with all the usual symptoms. No general