

do, but since from the very nature of things the majority of adhesions occur in narrow noses this method of wide excision is not often practical. If you dissect out an adhesion in a narrow nose only to have the reaction which results from the trauma carry the turbinate over to the septum and hold it there for a while, the adhesion is sure to return. A variety of substances, especially strips of rubber, have been used in the nose in the hope of keeping apart the two raw surfaces long enough for the stumps of the adhesions to skim over with mucous membrane. The splint must stay in the nose a long time in order to accomplish this, and when it is taken out it is often found that the pressure of the splint has caused new ulcerations and has established a vicious circle which it is very hard to break. Films of rubber have been found difficult to keep in place. The same is true of paper. The treatment of nasal adhesions, therefore, has reduced itself to this: generous excision when possible, and when it is not, to make a quick, clean cut through the adhesion. The idea of the latter is to do as little trauma as you can, in order that the resulting reaction will be slight and so permit a little of the adhesion to remain ununited. This process must be repeated again and again until the whole is separated and the former attachments of the adhesion are covered again with mucous membrane.

Within the last two years an animal membrane made from the peritoneum of the ox has been coming into use in abdominal work for the purpose of preventing adhesions. It is called after the name of the inventor Cargile membrane. The originator's name for it, "animal velum," describes it well. It looks much like gold beater's foil, and comes sterilized in a double envelope. Experimentation has shown that when it is applied to the raw service of the bowel it adheres without any supporting stitches, and forms an artificial peritoneum. Further, it has been demonstrated by killing animals which have been previously operated on that it is successful in preventing adhesions. Another use for it in abdominal work is to pack it about gauze drainage and on the edges of the incision where this is left open. The advantages of this procedure are obvious. The membrane possesses, also, the valuable property of stimulating and conducting the growth of epithelium.

Some time ago I tried the membrane in the nose, hoping to duplicate some of the results which had been obtained with it in the abdomen. I happened at the time to be working on a large post-operative adhesion which had been sent to me. I had gained a little on it by repeatedly cutting it through. Then I began with the membrane, and made quick and satisfactory progress. At once it was evident, however, that it could not be used in the nose exactly after the manner in which it was used in the abdomen, because it was very hard to make a single layer lie on the cut surfaces. With the bowel flat before the operator this is easy to do, but in a narrow nose the breath of the patient crumples the thin tissue into a tangled mass. If a drop of blood touches it the same thing happens. I found, however, that by folding the membrane into a wedge-shaped strip several layers thick, it would introduce more easily, and that I could then pack it firmly between the two cut ends of the adhesion. Packed in

securely in this way, much after the fashion in which one calks a seam, the membrane will stay in place for several days before it needs to be replaced. Since using the membrane on this case I have given it a rather extensive trial, and have found it to be of much help.

I have used it on turbinates after cauterizing, in order to keep the cauterized turbinate from cauterizing the septum opposite, and I have used it on the raw surface left by sawing off a spur. Other uses in the nose which readily suggest themselves are: As a dressing on the septum after the operation for the correction of deflection; as a sleeve for a packing which has to be left in the nose for any length of time; to hold down flaps of mucous membrane after the submucous dissection of cartilaginous spurs; as a guide and stimulant to the growth of epithelium in order to prevent the formation of a perforation, and in order to help toward the closure of perforations after the refreshing of their edges; and as a dressing for the cartilage of the septum whenever it is found to be exposed.

GONORRHEAL URETHRITIS WITHOUT SYMPTOMS.

BY ARTHUR L. CHUTE, M.D., BOSTON.

A FIRST attack of gonorrheal urethritis is usually a condition which is not easily overlooked by a patient; however, it may occasionally be so insidious, both in its onset and course, that even an observing person may not be aware of infection until some time after it has taken place.

Whether the condition which existed in the following cases is to be ascribed to an unusually high resistance on the part of the patient or to infection with a small number of unusually weak organisms, I shall not attempt to say. Perhaps neither is the proper explanation of this rather unusual condition.

The following cases illustrate very well the latency which may at times occur in gonorrheal urethritis:

CASE I. A student, twenty-two years old, who was seen by me about two years ago. He had chancroids a year before. He had been exposed to the possibility of infection many times, and from many different sources, but with the exception of the chancroids was unaware that he had had any venereal trouble. He never had any urethral discharge, ardor or frequency of urination. A week before he was seen, he noticed a slight swelling in the tail of one epididymis; there was also slight tenderness. A few days later the same condition appeared in the other epididymis. A short time before these swellings were noticed, a fine red eruption appeared on his body and the backs of his hands. This eruption itched a good deal. At the time of observation each epididymis was about the size of a pecan, rather hard, neither one especially tender. There was a feeling of uneasiness in both spermatic cords. No discharge, moisture or puffiness to be seen at the meatus.

He said that the fine red eruption had not changed since it first appeared. For three or four days previous to observation he had been taking ten grains of iodide of potash three times a day. The iodide had been given, because, in the absence

of any history of urethral infection, the combination of epididymitis and a rash had been suggestive of syphilis to his physician. This patient's urine contained shreds, which when stained showed gonococci. Between his fingers were burrows of scabies. These findings made the nature of the epididymitis and rash perfectly clear. The rash disappeared under the use of sulphur ointment; the double epididymitis ran the ordinary course of subacute gonorrheal epididymitis. Some days after the date of first observation there was a slight but noticeable urethral discharge.

This man was of good intelligence, feared he had syphilis and was most anxious to do everything in his power to clear up the diagnosis. Even after he was satisfied that he had gonorrhea, he was equally positive that there had never been any discharge, ardor or frequency. He could give no idea as to the probable duration of the disease.

CASE II. A boy eighteen years old, who never had any previous urinary or venereal trouble. His last and only recent exposure had been sixteen days previous to the time of observation. Until the afternoon of the day preceding he had had nothing suggestive of urethral disease; he then suddenly became unable to pass urine. When seen the next morning the retention had been absolute for about eighteen hours. He was in a good deal of pain, with his bladder distended to within one and a half inches of the umbilicus. The lips of the meatus were not puffy, a very little secretion was, however, expressed from the urethra, which on staining showed a few gonococci. His urethra was irrigated with a solution of boracic acid and a catheter passed; after emptying his bladder, it was very thoroughly washed.

His prostate was found enlarged, hot and very tender. Suppositories of opium and belladonna, one half grain each, were ordered, also hot rectal irrigations, hot sitz baths and rest in bed; there was no recurrence of the retention, though the prostatitis and urethro-cystitis gave considerable trouble for some little time. As soon as somewhat relieved he ceased attending the clinic, and was lost sight of.

In this boy the infection had been entirely without symptoms until it had reached the prostatic portion of the urethra and extended into the substance of the prostate; yet the infection must have occurred at the meatus and crept back the length of the anterior urethra and the greater part of the posterior urethra before giving signs of its presence.

Both these men were of good intelligence and apparently truthful. I see no reason to doubt the accuracy of their observations as to the complete absence of symptoms during the time the disease was confined to the urethra alone. Beside the above instances, I know of a case, occurring in the practice of another physician, which was about parallel with my second case. I have also seen several patients in whom the history, though very suggestive of a similar condition of affairs, was not entirely conclusive. I am inclined to believe that this condition, while relatively rare, is perhaps not so uncommon as we have supposed. Finger, in his book on gonorrhea, says, in substance, that occasionally gonorrhea may be wholly without symptoms until such time as the posterior urethra has become infected.

In these cases not only were there no symptoms during the time the disease was confined to the anterior urethra, but even the posterior urethritis was symptomless until complications in the shape of epididymitis and prostatitis had arisen. It would seem probable that in these cases, had the disease stopped short of the epididymis in the one instance, or the substance of the prostate in the other, the patients would have been unaware that they had been infected.

We know that *not all* ordinary attacks of gonorrhea extend to the posterior urethra, and that in a considerable percentage of those that do involve the posterior urethra the patient escapes further complications. I feel that these cases suggest very strongly the probability of men occasionally having gonorrheal urethritis without being aware of the fact. It suggests the advisability, in certain instances, of not putting too much weight on the denial of infection by a patient, even when it is plain that he is telling what he believes to be the truth; additional evidence should be sought, such, for instance, as the presence or absence of urethral shreds in his urine.

While this will be of most help in making clear the nature of lesions of the genito-urinary tract, it is by no means confined to such troubles. It may throw light on the nature of joint lesions, in which, because of the history, the possibility of gonorrheal origin had not been considered. It offers a rational explanation of the etiology of certain strictures which are *supposed* to have come about without either trauma or gonorrhea; it also may account for the great differences in the periods of incubation which have been noted in gonorrhea.

Medical Progress.

REPORT ON DERMATOLOGY.

BY JOHN T. BOWEN, M.D., BOSTON.

TRUE AND FALSE KELOIDS.

BERLINER¹ believes that the keloids should still be divided into spontaneous and scar keloids; a spontaneous keloid being that which is developed in the deeper part of the skin from either unknown or undemonstrable causes, which slowly grows to a certain size, has great tendency to recurrence, a slight tendency to degeneration, ceases to grow after a certain time, and sometimes undergoes involution and disappears spontaneously. The recurrences of spontaneous keloids, if they can be spoken of as such, are no different from scar keloids. The latter arise upon scars, from excoriations, wounds, burns and loss of substance of any kind; and show by their tendency to recurrence and their rapid growth a local malignancy which suggests that of spindle-celled sarcoma, with which they have much similarity histologically. The distinction between spontaneous and scar keloids, from a histological point of view, has usually rested on the condition of the papillae, it having been maintained that the papillary layer is preserved in the spontaneous variety.

A case is described in which a man of thirty

¹ Monatshefte f. prakt. Dermatologie, 1902, Band xxxiv.