

Other symptoms of the febrile process, such as accelerated action of the heart, increased frequency of respiratory movement, circulatory changes, alterations in secretion, assimilation and metabolism and in function generally, may be due to the same factors as the underlying morbid state or to the pyrexia, or to a combination of the two. The problems, therefore, that confront the clinician in the management of a patient exhibiting fever comprise the removal of the causative and underlying factors in so far as this is possible, and the restoration of the metabolic equilibrium, whose derangement is manifested in the various disorders of function. Often little or nothing can be done to fulfill the first indication, as the underlying morbid process is a specific and self-limited one insusceptible of abortion or abridgement, but unless there be some contra-indication, some form of elimination or evacuation or attenuation may with advantage be instituted, such as emesis, catharsis, diaphoresis, diuresis, enteroclysis, hypodermoclysis, intravenous transfusion. Through emesis irritants will be removed from the stomach and infection by way of this organ averted or absorption of poisonous substances from its cavity prevented. Catharsis will perform the same office for the intestinal tract, and besides exert a derivative effect. A like statement may be made with regard to diaphoresis for the skin, and with regard to diuresis for the kidneys, while by means of intestinal, subcutaneous and intravenous infusion poisons circulating in the blood will be diluted, and their elimination through the emunctories expedited, while a useful stimulating influence will be at the same time exerted.

With the aid of the measures named it may at times be possible to remove the primary cause of disturbance, but even when this can not be done we may be able in this way to mitigate the severity of its effects, and thus in part contribute also to the fulfilment of the second indication, namely, the restoration of the metabolic equilibrium and the correction of disordered function. Reduction of temperature may be indicated when the pyrexia is excessive, or has been unduly long continued. It is best effected by the application of cold, wet or dry, in the form of the tub bath, the sponge bath, the sprinkle, the affusion or compress, the spray, the coil, the ice bag or ironing with ice. Antipyretic drugs are as a rule not necessary, while their use is at times attended with danger. To sustain the respiration and the nervous system, alcohol, aromatic spirit of ammonia, strychnin, digitalis, strophanthus, caffeine or atropin may at times be needed. Should delirium and restlessness persist despite such treatment, bromid, chloral or morphin may be administered cautiously. The diet should be simple, bland, nutritious, easily assimilable, including milk, broths, eggs, beef juice and similar articles. Cracked ice and cool water or lemonade or orangeade and the like may be given with reasonable freedom, preferably in small amounts frequently. A daily movement of the bowels should be secured, if necessary by means of enemas or by the cautious administration of calomel followed by a saline.

**Statue of Pasteur at Chartres.**—The portrait statue recently unveiled at Chartres deserves more than a passing mention, as it is the work of a physician, anatomist and sculptor, a native of the town, Dr. P. Richer, now of Paris. The marble bust of Pasteur rises above a bronze bas-relief depicting scenes in the campaign against anthrax in sheep by the inoculations originated by Pasteur which have saved the chief industry of the province from destruction. The total height of the work is nearly fourteen feet, while the base is twenty-two feet in diameter.

## EARLY EYE SYMPTOMS IN A CASE OF MYASTHENIA GRAVIS.

CASSIUS D. WESCOTT, M.D., AND BROWN PUSEY, M.D.  
CHICAGO.

In a thesis<sup>1</sup> for the degree of M.D. at Cambridge on the subject of "Myasthenia Gravis," Chas. S. Myers records the undoubted and completely studied cases of this disease. His list contains 22 cases; in 12 there was partial or complete external ophthalmoplegia, in 9 diplopia, in 14 ptosis. These findings and the fact that in 13 of the 22 cases in Myers' list the paralyses of the eye muscles were of the very early symptoms that showed themselves, suggests the publication of the history of the eye symptoms of the following case.

Fortunately, our case has not been completely studied (Myers includes only cases that have come to autopsy), but it has gone far enough to emphasize the fact, which agrees with the findings of Myers and which has been pointed out before, e. g., in the recent article of Sir William Gowers,<sup>2</sup> that the eye symptoms may be the first complained of. The early diagnosis of the disease is certainly desirable, and may be very important, because of its bearing on treatment. It is reasonable to suppose that the chances for recovery will be favored by an early diagnosis, for suggestions have come regarding treatment as our knowledge of this obscure disease has increased, and cases have been reported in which the patients appear to have recovered. The following is an abstract of our notes:

Nov. 6, 1899. W. E. F., male, aged 20, a telegraph operator by occupation. Complains of red and uncomfortable eyelids, of blurred and double vision; when he looks at anything, it at first appears double, and he has to close one eye to see. The eyes have given trouble during the past summer. There is a chronic conjunctivitis. L. V.=6/9; R. V.=6/7. Esophoria 22°. L. hyperphoria 8°. Accommodation unaffected. Refraction under homatropin and cocain:

L. V.=6/5 with -1.00 D. Sph. -0.50 D. Cyl. Ax. 25°.  
R. V.=6/5 with -0.75 D. Sph. -0.25 D. Cyl. Ax. 120°.

The above correction, less 0.25 D. Sph., was given for constant use, and the patient was asked to return within ten days or two weeks for observation.

Nov. 17, 1899.—Patient states that he is improved, but still complains of blurred vision. Examination shows esophoria 12° (a decrease of 10°), left hyperphoria 8°. Encouraged by the decrease of esophoria, the patient was told to continue the use of the glasses and to report again in two weeks.

Dec. 8, 1899 (one month after the first examination). The patient states that he can work all day and until midnight, and that there is no blurring of the vision. No esophoria, left hyperphoria 3°.

Jan. 4, 1900.—Has been overtaxing the eyes, and they are red and weak again. Has some double vision at times. Esophoria 1°; right hyperphoria 3°.

The patient did not return again for two and a half years. July 3, 1902.—Recently has had double vision, and "focusing the eyes is difficult." Exophoria 11°, no hyperphoria. Accommodation normal, and the pupils react normally. Vision with glasses, left eye and right eye, 6/9. Has not noted anything wrong in his general condition. Advised re-examination of the refraction.

Aug. 6, 1902.—The patient returns complaining of the same symptoms that troubled him one month ago. Refraction under homatropin and cocain:

L. V.=6/5 with -1.62 D. Sph. -0.50 Cyl. Ax. 60°.  
R. V.=6/5 with -1.50 D. Sph. -0.50 Cyl. Ax. 110°.

The above correction, less 0.37 D. Sph., was given for constant use, and the patient was asked to return shortly.

1. Journal of Pathology and Bacteriology, 1902, September, viii, No. 111, p. 306.  
2. Myasthenia and Ophthalmoplegia. British Med. Jour., 1904, May 24.

One month and twenty days later he returned, when there was paralysis of convergence and slight ptosis of the left upper lid. The pupils reacted normally; the accommodation was not affected, and the patient said that he could work at his desk very comfortably when one eye was closed. The fundus was normal. He was referred to Dr. H. N. Moyer, who made the diagnosis of myasthenia gravis, and exhibited the patient before the Chicago Neurological Society.

Although the findings in this case will be more completely published later, it seems appropriate to call attention here to some of the facts pointed out by our notes. The most important one is that already cited, that the eye symptoms in this disease may be the first signs of trouble. Of course, this is assuming that our patient was afflicted with myasthenia gravis when he complained of double vision in November and December, 1899. Even if it is not granted that the disease existed at that time, it seems safe to venture the opinion, in the light of the after-history, that as marked a variation in the muscle balance as this case showed between Nov. 6 and Dec. 8, 1899, must attract unusual attention and be carefully studied, and, if possible, satisfactorily explained.

The absence of involvement of the muscles of accommodation in September, 1902, (when he could work at his desk very comfortably if one eye was closed) is interesting. Based on observations up to that time, this case agrees with the findings of Myers, who notes the absence of involvement of the ciliary muscles in the cases studied by him. The possibility of the escape of the ciliary muscle in this disease, and the fact of the difference histologically between it and the external muscles, could well give rise to some speculation. This, however, is upset by Gowers' report, in whose case there was interference with accommodation, and the same is now true of our patient.

The variation in the refraction may have some significance. According to our examinations, which were made with homatropin (homatropin hydrobromate, gr. x; cocain hydrochlorate, gr. x; water,  $\bar{5}$ i, of which mixture a drop was put into each eye every five minutes for thirty minutes, and the examination was made forty-five minutes after the last application), the myopia increased 0.75D, and the investigation of the subject brings a letter from the patient, which says: "In early life I seemed to be able to see fully as far as anyone, and, so far as I know, my vision was not shortened until just previous to my first call on you." It will be recalled that at the time of the first examination there was slight myopia. If there is any relation between the disease and the myopia, it would be curious. How is it to be explained?

The cessation of symptoms in this case for over two years calls attention to one of the three signs, which Myers says may be described as pathognomonic of this disease, viz.: exacerbations and remissions shown in its course, and warns us to be careful about pronouncing a recovery in any given case.

### Clinical Report.

#### PYONEPHROSIS WITH A KIDNEY-COLON FISTULA.

GEORGE E. McLAUGHLIN, M.D.

Pathologist to Christ Hospital.

JERSEY CITY.

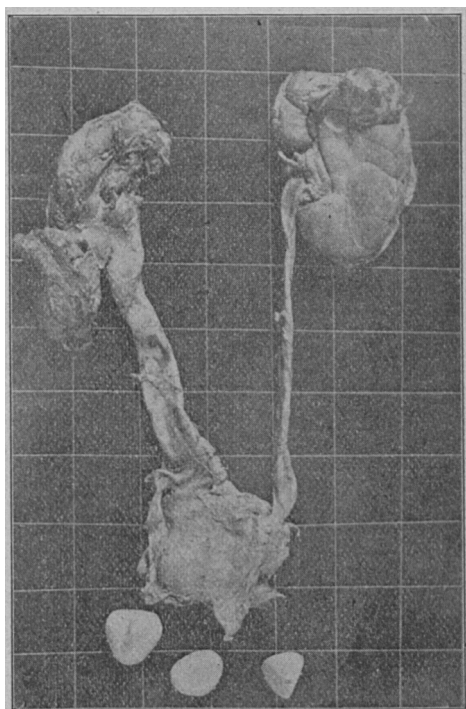
*History.*—The patient, a man, aged 37; white; occupation railroad conductor; entered the service of Dr. Gordon K. Dickerson at Christ Hospital, Jersey City, for operation, with a diagnosis of vesical calculus.

Family history was negative. The patient had the usual diseases of childhood; twenty-five years ago an attack of typhoid fever; five years later a gonorrhoea and a slight stricture of the urethra. He uses tobacco and alcoholics in moderation. Two and one-half years ago he began to complain of a burning sensation, and often severe pain on micturition, with interference to the free passage of urine, and at times a sudden stoppage during the act of passing it.

He states that he has never passed blood in his urine. Lately he noticed that he was losing weight and appetite. He states he has had no chills or fever since the attack of typhoid fever 25 years ago. He gives no history of constipation or diarrhea, and the evacuations of the bowels are regular. His temperature for the three days previous to operation was normal and subsequent to it not above 100 degrees.

*Operation.*—A suprapubic lithotomy was performed and three calculi weighing collectively 168 grams were removed. There was no suppression of urine subsequent to the operation. The third day the patient died.

*Necropsy.*—All the organs, with the exception of those later mentioned, were normal, save that the intestines showed some slight adhesions. The bladder wall was much thickened. The interior of the viscus had a ribbed appearance. The veins were somewhat prominent and the mucous membrane was



of a yellowish color, and covered with shreds of mucus and urinary salts. The right ureter measured one inch and a half in diameter, and was of a leathery consistence. The left ureter was about three times the usual size, being somewhat tough to the touch.

The right kidney was normal in size and was adherent at its lower end to the colon. On sectioning it proved to be a typical pyonephrotic kidney, only a thin wall of kidney structure, possibly one quarter of an inch thick, remaining. It was connected, as shown in the illustration, with the colon, by a fistulous tract one inch long. The left kidney was much enlarged, the capsule non-adherent, and projecting from its surface were three cysts, the one shown in the illustration at its upper portion being two inches in diameter. All these cysts contained a urinous fluid. This kidney showed a chronic diffuse nephritis and contained two half-inch calculi in its pelvis.

41 Crescent avenue.

Rules for writers, as given by the *Saturday Evening Post*, are as follows: 1. Have something to say. 2. Say it. 3. Quit writing.