organism was found either in the cultures made from the spinal fluid or in any of the sections of the meninges.

Multiple Neuritis (Non-diphtheritic) in Children.—H. M. Thomas and H. S. Greenbaum (Jour. Amer. Med. Assoc., 1907, xlviii, 1397) have been able to collect and tabulate from the literature 138 cases of non-diphtheritic multiple neuritis in children. Measles was claimed to have been the cause in 8, whooping-cough in 7, scarlet fever in 6, and 27 were due to other infectious conditions; of 48 toxic cases 19 followed lead and 19 arsenic chorea; in 33 the cause could not be determined. The condition is usually considered as very rare, but the authors believe it to be less uncommon than usually thought. They have seen 10 cases; 7 were in girls and 3 in boys; the ages varied from 3 to 12. In 3 the cause was found to have been typhoid fever, in 2 lead, in 1 arsenic and chorea (fatal), and in 4 the cause could not be determined. The cases are reported in detail. It is seen that the symptomatology does not differ materially from that of the disease in the adult. Sensory disturbances are said to be difficult to determine, and when present do not persist very long; reactions of degeneration with atrophy are generally noted; the deep reflexes are lost during the height of the attack, but return during recovery. The paralysis is usually widespread and symmetrical, affecting both upper and lower limbs; the legs are generally more severely involved than the arms. The differential diagnosis from poliomyelitis is not always easy: multiple neuritis comes on more insidiously, its cause is often apparent, it rarely is associated with fever at the outset, objective disturbances are more common in neuritis, the paralysis is more widespread and symmetrical, and recovery is more common. The prognosis in multiple neuritis of children is usually good, but few deaths having been recorded.

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OBSTETRICS.

UNDER THE CHARGE OF

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Two Cases of Repeated Ectopic Gestation.—Kynoch (Jour. Obstet. and Gyn. Brit. Empire, December, 1906) has collected 585 cases of ectopic gestation, among which there were 34 cases of repeated extra-uterine pregnancy. No authentic case of ectopic pregnancy occurring three times in the same patient has yet been reported. The most frequent form of repetition is in the opposite tube.

Kynoch’s first case was that of a woman married fourteen years, and having six children without miscarriages. Menstruation had been regular except during pregnancy. The last normal menstruation was ten weeks before admission to the hospital, and for a month before coming under observation the patient had complained of intermittent
pain in the left iliac region, with irregular hemorrhage. The pain came on suddenly and was severe, and made worse by defecation.

On examination the uterus was somewhat fixed and displaced by a swelling in the left side of the pelvis. Under anesthesia this was made out to be about the size of an orange, and in the left broad ligament. It was considered a hematoma as the result of a ruptured tubal pregnancy, and operation was deferred to await absorption. After ten weeks in the hospital the patient left in good health.

She was again admitted to the hospital about eighteen months afterward complaining of pain in the right iliac region. A tender swelling was found at the right side of the uterus, and upon operation the right tube was found adherent, and removed. The left uterine appendages were also adherent, and there was thickness in the upper part of the broad ligament.

On examining the specimen removed decidual cells were found, establishing a diagnosis of ectopic gestation. The case proved to be a six weeks’ ectopic gestation in the left Fallopian tube, rupturing into the broad ligament and becoming absorbed in two months, followed eighteen months afterward by pregnancy in the right Fallopian tube.

The second case had at first an ectopic gestation upon the right side, treated by operation. The right tube was distended with blood clot, and was removed. The left tube and ovary were normal. The patient made a good recovery from operation and was subsequently delivered by forceps of a healthy male child.

Her second ectopic pregnancy developed about eighteen months afterward in the left tube, and upon operation a clot the size of an orange was found surrounding the fimbriated extremity. This was removed and the patient made a good recovery.

The Pathology of Cornual Gestation.—Lockyer (Jour. Obstet. and Gyn. Brit. Empire, December, 1906) describes a specimen obtained by Doran of cornual gestation ending in rupture. Microscopically the ruptured cornu was of nearly square shape, with a laceration extending the whole width of the upper border. The wall of the gestation sac varied greatly in thickness, the fetus lying in a closed amniotic sac, covered in places by adherent blood clot. The placenta in its formation was very diffuse. The fetal side of the placenta was smooth, represented by chorion from which the amniotic sac had been stripped during the expulsion of the fetus. The pedicle of the gestation sac was solid, containing large vessels with thickened walls.

Nothing resembling a uterine mucosa or basal decidua was found in the specimen. The villi of the chorion were planted directly on the uterine muscle by masses of Langhans’ cells. Where this came in contact with the muscle there was an inflammatory area mixed with cells of fetal origin, forming an infiltrating zone. Just beneath this the muscle was in cloudy swelling. The appearances were those of ordinary inflammation.

The walls of the pregnant cornu were thicker than the walls of a pregnant Fallopian tube. The eroding action of the ectodermal tissue could be very plainly studied. The placenta was attached to the whole surface of the sac wall, and rupture occurred through the upper pole where the rudimentary horn is thinnest. In such tissue there is no
retraction and relaxation, and hence the point of rupture. No vestige of normal glandular mucous membrane was found, and no decidua. The villi were dissecting the muscle layers, opening vessels and lymphatics. This resembled a malignant process with total absence of decidua. By repeated sections through a uterine gestation, it has been observed that the vesical of the embryo and its chorionic offshoots do not approach the muscular tissue of the uterus. In the gravid cornu the villi attach themselves directly to the muscular tissue by clusters of the ectodermal cells; while in the normal uterus the ovum is embedded in mucous membrane, in the rudimentary horn, the ovum seeks nutrition directly from the muscle. If the horn of the uterus be well developed the pregnancy will go to full term; if feebly developed, the muscular wall will rupture. The weakest point in the muscle wall against invasion by fetal ectoderm is found by microscopic study to be the vessels. This is illustrated by microscopic drawings. The muscle fibers fail to form a compact decidua, the characteristic decidua being never evolved from muscle cells. After the rupture of the cornual sac the thinned-out muscular tissue is thrown into convolutions, the clefts of which are filled with fibrinous material from lymph and blood clot. The muscular convolutions form before rupture and are caused to rupture by the contraction of the muscular tissue. Over the weakest point in the gestation sac was found a covering of lymph with extravasated blood. This had probably exuded before the escape of the ovum. The latter occurred during the examination of the patient in the clinic by bimanual palpation. This has repeatedly happened in the experience of other observers.

Ectopic Gestation at Full Term, with Abdominal Section.—Tate (Jour. Obstet. and Gyn. Brit. Empire, December, 1906) reports the case of a patient admitted to St. Thomas' Hospital in her first pregnancy. Some time previously, when about three months pregnant, the patient had an attack of severe pain in the lower abdomen, continuing for several days, and in a lesser degree for about a month. This pain returned, and the patient was in bed about two months. During the early part of the day, while in pain, blood clots were passed from the vagina. Since leaving her bed the patient felt weak, with abdominal pain, and the abdomen increased in size. Fecal movements were recognized for about six weeks, and then ceased.

False labor developed, which subsided, recurring a month later. As normal labor did not develop, the patient went to the hospital, where a diagnosis of ectopic gestation was made.

On examination, the fetus could be plainly felt, made out in an abdominal tumor, extending about two inches above the umbilicus. The uterus could be recognized as not in the tumor, and the fetal heart could not be heard. On abdominal section the dead fetus was found free in the peritoneal cavity. The omentum and intestines were stained with meconium; the cord extended to a large elastic swelling in the lower abdomen, formed by the placenta, Fallopian tube, and broad ligament. This mass was removed entire by a series of ligatures, and vessels, in addition, were tied. There was considerable hemorrhage during enucleation of this mass. The patient was given intravenous saline transfusions and at once improved. She ultimately made a
right broad ligament. A large placenta in a partially broken down condition was found.

This case illustrates how difficult it is to trace the entire sac of an abdominal pregnancy, and how persistent is the circulation in these cases when active hemorrhage occurs six weeks after the death of the foetus. Cultures taken from the sac were practically sterile.

Full-term Pregnancy in a Bicornate Uterus, with its Removal.---ROBERTS (Jour. Obstet. and Gyn. Brit. Empire, December, 1906) reports a remarkably interesting case in which a foetus went to term in a rudimentary horn of a bicornate uterus. The foetal sac did not rupture; the foetus died and was retained in the abdomen for six months. During this pregnancy the patient was almost as well as usual, complaining of very little except the inconvenience caused by the tumor. Upon operation the tumor was covered by adherent omentum. It had a grayish-brown appearance, often seen in ovarian cysts which are degenerated. In trying to lift up the tumor the adhesions had to be separated. Its attachments or base were the left tube and ovary, where good-sized vessels had to be divided before the tumor could be removed. The right tube and ovary were normal. The pedicle of the tumor was the remains of the left tube and a portion of the broad ligament. The patient made a good recovery.

A similar case is reported by Mauriceau. In describing it Mauriceau distinguished plainly between tubal and cornual pregnancy, basing his distinction on the relations between the round ligament and the gestation sac. The condition was discovered at an autopsy in the seventeenth century, in a woman who died suddenly after abdominal pain, which was intense for three days.

OPHTHALMOLOGY.

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Hereditity in Myopia.—WORTH (Brit. Med. Jour., February, 1906) analyzes 687 cases of myopia, of which 33 were malignant, with reference to heredity. This factor was present in 56 per cent. of the non-malignant, and in only 24 per cent. of the malignant cases. In one family all the males were myopic, the females not, but it was through the latter that the myopia was transmitted. All the non-myopes had blue irides, the myopes brown. Of the 374 hereditary cases the parents were affected in 159; in the remainder it was the uncles, aunts, and grandparents who were myopic.