these formulas; very good, but I also note that, as prepared and furnished the profession by Parke, Davis & Co., they are better than if obtained anywhere else; a nice advertisement for that firm, and not exactly in line with the Code of Ethics of this ASSOCIATION. Formula No. 1, dose one tablet every fifteen minutes for twenty-four or forty-eight hours; (quantity of medicine taken in that time, calomel, guaiacol-carbonate, menthol, each 12 grains, eucalyptol q. s.). Formula No. 2, same only smaller dose, with the addition of thymol; to be given for several days until, during the period of administration, "five or six, not less, free evacuations of the bowels are secured." On fifth or sixth day Formula No. 3 is commenced, given every three or four hours, alternating with tablets Nos. 1 and 2. All this washed down "with copious draughts of distilled or sterilized, or if indicated, some good laxative or diuretic water." Just think of it, the annoyance of such frequent dosage and no time for sleep. When will the stomach take and tolerate nourishment? The constant unrest of such copious purgations, to say nothing of so apparent a fact as the exhaustion incident to it! Now "this treatment begun early, none other needed." It has failed in no instance, if seen before the eighth day. In the hands of other men, with 800 cases treated, there were only 9 deaths. Eliminate all ordinary causes of death except hemorrhage and perforation, and minimize these. One case is cited when patient died because of too small a dose, having received it every three hours instead of every fifteen minutes! Finally, I note many of these cases had treatment begun on tenth or twelfth day, normal temperature on nineteenth to twenty-third day. This proves nothing, because many cases that never have this marvelous treatment have normal temperature as soon as this.

Finally, we are told, "this language is unintelligible to the greatest thinkers." Is it not strange that after two years no authority has yet endorsed or commended this treatment? The more we know of the etiology and pathology of this disease, the less we feel inclined to try it. The issues are too serious, the stake too important to be made the object of such experimentation, and to renounce the convictions of years, enforced and established by long experience. I would be glad to have convincing proof of the brilliant results claimed, and be able to approach the treatment of my cases of typhoid fever with the assurance of its harmless nature and certainty of cure, but with expression of greatest regard for Dr. Woodbridge's earnest and honest efforts, I frankly tell him his assertions of success must partake more of the positiveness of a true scientist, backed by the evidence of correct diagnosis, other than that of bald assertions.

A recent writer says: "Intestinal antisepsis, in so far as the pathogenic organisms of enteric fever are concerned, is directed against specific germs not present in the bowels prior to the breaking down of the intestinal lymph elements, and is therefore largely inoperative; general antisepsis, if by that we are to understand a germicidal influence upon bacteriologic forms diffusely implanted in the lymph tissues throughout the organism, is a vain fancy wholly unsupported by facts. The parasite is more resistant to such influences than is the host. Clinical and pathologic considerations are alike opposed to the whole subject of the antiseptic treatment of enteric fever." (J. C. Wilson in Loomis-Thompson, "American System of Practical Medicine," Vol. i, p. 222). Again, "the antiseptic treatment has not a truly rational basis, while the extravagant claims of its advocates discredit their results." (Tyson's Practice, p. 46).

Treatment of convalescence.—Great care should be exercised during this period. No solid food should be allowed for a week or ten days after return to normal temperature. The diet should be restricted to milk, milk toast, eggs, animal broths. At the end of a week after return to normal temperature the patient may be allowed to sit up for a short period, increasing the time each day, and care should be exercised as to exertion. It must be remembered how much the heart muscle has suffered, and that it requires some time for it to be restored its original integrity. Over exertion, too, may cause a relapse. Should a relapse occur, no special treatment is required, but the treatment is the same as in the original attack.

210 W. Grace St.

PREGNANCY COMPLICATED BY OVARIAN AND FIBROID TUMORS. REMARKS UPON INDICATIONS FOR TREATMENT.

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It is not my purpose to enter into a systematic or profound discussion of the subject indicated in my title. It is rather to remark in a practical way upon the indications for treatment, and to give point and emphaais to my remarks by a few illustrative cases, that this paper has been written.

The presence of an ovarian tumor during pregnancy is a menace to the life of the patient. Abortion is not so prone to occur as in case of pregnancy complicated by a fibroid tumor. The dangers appear in consequence of serious happenings to the cyst and by the irritation produced by the presence of the tumor. These happenings may be mentioned in the order of their frequency: 1, peritonitis with adhesions; 2, suppuration of the cyst; 3, torsion of the pedicle; 4, gangrene of the cyst walls; 5, hemorrhage into the cyst.

In an able article by Mangiagalli,[1] of which a summary is given in the "Annals of Universal Medical Sciences" for 1894, he shows that primary suppuration of the cyst is of frequent occurrence. Of 150 ovariotomies, 5 were done during pregnancy and 11 soon after the puerperium. In 5 of these 16 cases, there was primary suppuration of the cyst; in 2, there was torsion of the pedicle with peritonitis; torsion of the pedicle, suppuration and rupture of the cyst in 1, and hemorrhage into the cyst in 1.

Playfair[2] has shown the great danger to the mother in allowing pregnancy to go to full term. He says, that, "Of 13 cases of delivery by the natural powers which I collected in a paper on 'Labor Complicated by Ovarian Tumors,' far more than half proved fatal."

Contrast these results with those obtained by Russian surgeons under operative measures, as shown by Gordon in his report of 1894. There had been up to that time 204 ovariotomies performed during pregnancy, in Russia. Twenty-one cases could not be followed. In 7 cases the uterus was wounded and 2 died. Of the remaining 176 cases, 164 recovered completely and 122 of these went on to full delivery. Twelve died.

We have thus 183 cases operated upon with 14 deaths, a fatality of .076 per cent., which is but slightly above the mortality occurring when the operation is done in non-pregnant women. The concensus of opinion as I read it in the literature of the last few years is decidedly in favor of removing the tumor as soon as diagnosed. Due regard must be given to the condition of the patient.

In our own case it was my belief that the combined shock of delivery and ovariotomy, in the exhausted condition of the patient, would speedily have proven fatal. Early operations, before complications arise, are to be resorted to, not only because less dangerous to the life of the patient, but also because less liable to induce abortion.

I can find no authority whatever in the late text-books, nor in recent journal articles by eminent writers, justifying an expectant treatment in cases of ovarian tumor complicating gestation. Prompt action is an imperative duty. A correct diagnosis is all-important and is not infrequently effected with difficulty. Fortunately, in some instances, the pregnant woman and the attendant physician both possess the knowledge that the tumor was present before pregnancy occurred. With this clue it is not difficult, as a rule, by palpation and percussion, to determine the presence, size, shape and location of the neoplasm. A distinct, circumscribed, fluctuating tumor, located to one side or above the uterus and changing its position with the growth of the uterus, may with little hesitation be declared an ovarian tumor, especially if it can be moved independently and is attended by none other than pressure symptoms. When suppuration occurs in such a cyst it is attended by a most profound effect upon the patient. Fever appears, and later, chills and night-sweats supervene. Torsion of the pedicle induces necrosis of the cyst walls or hemorrhage into the cyst cavity. In the former case fever and exhaustion gradually develop, and in the latter, shock, amounting in many instances to collapse. In all such instances the indications are for immediate interference.

I shall not attempt a review of the recent literature of pregnancy complicated by fibroid tumors, but content myself with stating what I believe to be the concensus of opinion of authoritative writers.

Pedunculated subserous fibroid tumors, unless large or adherent in unfavorable locations, give rise to few symptoms during pregnancy. When very large, however, or adherent, they sometimes induce pressure symptoms leading to impairment of the general health of the patient, and may even threaten life. Only under such circumstances do they call for extirpation, or induction of abortion.

Interstitial tumors of the body and fundus of the uterus seldom produce marked symptoms during pregnancy. It can not be denied, however, that when associated with pus tubes and pelvic adhesions, as they not infrequently are, the growth of the uterus is attended by pain, and sometimes general peritonitis and septic symptoms appear. Under the latter mentioned circumstances hysterectomy is indicated, but is attended by much danger to the mother.

Fibroma of the cervix not infrequently impedes labor and demands an extirpation of the tumor before delivery can be effected. That the presence of a small, pedunculated, submucous fibroid does not always induce abortion is demonstrated by our sixth case.

Hoffmeier[3] contends that the presence of a fibroid in the uterus does not tend to induce abortion, but the reported experiences of numerous other observers does not accord with his views.

That the presence of endometritis predisposes to abortion is generally conceded. Any one who has examined the endometrium, in uteri removed for fibroma, must have noticed the almost universal presence of endometritis of the glandular or polypoid forms. In this morbid condition of the endometrium may be found a prolific source of sterility and of abortion. When it exists in pregnancy the decidua vera becomes thickened and abnormally vascular, so that hemorrhage is prone to occur and abortion result.

I think it may be stated as a rule that fibroid uteri which do not well tolerate the presence and growth of the fetus and growth of the uterus, abort, so that it is safe to adopt a non-interference plan so long as gestation proceeds normally.

If we may truly estimate the views of the profession by the articles published of late in journals and books we may safely say that there has been during the last three years a rapid rise and gradual decline of the sentiment favoring hysterectomy and myomectomy in uterine fibroids complicating gestation.

The operation is new in this country. Long[4] in 1894 was the first American to deliberately extirpate the uterus in a case of fibroid tumor and pregnancy.

Hysterectomy should be the operation of choice when the tumor is of the pedunculated, subserous variety and when it is not too deeply imbedded in the uterine wall.

I wish to report the following cases as bearing upon the subject under discussion:

Case 1.—Mrs. A., aged 35 years; mother of four children. The last one was born Dec. 15, 1896 (two and one-half months ago). She was aware that she had a small tumor before she became pregnant. It grew somewhat during pregnancy, so that at term she was unusually large and suffered much from pressure in the upper portion of the abdomen, which region the tumor occupied during gestation. After delivery the tumor filled the lower portion of the abdomen, extending above the umbilicus. The child was born in a normal manner, weighed four and one-half pounds, was perfectly formed and healthy. The mother nursed the child and both did well. The tumor grew rapidly after delivery and when she came to me was much larger than a gravid uterus at full term. It was extirpated Feb. 26, 1897, two months and eleven days after delivery. There were many adhesions. The sac was adherent to the anterior abdominal wall in front, while the intestines and omentum covered the upper and posterior surface of the tumor. The adhesions were so recent that no difficulty was experienced in separating them, and the patient made an excellent recovery.

Case 2.—Mrs. B. was referred to me July 11, 1895. There was present a large interstitial fibroid of the uterus, and the patient was three months pregnant. She had borne one child since the tumor was discovered, and as the tumor was growing the patient felt uneasy, fearing lest the large size of the tumor might interfere with delivery. In view of the progressive emaciation of the patient and steady growth of the tumor, and her great anxiety, I favored operation but did not strongly advise it. Active interference was rejected. The patient went to full term and was delivered in a normal manner of a healthy child.

Case 3.—Mrs. C., March 29, 1896, had been in labor between one and two days, but had made little progress. Her abdomen was enormously distended and the upper portion contained a cystic tumor. After examination I concluded to attempt delivery first, and if successful operate a few days later. The os was dilatable and the head could be felt above the upper strait. Delivery was easily effected by turning. The patient was much prostrated after the delivery and I felt glad that we had not performed ovariotomy previous to the delivery. The patient rallied after a few hours and was doing seemingly well for five days, when suddenly symptoms of collapse appeared. She died two days later.

I am indebted to Dr. J. C. Webster, her attending physician, for the following facts: "The patient was tapped at the umbilicus March 20 and a considerable amount of fluid withdrawn. She was delivered on March 29. She lived until Sunday, April 4. On Friday before she died she suddenly collapsed but was kept alive until Sunday. An autopsy showed a hemorrhage into one of the compartments of the cyst. This hemorrhage was probably the immediate cause of the collapse and death. About two gallons of ascitic fluid were found in the abdominal cavity. The cyst wall had not been punctured when the abdomen was tapped. The tumor was multilocular. The cysts contained fluid of varying consistency, some thin, some thick and gelatinous. The tumor contained about eight gallons of fluid. The peritoneal surface was studded by a vast number of small cysts. I do not believe she could have survived an ovariotomy."

Case 4.—Mrs. D. Came under my observation when three and one-half months pregnant. I was called to consider the advisability of extirpating a fibroid tumor of the uterus. The tumor was small, not larger than a lemon, and in the anterior wall of the uterus. The patient was greatly agitated and desired an operation. I declined to remove the tumor. A few weeks later, viz., April 1, the patient came to my sanitarium still desiring an operation. The tumor had not grown, though the pregnant uterus had gradually and normally developed since my visit. The patient had felt motion a few days previously and the movements of the child continued active during her two weeks' stay in the sanitarium. During the patient's stay at the sanitarium she manifested marked nervous symptoms of a hysterical nature, but they gradually subsided and very nearly disappeared. Finally she concluded to remain in the city until after her confinement and went to a friend's home to await the event. Dr. Hodges assumed charge of the case. Soon after leaving the sanitarium she began suffering from uterine pains which seemed to indicate an impending miscarriage. She finally miscarried the latter part of May. Nothing untoward occurred at the time of miscarriage except that she was excessively nervous and made a slow recovery. I saw her Sept. 27, 1896. The tumor had diminished in size, at that time being scarcely largely than a walnut without its hull.

Case 5.—Mrs. E., aged 19 years. Married and mother of one child which died when eight months old. She and her physician gave the following history: During the last months of pregnancy she was unusually large and suffered from dyspnea, but the presence of a tumor was not suspected. After delivery she remained large and in a few weeks her physician had decided she had an ovarian tumor. It grew rapidly and was tapped three times. She was operated upon Sept. 3, 1896, eight months after delivery. There were most extensive adhesions of the sac to the peritoneum, intestines and omentum. The tumor was large, it and its contents weighing sixty-one pounds. It was a multilocular ovarian cyst of the glandular variety. She made an uninterrupted recovery and is now seemingly in perfect health.

Case 6.—Was one of pedunculated, submucous, fibroid of the uterus. I saw the patient about two years ago. The occasion of my being called was a profuse hemorrhage occurring ten days after a normal delivery. The os was patulous so that I introduced two fingers into the uterine cavity, when I encountered a pedunculated fibroid as large as a small lemon. The peduncle was probably an inch long and attached to the right of the median line upon the anterior wall of the uterus, while the uneven surface of the placental attachment was felt to the left. The tumor was friable, but the pedicle was firm. It was removed by torsion. The uterine cavity was irrigated with hot water and packed with iodoform gauze. No further hemorrhage occurred and the patient made an excellent recovery. The tumor was examined after removal and found to be necrotic.

Case 7.—Mrs. Z. was referred to me Dec. 3, 1896, with an interstitial fibroid tumor as large as a pregnant uterus at four months. She had been able to feel this tumor for thirteen or fourteen years above the pubic bone, and eleven years ago, two or three years after the tumor was first discovered, she had an accidental miscarriage at three and one-half months.

These cases are thus briefly reported to emphasize a few points I believe to be of practical value. They tend to show that a pregnant woman having a fibroid tumor is prone to miscarry, but that the presence of the tumor is not a menace to life, while the presence of an ovarian tumor complicating pregnancy frequently leads even in favorable cases to severe pressure symptoms, peritonitis with adhesions, and not infrequently (in less favorable cases) to the death of the patient.

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1 Berliner Klinische Wochenschrift, May 21, 1891.
2 Midwifery, p. 226.
3 Annals, 1896, Vol. ii, G. 7.
4 Annals.

INTRA-UTERINE AMPUTATION.

Read in the Section on Practice of Medicine, at the Forty-eighth Annual Meeting of the American Medical Association held at Philadelphia, Pa., June 1-4, 1897.

BY M. H. FUSSELL, M.D.
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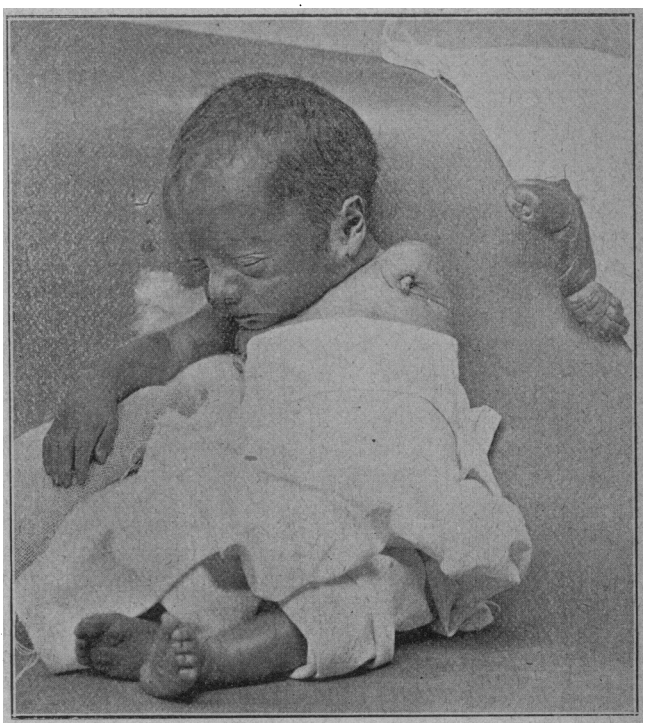
The following notes and accompanying specimens are due entirely to Dr. Thomas W. Brockbank of Philadelphia.

I was called May 13, 1895, to attend Mrs. D., aged 36, healthy Pennsylvania German, mother of nine children, eight of which are living and healthy. Mrs. D. first menstruated at 15 years of age, has always been regular, and was married at 16. Her husband is



also of Pennsylvania German type and healthy. I found her in labor at the end of the seventh month of gestation; external palpation showed nothing abnormal; bimanual examination showed genital organs and pelvis normal; cervix three-fourths dilated; position L. O. A. with vertex presentation; membranes had already ruptured and the waters escaped. Dilatation was soon complete and under good uterine contraction the head advanced rapidly. The extension and rotation were normal and complete, body rotating one-half circumference. The head and shoulders having been expelled from the vagina the uterine contractions ceased. I passed my hand under the covers for the purpose of grasping the shoulders and completing the delivery, and in doing so I was attracted by a sharp substance coming in contact with my hand which indicated some abnormality. On making an examination I found that the left arm was missing from a point about one inch from the shoulder. A close inspection showed that the soft parts had appar-