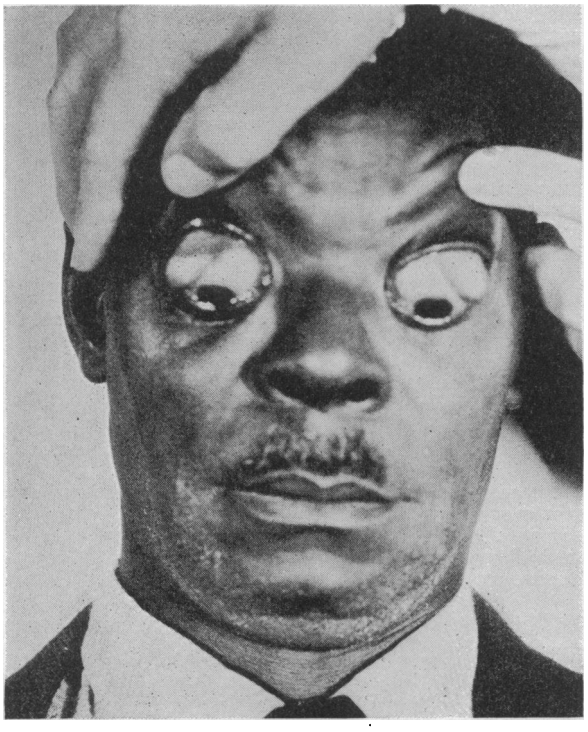

Fig. 1.—Subconjunctival tumor in right and left eyes.

ish subconjunctival mass about the size and shape of a forefinger tip extending downward and medially, from the lower margin of the lachrymal glands to a point one and one-half centimeters from the limbus. The upper and outer margins were not visible, apparently extending back into the orbit. The right cornea was roughened and stained slightly with fluorescin. The fields were normal. The fundi were fairly well seen and were normal.

The Hertl exophthalmometer showed: R. 22, L. 20.

Blood and urine negative.

Basal metabolism: Plus 23.

Pulse: 70, regular. B. P. 124/72.

Course.—November 23, 1937: The right tumor mass was dissected out without difficulty. The mass was a comparatively nonvascular, yellowish tumor, one and one-half centimeters wide and two centimeters long. It extended a narrow pedicle into the orbit. Biopsy showed fatty tissue only.

December 4, 1937: The left was operated upon with similar findings.

December 14, 1937: Both conjunctival wounds were well healed. The weeping had stopped and the patient was comfortable. The corneae were clear, showing no staining reaction with fluorescin.

February 3, 1938: Vision—Right, 20/30; left, 20/20. Distance vision not improved with correction.

With the exophthalmometer the right eye showed 22 mm., the left 20. The patient was delighted with the improvement in his appearance.

576 Hartnell Street.

HYPEREMESIS GRAVIDARUM: NOTES ON TREATMENT

By William Buster McGee, M.D.
San Diego

THE treatment of vomiting of pregnancy has changed very little in the past few years, in spite of the fact that there have been many advances in our knowledge of the vitamin and hormone deficiencies. Probably vitamins B1 and G are involved more than any of the others. As a whole, the use of female sex hormones has been very disappointing, with the possible psychic effect of hypodermic injections.

We have divided hyperemesis gravidarum into four clinical groups and, depending on the severity of the case, we decide which form of treatment is to be used. No routine procedure can be successful, as each is an individual problem. The serious cases are started, for about two days, on the severe regimen, intravenous and subcutaneous fluids, with nasal tube feedings, on the third and fourth days, then fifth and sixth days on the vomiting diet, and on the seventh and eighth days a dry diet. The patient may be started on any of the four diets; and, depending on her reaction to the therapy, it may be worked either forward or backward.

I. MILD TYPE

Carbohydrate, 400; protein, 50; fat, 25.

Omit liquids one hour before and one hour after meals.

Six a. m. and midnight feedings.

Dry toast or crackers before rising.

Sweetened fruit juices between meals.

Ferrous sulphate, grains five, after meals, if anemic.

Phenobarbital, grains three-fourths, morning and evening.

II. MODERATE TYPE

Carbohydrate, 400; protein, 50; fat, 0.

Dilute HCl, fifteen drops, before meals, if gastric analysis shows low reading.

If pulse is over 90, Lugol's solution, five drops after meals.

Phenobarbital, grains three-fourths, given with liquids, three times a day.

Substitute dicalcium phosphate and A B D capsules for milk.

No coitus allowed.

Daily enema, if necessary, for constipation.

Diet for Moderate Type

1. Take solid food at 8 a. m., 12 noon, 4 p. m., and 8 p. m.
2. Take liquids at 10 a. m., 2 p. m., 6 p. m., and 10 p. m.
3. Take any medication with liquids.
4. No fat or greasy foods.
5. Solid foods:

(*a*) Stewed fruits, with plenty of sugar.

(*b*) Cooked or dry cereal, with plenty of sugar.

(*c*) Toast, crackers, corn bread, Graham muffins, whole-wheat bread, with preserves, honey, jelly, molasses.

(*d*) Lean meats, crisp bacon or ham, cheese, hard-boiled eggs; sandwich with toasted bread (no butter or mayonnaise).

(*e*) Baked, mashed or boiled potatoes, baked sweet potatoes, macaroni, spaghetti (plain), rice.

(*f*) Fresh, raw vegetables, such as lettuce, tomatoes, celery, and radishes.

(*g*) Raw fruits, such as bananas, oranges, apples, lemons, and grapefruit.

(*h*) Cooked vegetables, spinach, asparagus, peas, white onions, cauliflower, carrots, beets, corn, and beans.

(*i*) Gelatin, jello, custard, prunes, tapioca, ice cream, and fruit ices.

6. Liquids: Fruit juices (orange, lemon, pineapple, grapefruit), coco-cola, skim milk, tea, ginger ale, and water.

III. MODERATELY SEVERE TYPE

Hospitalize.

Physical and pelvic examination.

Blood count and urine examination (acetone and diacetic acid).

Darkened room and no visitors (including husband).

Absolute bed rest.

Daily enema.

Temperature, pulse, respiration, every four hours.

Measure intake and output.

Insert Levine nasal tube into the duodenum at 7 a. m., which may be removed at 10 p. m.

Make up a formula as follows:

Tube-Feeding Formula

Milk	800 cc.
Lactose	200 gm.
Eggs	4
Peptone	24 gm.
Salt	5 gm.
Cevitamic acid	50 mgm.
Cod-liver oil concentrate	20 drops
Vitamin B1 crystals	2 mgm.

One hour after the tube has been inserted start formula as a slow continuous drip. If vomiting occurs, reinsert tube and wait one hour, with the patient on right side before starting drip. Give phenobarbital, dilute HCl, or Lugol's solution, if indicated, through the tube. Maintain the fluid intake up to 3,500 cubic centimeters per day by hypodermoclysis of normal saline or Ringer's solution; or, if acetone and diacetic acid in the urine, 20 per cent glucose by intravenous drip. The glucose may be covered with insulin.

IV. SEVERE TYPE

Nothing by mouth, except small amount of cracked ice. Bed rest; temperature, pulse, respiration, every four hours. Measure intake and output. Transfusion, if hemoglobin is 70 per cent or less, sodium phenobarbital, grains four, hypodermic, then two grains every six hours until drowsy; then every eight hours for two days. Sodium bromid crystals, 75 grains in 100 cubic centimeters of starch water, as a retention enema, the first night. Give 1,000 cubic centimeters 20 per cent glucose infusion twice daily, over a period of ninety minutes. Get CO_2, urea and NaCl blood chemistry at the time of the infusion each morning; 1,000 cubic centimeters of normal saline by hypodermoclysis twice daily, alternating between subpectorally and in the thighs, always several hours, after the glucose. (Use procain wheal.) Hartman's solution may be added if acidosis or alkalosis is present. Daily urine examination for acetone and diacetic acid. Eye-grounds examination. If no improvement, interruption of the pregnancy should be considered.

233 A Street.

SULFANILAMID: A SPECIFIC FOR THE FRIEDLANDER BACILLUS

By PHILIP KING BROWN, M.D.
San Francisco

ONE case can rarely be considered the ground for drawing so definite a conclusion as the title indicates, but the history of the case makes it remarkable.

REPORT OF CASE

Miss B. K. had her tonsils removed in February, 1917, following which she developed a condition in the right lung which proved later to be an abscess. The abscess was in about the middle of the right lung field toward the back, and was considered to be in the upper part of the right lower lobe. Pleurisy developed under the right shoulder blade. Partly to relieve that pain, and because the abscess did not drain well, the use of a small pneumothorax was attempted successfully, and it was found promptly that the abscess both discharged better and there was no tendency to spread. A moderate pneumothorax was kept up until all discharge ceased, and the lung field seemed to be definitely clearing. The nature of the infecting organism was not determined.

Following the expansion of the lung there developed a slight cough and expectoration, and a lipiodol injection showed that there was a definite dilatation of the large bronchus extending from the middle of the hilus, definitely toward the back in the vicinity of the shoulder blade. The use of the lipiodol relieved the green expectoration for a considerable period of time, although it did not disappear entirely. A fresh cold would increase the amount from one to two drams a day to several ounces. On numerous occasions this was cultured, and a pure growth of Friedlander bacillus was found. In the seventeen years which followed the abscess there continued constantly to be a small amount of expectoration when the patient was quite well, which was increased decidedly following every cold, and was not relieved until lipiodol was put into the dilated bronchus. There continued to be a slight increase in the pain under the lower end of the right shoulder blade.

The patient all these years worked as a private secretary, but was constantly annoyed by the sweetish-green expectoration which showed so ready a tendency to increase with every slight cold.

In the summer of 1937, after a severe cold, she was instructed to spend two weeks at an elevation of 2,500 feet in a hot, dry locality, doing all she could with postural drainage and iodid of potash. At the end of a week no material benefit having resulted in the way of lessening the amount of expectoration, which was between two and three ounces a day, she was instructed to take sulfanilamid in the following doses: 30 grains the first day, 45 the second, and 60 the third, dropping back to 45 grains, and 30 on the fifth day. At the end of the third day there was absolutely no expectoration, and the pain in her back disappeared. She kept in touch with me, although several hundred miles away, and was instructed to continue taking small doses for a while longer.

Six months have gone by and there has been no evidence whatever of any return of the expectoration. She has had several slight colds, but has promptly taken small doses of sulfanilamid, and none of them have resulted in the productive cough.

COMMENT

The case is reported because the cultures were made by Dr. A. M. Moody, pathologist of the Saint Francis Hospital, during all this period. The result was so absolutely clean-cut that it seems to the writer worth putting on record.

We have since tried the drug once on an arrested case of tuberculosis, with a left upper thoracoplasty which had not completely stopped the productive cough. Friedlander organisms predominated in the sputum and no tubercle bacilli have been found for years. A cautious trial of sulfanilamid was made after a fresh cold which increased the amount of sputum, and again a remarkable drop in the amount resulted at once. As the tendency to the production of fibrosis is one of the characteristics of this organism, the problem presented itself as to whether the removal of one or two more ribs was a safer treatment than continuing the use of this drug. The patient in the meantime was not pressed for any decision in the matter. The newspaper publicity about sulfanilamid disturbed him, and he had no great desire to undergo further surgery.

909 Hyde Street.

NECROPSIES IN HOSPITALS IN SAN FRANCISCO*

By J. C. GEIGER, M.D.
AND
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San Francisco

IT has been the custom for some years in certain of the large cities of the United States to survey and report the necropsies performed, together with the numbers credited to each hospital in that locality, and the percentage of permissions obtained. In order to make this information available for use in San Francisco, an effort was made at the beginning of 1937 to collect the necessary statistics with which to formulate a table presenting salient facts relating to necropsies.

* From the Department of Public Health, City and County of San Francisco.