

1. Uncorrected vision of $20/20$ in each eye.
 2. Binocular vision.
 3. Absence of nystagmus.
 4. Normal muscle balance and competent ocular muscles.
 5. Normal pupillary reaction and no pupil irregularities when dilated.
 6. Normal media and fundi.
 7. Normal visual fields, by perimetric examination.
 8. Normal color sense.
- 7 West Madison Street.

HORSE ASTHMA

TREATMENT OF A CASE WITH NORMAL HORSE SERUM

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Mrs. L. B., aged 28, widow, came under my care in July, 1916. The family history was negative. She had been subject to severe attacks of horse asthma since childhood, whenever she was near horses for a few minutes. She could neither ride nor drive for this reason. Two years ago she had the anterior portion of both lower turbinates removed, on account of nasal obstruction, with no effect on the asthma, and only slight relief of nasal obstruction. The personal history otherwise was negative. The patient was not neurotic.

July 4, I rode horseback with the patient and witnessed an attack. Thirty minutes after beginning the ride she began to sneeze, and at the end of an hour she was almost prostrated, with constant sneezing, severe lacrimation, intensely congested sclera, considerable edema of glottis, and complete nasal occlusion.

August 1, I gave the patient 25 c.c. of normal horse serum intravenously. By the time half the dose was introduced, she began to sneeze, and within a few minutes she was undergoing a severe attack of horse asthma, similar to the one I witnessed in July, only with symptoms more pronounced, if possible, especially the glottic edema. Under applications of epinephrin solution, 1:1,000, the edema subsided.

About two weeks later on exposure to horses she developed an attack of asthma, milder than usual. At the end of three weeks I gave 12 c.c. intravenously without any reaction. This was followed at intervals of about two weeks with doses of 25, 40 and 60 c.c. hypodermically, without any reaction.

Now, six months later, she reports that she has not had an attack since the second dose of serum, that she rides and drives at pleasure, has gained in weight and is delighted with the result.

THE PNEUMOCOCCUS FOUND IN A CASE OF STILLBIRTH

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Recently Dr. Joseph B. De Lee¹ reported three cases of infection as a cause of stillbirth. To this list I wish to add the following case (Case 90153, Michael Reese Hospital): The patient, aged 26, married four years, came under my care, May 4, 1916. She had had a stillbirth with the first child at full term. At this delivery it was stated that the child had a nasal discharge. No cultures were made. The infant weighed $7\frac{1}{2}$ pounds. Two years later she had a miscarriage which required a curettement. The perineum was repaired at that time. The date of her last period was Oct. 9, 1915. Life was felt about the fourth month. In May the patient complained of feeling weak and of severe cramps in the abdomen. Under appropriate bowel medication she improved. She has had frequent nosebleeds for years. The

1. De Lee, J. B.: A Bacteriologic Study of the Causes of Some Stillbirths, *THE JOURNAL A. M. A.*, July 29, 1916, p. 344.

appendix had been removed three years before; the tonsils had been removed six years before (apparently clipped or incompletely removed). The patient's habits were regular, and she did not use alcoholics.

Examination revealed a nervous woman, whose general appearance was good. The blood pressure was 130-70. The measurements were external, 23-26-28-19 cm.; internal diagonal, 12 cm. Urinalysis was negative. June 21, 1916, the blood pressure was 120-70. The patient felt well, and the urine was negative.

July 19, 1916, the patient was still in good condition. The child, though not a large one, was kicking well. The head was still floating. The heart tones were good, the rate being 132.

Aug. 3, 1916, at 8 p. m., the patient was admitted to the hospital, having been in light labor since 2 p. m. On rectal examination the cervix was dilated two fingers and thin. The head was not engaged. The fetal heart rate was 140. At 10:30 p. m. there was a dilatation of three and a half fingers. The fetal heart rate was 136. The head was fixed in the pelvis in right occipito-anterior presentation. At 1:30 a. m. the same findings were present. The pains were then becoming stronger. The heart rate was: 12 p. m., 140; 1 a. m., 132; 2 a. m., 132; 3 a. m., 132; 4 a. m., 124; 4:20 a. m., 124; 4:42 a. m., 116; 4:50 a. m., 112.

The bag of waters was ruptured artificially at 4:50. Before artificial delivery could be accomplished, the infant died. The liquor amnii was filled with meconium. At 6:20 a. m., 3 minims of pituitary extract were given to stimulate the pains, and a female was born at 7 a. m. It was in a state of asphyxia pallida. The weight was 6 pounds, 5 ounces. Necropsy on the infant revealed nothing pathologic, except that all the serous cavities contained more fluid than is usual.

Cultures were made from the dura, pericardium, nose, heart's blood and pleural and abdominal cavities. The pericardium gave a pneumococcus and a gram-positive bacillus. The pleural cavity gave a pneumococcus and a staphylococcus. The Wassermann reaction was negative.

A Wassermann test on the mother was also negative. A culture from the tonsil crypts and from the vaginal discharge showed the pneumococcus and the staphylococcus in each. In spite of this, the episiotomy wound healed by first intention.

It is my purpose to attempt to deliver a live baby later by having the mother's nose and throat put in good condition and to keep on the lookout for a focal infection by having the blood and vaginal secretions examined for pneumococci and staphylococci.

The bacteriology was done in the hospital laboratory.

122 South Michigan Avenue.

A CASE OF MULTIPLE PREGNANCY, RUPTURED TUBAL AND UTERINE

E. A. SULLIVAN, M.D., AMBOY, ILL.

Mrs. J. S., aged 42, tertigravida, May 6, 1916, at 4 p. m., while doing housework, was seized with an agonizing pain, referred to the diaphragm. When I saw the patient she was pale and had a pinched facial expression. The pulse was dicrotic; the rate was 160. The temperature was subnormal. At this time I administered $\frac{1}{2}$ grain of morphin hypodermically to relieve the pain. On examination I found the uterus somewhat enlarged, the cervix elongated, the external os patulous. There was a serous bloody discharge. At this examination nothing abnormal was found in the culdesac or abdomen; but two hours later a tumefaction in the culdesac suggested ruptured tubal pregnancy. The patient was moved to the Amboy Hospital, and Dr. Karl F. Snyder of Freeport was called to operate.

The pelvis and culdesac were filled with clotted blood and a fetus; these were removed and the bleeding tube ligated and sewed; drainage was put in and the abdominal wound sewed up. During the operation pressure on the uterine walls

outlined a fetus in the uterus, leading to a diagnosis of multiple pregnancy. The patient was removed from the operating room and put in the Fowler position. Physiologic sodium chlorid solution was given with epinephrin solution hypodermically to combat shock. The patient made an uninterrupted recovery and, December 24, was delivered of an 11 pound boy.

AURICULAR FLUTTER DETECTED BY THE FLUOROSCOPE*

GEORGE W. HOLMES, M.D., AND PAUL D. WHITE, M.D., BOSTON

The fluoroscope has often been used in the examination of arrhythmic hearts. The discovery, however, of an unsuspected auricular flutter during a routine chest examination of a patient with suspected gastro-intestinal lesion is of such interest that it deserves special mention.

History.—G. B., man, aged 62, employed for over forty years as painter and paperhanger, referred to the Massachusetts General Hospital for diagnosis, complaining of indigestion, had always been well until four months before visiting the hospital. At that time attacks of pain in the region of the umbilicus began. They were most frequent early in the morning, waking the patient at about 2 o'clock and compelling him to rise and pace the floor. Gradually the pain had become more persistent, until it was present much of the time. Hot applications gave some relief. There had been no nausea or vomiting. No relationship could be discovered between the kind or time of meals and the pain.

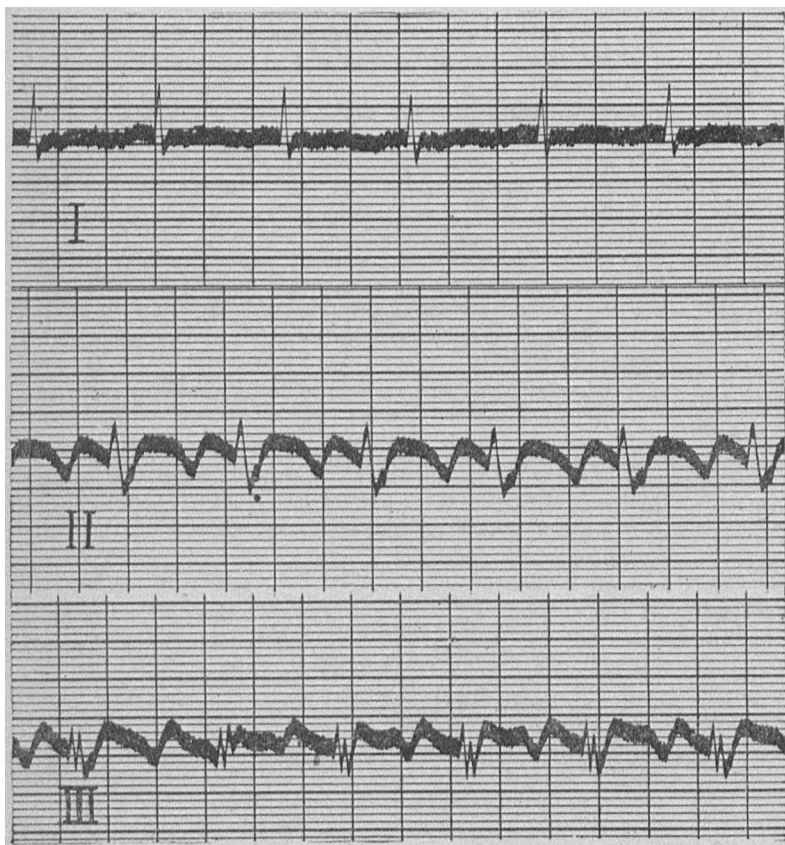


Fig. 1.—Leads I, II and III of electrocardiogram showing auricular flutter; abscissa, 0.2 second; ordinate, 10^{-4} volt.

Yet the patient had been afraid to eat much and had lost 30 pounds in weight in the four months. He was slightly constipated. There had been no weakness of the hands or feet, and no dyspnea, edema or precordial pain.

* From the Massachusetts General Hospital.

Examination.—The patient, June 30 and July 7, 1916, was pale and underweight. All the teeth were false. The tongue was coated. The pupils reacted normally. The lungs were normal. There was slight enlargement of the heart to per-

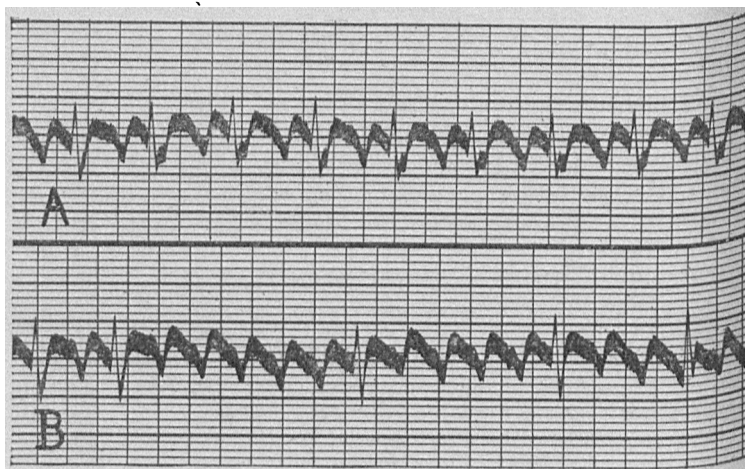


Fig. 2.—Lead II of electrocardiogram showing auricular flutter: A, before vagal pressure, B, during right vagal pressure; abscissa, 0.2 second; ordinate, 10^{-4} volt.

cussion; the apex impulse was in the fifth space. The action was regular and rapid (115 a minute). The sounds were faint and clear. There was absence of abdominal tenderness, spasm and masses. The liver and the spleen were not felt. There was a marked venous prominence at the costal borders. There was a double inguinal hernia. Rectal examination was negative. The reflexes were normal. The temperature was normal. A blood smear was normal; there was no stippling. Hemoglobin was 90 per cent. The urine was cloudy; specific gravity, 1.022; there was no albumin or sugar; the sediment showed nothing remarkable. Fluoroscopic examination by means of a bismuth meal showed no abnormality in the gastro-intestinal tract.

Fluoroscopic Examination of Heart.—The right and left borders were clearly outlined, the left border pulsating regularly at the rate of 115 a minute and the right border regularly at apparently twice the rate. A diagnosis of auricular flutter was made and confirmed a few minutes later by the electrocardiograph.

Electrocardiograms.—There was auricular flutter with 2:1 A-V block. The auricular rate was 230, ventricular rate, 115 (Fig. 1). Right vagal pressure increased instantly the grade of block, bringing out clearly the separate auricular deflections (Fig. 2.).

Unusual Foreign Bodies in the Rectum.—It is not unusual to find foreign bodies in the rectum which have been inserted by the patients themselves, who are usually sexual perverts. I recently had three cases in which the object inserted was an ordinary jelly glass. Another case proves that glass electrodes inserted into the rectum for the treatment of hemorrhoids and prostatic troubles are not without some danger. In this case, a physician was using an ordinary high-frequency glass electrode for the treatment of the prostate. The tube suddenly exploded while inserted 3 or 4 inches into the patient's rectum. It was broken into many pieces, and I removed it with considerable difficulty. The bowel, however, was not lacerated, and the patient suffered no injury.—WILLIAM H. KIGER, M.D., Los Angeles.