

rotin's cases of ovarian abscess following abortion, and I have found in such cases, as the cause of the septic process, staphylococci, streptococci, diplococci, and the colon bacillus.

Tetanus has also been observed following criminal instrumental abortion with severe traumatism. Sudden death in consequence of embolism has been recorded following intrauterine manipulations with instruments and intrauterine air, water, or glycerin injections.

If now we attempt to outline the general principles of the pathology of the criminal abortion, we may perhaps characterize them as follows:

1. Premature expulsion of the ovum, if it occurs as the result of the internal administration of abortifacients, is an integral part of the general toxic symptoms, changes and processes due to those drugs or chemicals, acting in their deleterious influence on both mother and child.

2. Premature expulsion of the ovum if it occurs after detachment of the membranes, perforation of the amniotic cavity, etc., is brought about, because after such manipulations which may or may not bring about the speedy death of the embryo, the ovum acts as a foreign body and stimulates the uterine muscularis to contractions, or because intervillous or interdecidual hemorrhages occur.

3. Septic infection in its broadest sense, following criminal abortion is—*ceteris paribus*—not fundamentally different in its general and special pathology, its sequelæ and complications from other septic infections.

I have almost entirely neglected a pathologic consideration of criminal abortion brought about by copious hot douches, irritating applications to the cervix, etc. I have not been able to find a firm physiologic basis for even a modest attempt at explanation of the causal nexus between these means and the desired or accomplished result. I have to repeat in this respect, in conclusion, what was said above in the beginning: The trouble in trying to clear up the intrinsic pathology of certain types of criminal abortion lies in the fact that we practically know nothing definite about the primary factors which initiate normal labor at full term.

COMPLETE OCCLUSION OF BOWEL.

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Nov. 2, 1899, I saw Mrs. A. B. R., of Greene, N. Y., in consultation with Dr. Williams of that town, who gave the following history: An American, aged 63, her family history was good. She had been married for forty-five years and had one child forty-two years ago. She had been troubled with what she called "bilious" attacks ever since she could remember. About thirty-five years ago she had a very severe illness which was described as inflammation of the bowels and, though "given up" to die, she gradually recovered. Since that time her troubles with her stomach, or "bilious attacks," have been more or less constant.

On September 4, last, she was attacked with vomiting and free purging, and after a week felt some better. In a few days there was another and one week later a third attack lasting about one week, after which there was no more purging, but the stomach sooner or later rejected everything taken, nothing having been retained for more than ten hours.

She was attended by a homeopath for four weeks and, for the week previous to my seeing her, by a clairvoyant. Dr. Williams saw her for the first time about six hours

before my arrival. There had been rapid emaciation, due to inability to retain any nourishment except rectal enemas, while these had not been able to keep up the vital forces. Temperature was 99; pulse 84 and feeble. There was no headache, and but slight soreness over the abdomen, though no point of marked tenderness. The bowels were much distended with gas so that their outline could be easily discerned through the abdominal wall. There was no dulness on percussion, but tympanitis everywhere. The urine was practically normal. Everything given by mouth distressed her, with the exception of 1/10-gr. doses of calomel and a small quantity of peroxid of hydrogen and "alkalol" in water. There had been no movement of bowels for four weeks, except as enemata were given, and the question that confronted us was whether the obstipation was due to some obstruction or paralysis of the muscular coat. The vomitus consisted of whatever might be taken, together with a tasteless and odorless frothy mucus. On November 5 there was no change in conditions, except that the patient was weaker and more easily exhausted. A saturated solution of sulphate of magnesia to the extent of twenty-four teaspoonfuls—a teaspoonful every ten minutes—was given with no result. Gentle massage over the bowels seemed to give relief. A large enema brought some fecal matter and gas. On November 9, when I saw her for the third time, the pulse was very rapid and the vital forces nearly exhausted, the temperature being 97, the pulse 132. There was no fecal vomiting, although the stomach refused to retain even water. There was no pain, except distress produced by distension of the bowels with gas and pressure against the diaphragm. Deeming the case *in extremis*, I advised against any operative measures. The patient died November 10.

Autopsy was held November 11, with Drs. Williams of Greene, Hitchcock of South Oxford and myself present. The body was very much emaciated and the abdomen tympanitic from the distended bowel. An incision extending from the ensiform cartilage to the symphysis disclosed no subperitoneal fat. The cecum and colon, ascending and transverse, were enormously distended with gas, the small intestine but slightly distended. At the junction of the transverse and descending colon there was a constriction five-eighths of an inch in length and three-quarters in diameter, which completely occluded the lumen of the bowel. On the gastric side of the obstruction there were five old cicatrices, probably from ulcers which had existed at some time, but were now only in evidence by their scars.

There was about one quart of liquid feces in the large intestine, and probably much more in the small, but there were no enteroliths larger than a pea and very few of these. On the mesenteric side of the constriction there was a firm band of adhesion, fan-shaped, with its broad extremity attached to the parietal peritoneum. Attempts to loosen this attachment caused the bowel to rupture on the gastric side of the obstruction. The bowels were emptied of gas and feces and the diseased portion excised. The liver was displaced to the left so that the left lobe lay entirely to the left of the stomach, and the right lobe lay directly on the stomach, as did the distended colon. The stomach was empty.

All the organs in the body were healthy and normal with the exception of the point described in the colon. This constricted part consisted of cicatricial tissue only, indicating that it was caused by ulceration and destruction of mucous and muscular coats of the bowel, and subsequent contraction.

The chief points to me are: 1. Why did we not get fecal vomiting? 2. Why did she not have either localized pain, tenderness or headache? 3. Why had this existing condition of incomplete closure not sooner become complete? 4. Should anything have been done for this patient in the line of surgical operation at the time I saw her?

My answer to these questions would be as follows:

1. The fact that the obstruction was so far removed from the stomach and the enormous size of the bowel beyond the ileocecal valve will in a measure account for our not getting fecal vomiting. Also the pressure of the liver and the colon on the stomach prevented the accumulation of any amount in the stomach, forcing it back by mechanical pressure and thus not only preventing the accumulation of food, but also acting as a cut-off for anything regurgitating from the bowels. Another thing is the length of intestinal tract available for absorption.

2. It would be conjectural to say why she did not have either pain, localized tenderness or headaches. My theory is that in the attack in September last, enough irritation was produced at the ulcerated point to cause inflammatory action sufficient to entirely close the lumen of the partially occluded gut, thus producing complete intestinal obstruction, but so low down in the bowel that absorption still took place. Her diet had been very simple and so little of it was retained after complete closure that there was not enough excrementitious matter to produce auto-infection. The real mischief, in my opinion, was done thirty-five years ago, hence there was no acute congestion or pressure on nerve filaments, but simply the discomfort caused by the great balloon in the abdominal cavity.

3. As to why this existing condition of almost complete closure had not sooner become complete, her history was that for the past three years her bowels had been more regular and her health much better, until the attack in September. Still, the same caution in regard to the diet had to be observed. Now why it did not sooner cause a wreck, no one knows.

4. As to whether anything should have been done in a surgical way at the time I saw her, I presume many would say a resection should have been made at once. But we should bear in mind that Dr. Williams had seen her but a few hours before I saw her, also for the first time. We had nothing but her history as given us, and she was then so weak that she would have to rest after every sentence and then the sentence had to be short. Her emaciation was marked and there was no vital energy stored up, the reserve, as the result proved, being nearly exhausted. Again, a median exploratory incision would not have given room to operate on the diseased portion, and the only way would have been to close the central incision and make an oblique incision parallel with the ribs on the left side, directly over the constricted portion of the bowel. This would have been a formidable undertaking under any circumstances, even with a large reserve of vital force to rely on for recovery. Still, I feel now that were I to meet a similar condition again, I would urge an exploratory operation.

THE EDITOR of the *N. Y. Christian Advocate*, Dr. Buckley, recently said that "Christian Science," as a system of therapeutics, would have died ere this if it had not been put forward as a religion; and it would have died as a religion if it had not been put forward as a system of therapeutics.

QUININ AMBLYOPIA.

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Mrs. S., with her boy, 3 years old, called at my office on Dec. 2, 1899, stating that her child had not been feeling well for the last few days, and that his bowels were very loose. The family history was negative, the child's complexion was sallow, with slight anemia, and a coated tongue. He looked dull and depressed and refused to answer any question, not taking any interest in his surroundings. Temperature per rectum was 98.8 F., pulse 106, respiration 38. His mother stated that his bowels moved about eight or ten times during the day, that he had no appetite, and had ceased to play as he once did.

I prescribed small doses of calomel followed by magnesium sulphate and an antidiarrheal and tonic mixture, put him on a liquid diet, told the mother that she must keep him in bed, and if he was not better to let me know.

On Dec. 3, at 9 a.m., I was called and found my little patient vomiting, with a flushed face, injected eyes, the surface of the body hot, and asking for water all the time. Temperature per rectum was 102 F., pulse 126, respiration 44. Thoracic and abdominal examination revealed a yellowish skin, enlargement of the liver and spleen, particularly the latter, and tenderness all over the abdomen.

The mother said that "the child felt very cold about an hour ago, and acted as if he would have had convulsions;" also that he complained of feeling cold before, and sometimes he shivered, but she did not pay much attention to it, thinking that it was due to the weather; she was unable, however, to say when he commenced to complain of feeling cold, and how often.

With the aid of the microscope I diagnosed it a case of malarial fever of the quotidian type. I ordered cool sponging and cold lemonade frequently, and prescribed the following:

R. Quininae sulph. 3
Syrup yerbæ santæ comp. 60
M. Sig. One teaspoonful t. i. d.

I ordered her, verbally, to give two teaspoonfuls the next morning, about 7:10 o'clock, after the child had taken some food; after that she was to follow the previous directions.

I called on December 4, about 2 p.m., and found my patient asleep, and being informed that he was much better and did not have any attack that morning, I left without making any further inquiry, promising to come earlier the next day. On the following day I saw him about 10 a.m., and was astonished to find him complaining of not being able to see, asking where he was and why they did not light the gas or the lamps.

On questioning the mother, I was told that she gave him two teaspoonfuls four times the previous day, and once on the morning of the same day, so that he had taken about 30 grains in twenty-four hours. On examination I found total blindness of both eyes. The ophthalmoscope showed a pale optic disc, and it was very difficult to make out the condition of the retinal arteries. I at once discontinued the quinin and prescribed strychnin, 1/200 gr. t. i. d. The patient recovered gradually, and on the fifth day, viz., on December 10, could see almost as well as he did before.

A similar case came under my observation during my service at the Lebanon Hospital, which history I will describe in brief: